I. OVERVIEW

A. Unmet needs of patients with mental health challenges.
B. Vulnerabilities of this population.
C. Role of antipsychotic drugs in caring for patients with mental health needs; impact of opioid crisis and orthodoxy in care establishment.
D. Need for mental health assessment, capacity determination, and integration of mental and physical health care.
E. Role of electronic medical record in preventing adverse drug interactions.
F. Federal and state public policy implications of mental health crisis.

II. UNMET MENTAL HEALTH NEEDS

A. Data re Incidence– sources: Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), National Alliance on Mental Illness (NAMI)

1. One in two Americans will develop mental illness over his/her lifetime.
2. Associated with heart disease, obesity, cancer, and substance abuse; treating mental illness can reduce symptoms.
3. In 2009, 11 million Americans suffered from a serious mental illness. 8.4 million had suicidal ideation, 2.2 million had a suicidal plan, and 1 million attempted suicide.
4. One in six Americans living in poverty suffers from severe mental illness; without access to treatment, they have difficulty finding work, do not qualify for disability benefits, and cannot obtain employer-provided health insurance.
5. 50% of those with lifetime chronic mental illness have onset of symptoms by age 14; 75% have onset by age 24. (NAMI).

6. Average delay between symptoms and start of treatment is 8-10 years.

7. Incidence of mental disorders (NAMI):
   (a) 2.4 million (1%): Schizophrenia
   (b) 6.1 million (2.6%): Bipolar disorder
   (c) 16 million (6.9%): Depression
   (d) 42 million (18%): Anxiety
   (e) 6 million (2.6%): Dementia
   (f) 2.6 million (1%): Substance Abuse


1. Data – Costs; Impact on Workforce, Lost Productivity
   (a) Untreated mental illness costs the U.S. $100 billion per year in lost productivity. (NAMI)
   (b) Care of patients with diabetes mellitus (DM) and depression costs 4.5 times more than care of those with DM alone.
   (c) Back pain + depression results in twice as many sick days as back pain alone.
   (d) Oregon's elimination of mental health insurance resulted in spike in emergency room admissions for mental health. (NAMI)
   (e) Total bill for dementia care in 2017 is projected at $259 billion. There are 11 million (mostly unpaid) caregivers for dementia.

C. Access to Affordable Medical Care for Mental Health Needs: See Appendix A

III. VULNERABILITIES OF PATIENTS WITH MENTAL HEALTH ISSUES

A. Increased sexually transmitted disease, unplanned pregnancies, child neglect (second generation harm).

B. Incarceration (NAMI)
   1. 70% of youth in juvenile justice system have a mental illness.
   2. In US, incidence of severe mental illness is ten times higher in prisons than in state psychiatric hospitals.
   3. 356,000 Americans with severe mental illness are imprisoned at a total cost of $11 billion per year. (Treatment Advocacy Center)
      (a) Study of 132 suicide attempts in a county jail -- 77% had chronic mental illness v. 15% in rest of jail population.
4. 15% of State prisoners and 24% of jail inmates have a psychiatric disorder. (DOJ)


C. Financial Abuse; Undue Influence
1. Definition of undue influence in (in California): "excessive persuasion that causes another person to act or refrain from acting by overcoming that person's free will and results in inequity" (California Welfare and Institutions Code §15610.70(a)).

2. Victims' risk factors: loneliness, isolation, assets, cognitive decline, loss, media.


D. Untreated Pain
1. Leads to stress, depression, agitation, death resulting from increased cortisol, decreased sleep, anger, and if person has dementia, agitation leading to treatment with psychoactive medications.

E. Common Untreated Medical Conditions – seniors
1. Osteoporosis, gait abnormality, stroke risk

F. Overmedication; Adverse Drug Interactions; “Poly-pharmacy”
1. Too many doctors; too many specialists.
2. Too many prescriptions: often 6+ (and possibly 12-20) meds/day.
3. Poor medication management: primary care provider not likely to advise specialist to stop or change meds that specialist prescribed.
4. Medicating for behavior: Overuse of “anti-anxiety” or “sleep” meds leads to more agitation, confusion, and falls.
   (a) Aggression
   (b) Anxiety
   (c) Depression
   (d) Wandering
   (e) Not eating

5. Over-the-counter medications
   (a) Use is not reported.
   (b) Can cause negative interaction with other medications.
Can include anticholinergics (Tylenol PM, allergy pills, bladder
pills); sleeping medications; alternative medications: herbs,
Eastern meds, “as-seen-on-TV” meds.

6. Why is this so dangerous?
   (a) Increased risk of falls, fractures and head injuries if sedated
   (b) Drug interactions
   (c) Hypotension
   (d) Falls
   (e) Increased bleeding risk
   (f) Agitation

IV. ROLE OF ANTIPSYCHOTIC DRUGS; OPIOID CRISIS; ORTHODOXY RE: ADDICTION

A. Antipsychotic Drugs
   1. Common drugs include Haldol, Seroquel, and Risperdal.
   2. Indicated uses: severe delirium, aggression, or delusions causing great
distress.
   3. Adverse side effects: 2% increased stroke risk and 1% increased sudden
death risk.

B. Opioid Addiction
   1. Social and economic issue; not just a medical issue.
      (a) Heroin use doubled among young whites from 2000 to 2013 (non-
          Medicaid beneficiaries). (CDC)
   2. Treatment programs, employment opportunities, and education are most
effective in combating addiction. States most severely affected are often
in economic decline. (CDC)

C. Challenging Orthodoxy in Care Establishment
   1. Seniors may not be at same risk for addiction as youth; seniors with
   severe pain tend not to escalate dose of narcotics. (CDC)
   2. Must consider impact of untreated pain and symptoms in a controlled
environment.

V. NEEDS FOR ASSESSMENT, CAPACITY DETERMINATION, INTEGRATED CARE

A. Capacity
   1. What is it?
      (a) Medical definition: Ability to give informed consent, understand
the risks and benefits of a course of treatment.
(b) Distinction from legal competency, which (in the civil context) focuses on ability to enter into a contract or transaction.

(c) Consider cognitive changes in seniors.
   (i) Short-term memory starts to decline in early thirties.
   (ii) However, normal aging does not include a decline in memory, judgment, spatial ability, abstract reasoning, or risk assessment to the point that it interferes with independent activities of daily living (IADLs).

2. Testing for Capacity: Options
   (a) Cognitive tests: Mini Mental Status Exam (MMSE), Montreal Cognitive Assessment (MoCA), St. Louis University Mental Status Exam (SLUMS), Mini-Cog assessment; abstract problems (e.g., 25% of $22.50, 11:10 clock draw).
   (b) Neuropsychological testing.
   (c) Medical exam - ruling out Vitamin B12 deficiency, thyroid abnormalities, blood pressure, blood sugar, brain tumor.
   (d) Review of medications - sleeping pills, “anti-anxiety” drugs, anticholinergics, antipsychotics, Parkinson’s meds, seizure meds. Sedatives can impair alertness, cognitive abilities; can give appearance of dementia.

B. Integrating Care – Recommendations:
   1. Consultation with mental health specialist, geriatrician (if applicable).
   2. Possible change in doctors.
   3. Adjustment of or reduction in medications.
   4. Education of family, caregivers.
   5. Interdisciplinary team approach to care: caregivers, family, friends, professionals.
   6. Holistic approach to mental and physical care needs.
   7. Awareness of any addictive tendencies.
      (a) Potential involvement of APS, Ombudsman, fiduciary, attorney.

VI. ROLE OF ELECTRONIC MEDICAL RECORD
   A. “Central clearinghouse” for health care visits, diagnoses, prescriptions, etc.
   B. Can be useful tool in preventing or minimizing adverse effects of polypharmacy.
C. Do primary care providers defer to prescriptions ordered by specialists?
D. More geriatric and mental health education is needed for all medical disciplines.

VII. FEDERAL AND STATE POLICY IMPLICATIONS
A. Recognition of opioid problem; federal priority
   1. 21st Century Cures Act (2016) earmarked $1 billion in grants (over 2 years) to states and territories for opioid abuse treatment and prevention.
   2. CDC reported 59,000 opioid deaths in 2016.
   3. President declared a public health emergency on October 26, 2017.
      (a) Not a national emergency.
      (b) Designation expires after 90 days if not renewed.
      (c) Focus is on expanded telemedicine, expedited hiring of medical specialists, and education about safe prescription practices.
      (d) Funding for dislocated workers, people w/HIV/AIDS can be used to treat their addictions; commission is exploring Medicaid waiver.
      (e) Question remains about adequate funding of addiction treatment
B. Mental Health First Aid education campaign.
C. De-stigmatization of mental health needs.
D. Improved benefits for mental health care, integrated care, follow-up care.
   1. Start with Medicaid? Medicare? Employer-provided insurance?
E. Increased focus on adolescents, youth.
F. Interdisciplinary team model.

VIII. RESOURCES
A. Nat'l Alliance on Mental Illness (NAMI):  www.nami.org
   1. See Mental Health Facts (children and teens, multicultural).
B. Centers for Disease Control and Prevention (CDC):  www.cdc.gov/mentalhealth
C. Office of Justice Programs, Bureau of Justice Statistics (BJS):
   www.bjs.gov/index.cfm?iid=789&ty=pbdetail
D. Substance Abuse and Mental Health Service Administration (SAMHSA):
   www.samhsa.gov
E. Mental Health First Aid:  www.mentalhealthfirstaid.org
F. Treatment Advocacy Center:  www.treatmentadvocacycenter.org
Appendix A
Access to Affordable Medical Care (2014)