Mission:
To provide opportunities for professional, consumer and government organizations to work together towards improving the availability and quality of mental health preventive and treatment strategies to older Americans and their families through education, research and increased public awareness.

Visit: www.ncmha.org
History, Membership and Activities:

- Formed in 1991 by a group of organizations from the aging and mental health fields
- Comprised of 100 national and state associations, state coalitions, and governmental agencies, e.g., SAMHSA and ACL.
- Co-sponsor events to highlight challenges of mental health and aging
- Identify new approaches to addressing problems.
NCOA: Who We Are

We believe every person deserves to age well

OUR VISION
A just and caring society in which each of us, as we age, lives with dignity, purpose, and security

OUR MISSION
Improve the lives of millions of older adults, especially those who are struggling
NCOA’s Center for Healthy Aging

- **Goal**: Increase the quality and years of healthy life for older adults and adults with disabilities

- **Two national resource centers funded by the Administration for Community Living**
  - Chronic Disease Self-Management Education (CDSME)
  - Falls Prevention

- **Other key areas**: Behavioral health, physical activity, immunizations, oral health
Webinar Series on “Addressing Disparities in Behavioral Health Care for Older Adults”

- Following the May 20th National Older Adult Mental Health Awareness Day (OAMHD) events, NCMHA developed a plan to collaborate with interested government agencies, private sector groups, and experts to maintain the momentum and recommendations generated from OAMHD.

- A series of webinars during 2019/2020 that target specific topics with a practical focus and accompanying tools/resources to address the needs of older adults with mental health conditions, as well as state/local efforts/best practices.

- A special feature of the webinars will be that the sessions will coincide with monthly, weekly and daily national mental health or aging observances.
Key Objectives of the Webinar Series

• Identify specific approaches that address disparities in behavioral health care for older adults

• Ensure that older adults with mental health and addiction-related conditions are integrated within all MH awareness raising, policy, programmatic and research efforts going forward.

• Raise awareness among primary care, mental health, other health service providers and the aging network about the impact of suicide, opioid use, and interrelated problems, and impact provider practice patterns for older adults.

• Identify specific tools such as geriatric assessment, questions – suicide ideation, firearm presence, opioid use and other screening tools – and detailed guidance.
Webinar Series Roll Out – 2019-2020

July 23, 2019 (2:00 PM EDT) – National Minority Mental Health Month
“Integrating Culturally Relevant Mental Health Services in Primary Care Medicine for Older Adults (Co-sponsored by the Amer. Psychological Assoc.)

August 21 (12:00 PM EDT) – Senior Citizen’s Day
“Prevention and Health Promotion for Late-Life Mental Health Disorders”

September 18 (12 PM EDT) – Suicide and Healthy Aging Month
“Strategies for Reducing Suicide in Older Adults”

October 10 (2:00 PM EDT) – World Mental Health Day
“Home & Community-Based Mental Health Services: Meeting the Needs of Older Adults”
Webinar Series Roll Out – 2019-2020

November 13 – Family Caregivers and Alzheimer’s Awareness Month
“The Invisible Health Care Provider: Family Caregivers of Individuals with Dementia”

January 23, 2020 (12:00 PM EST) – Mental Health Wellness Month
“Solutions to Behavioral Health Workforce Shortages & Lack of Funding”

February 27 (2:00 PM EST) – Eating Disorders and Mental Health Month
“Bridging the Science-Practice Gap: Potential Opportunities for Geriatric Mental Health”

March 26 (3:00 PM EDT) – National Brain Injury Awareness Month
“Traumatic Brain Injury and Mental Illness Among Older Adults: The Problem and New Management Approaches”
Today’s Webinar on “Senior Citizen’s Day”

“Prevention and Health Promotion for Late-Life Mental Health Disorders”

Presenter: Amanda Leggett, Ph.D.

Dr. Leggett is a Research Assistant Professor in the Program for Positive Aging and Geriatric Psychiatry Section of the Psychiatry Department, at the University of Michigan
Prevention and Health Promotion for Late-Life Mental Health Disorders

Amanda Leggett, PhD
Research Assistant Professor
Department of Psychiatry, Geriatric Psychiatry Section
1. Why prevention?

2. Prevention terminology

3. Risk and protective factors

4. Pharmacological prevention

5. Psychological prevention

6. Other forms of prevention and intervention

7. Conclusions and future directions

An ounce of prevention is worth a pound of cure

*Benjamin Franklin*
Why prevention?
PKU (Phenylketonuria)

• An intellectual and seizure disorder

• Early diagnosis and special diet can lead to normal lifespan and mental development
But what about mental disorders?
Depression is prevalent in older adults

6-10% in primary care settings

30% in medical and long-term care settings

(Hindi et al., 2011)
Subsyndromal states may be more reversible
Leading cause of years lived with disability worldwide

Mental and substance use disorders

(Whiteford et al., 2013)
Excess mortality after myocardial infarction, stroke and cancer

Depression results in
(Hindi et al., 2011)
Especially in older white men

Major risk factor for suicide

(Van Orden & Conwell, 2011)
Shrinking number of specialty geriatric mental health providers
Importance of prevention: Reducing other downstream negative outcomes

- Cognitive decline
- Better pain control
- Caregiver burden
- Cardiovascular and cerebrovascular health
- Healthcare costs
Prevention terminology
Caplan’s (1964) public health framework:

**Primary**
- Prevent disease before it occurs

**Secondary**
- Reduce impact of a disease
  - Early detection and intervention

**Tertiary**
- “soften” impact of chronic illness/problem and delay disability
Gordon’s (1987) framework (adopted by the Institute of Medicine):

- **Universal**: aimed at an entire population
- **Selected**: target those at high risk
- **Indicated**: focus on individuals who already show early signs or symptoms of a disorder
Prevention conundrum

If individuals in the control group do not develop the clinical disorder at a certain rate, difficult to see effect in the intervention group without a very large sample size.

Statistical significance
Risk and Protective Factors
Risk factors - associated with increased likelihood of a negative outcome
- Early childhood adverse events
- Low SES
- Insomnia
- Stress
- Disability
- Isolation
- Bereavement

Protective factors - associated with lower likelihood of negative outcome
- Social support
- Self-efficacy
- Higher income
- Mature coping style
- Mastery

Individual, family, community level
Potential Brain Mechanisms for Preventative Strategies in Dementia

Pharmacological prevention
Preventing relapse

• Reynolds et al. (2006): adults (age 70+) who recovered from MDD and then received two years of paroxetine (Paxil) were less likely to develop a new episode of MDD
Following medical crisis

- **Robinson et al. (2008):** Adults (age 50-90) who had suffered a stroke in the past 3 months; a 12-month trial

<table>
<thead>
<tr>
<th>Escitalopram</th>
<th>Problem-solving therapy (PST)</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.5%</td>
<td>11.9%</td>
<td>22.4%</td>
</tr>
</tbody>
</table>

NNT = 8
Limitations of Pharmacological Prevention

- Results are mixed

- Ethical concerns- prescribing without diagnosed disorder?

- Less effective for mild symptoms

- Side-effects (e.g. fall risk, cognitive impairment)

- Older adults already take many medications

- Non-pharmacological treatment preferred by older adults
Psychological intervention
Cognitive Behavioral Therapy Approach

targets dysfunctional thoughts and levels of activity, aiming to restructure one’s thoughts and ultimately change behavior.
“Coping with Stress” Course

in nursing home residents with SSD
(13 sessions over 7 weeks)
(Konnert, Dobson and Stelmach, 2009)

Baseline to 6 months post-treatment

Scores on the Geriatric Depression Scale declined significantly and were significantly better compared to the control group

No significant improvement on CES-D and DASMIE scales
Problem Solving Therapy (Rovner & Casten, 2008)

6 hour-long sessions across 8 weeks that targeted non-depressed individuals with macular degeneration.

At 2 months the experimental group had half the incidence rate of depression compared to the control group (11.6% vs. 23.2%).

No differences in incidence at 6 months; however, activities were better maintained in the experimental group.

targeting inaccurate appraisals of problems and teaching skills to solve these problems adaptively.
Other forms of prevention and intervention
Stepped Care

- Van’t Veer-Tazelaar et al. (2009) older adults (75 yrs or older) in primary care over three 4-month periods

- Watchful waiting

- Bibliotherapy (Coping with Depression) with nurse visit and follow-up

- 7 session Problem Solving Therapy

- Primary care referral for antidepressant treatment

Reduced odds of developing an anxiety or depressive disorder by half over a year .12 vs .24
Care management & Suicide Prevention (Alexopoulos et al., 2009)

- Primary care patients (age 60+) with minor or major depression
  - Care Managers gave recommendations to physicians and helped patients maintain treatment adherence
- More likely to receive antidepressant and/or psychotherapy (85-89% vs 49-62%)
- 2.2 times greater decline in suicidal ideation
Internet based

- Spek et al. (2008) adults 50 and over with SSD; 10 week Coping with Depression group Course vs. 8 session Internet-based CBT self-help vs. Wait list control
  - 62% of internet based below threshold
  - 45% of group CBT below threshold
  - 38% of waitlist control below threshold
Light therapy

• Re-Timer (30 mins a day for 2 weeks older adults with SSD and poor sleep quality)

• Feasibility and acceptability
  • 91% reported it very easy to use
  • 93% adhered to the intervention
  • 64% would continue to wear
  • No adverse events

Depressive symptoms declined and self-reported sleep improved significantly

(Leggett et al., 2018)
Brief Behavioral Treatment of Insomnia (BBTI): Education about sleep regulation, what influences sleep, behaviors that inhibit or promote sleep

- Germain et al. (2006) 60+ yrs with diagnosed insomnia
  - Spend only the amount of time in bed one expects to sleep
  - Wake up at the same time each day
  - Only go to bed when sleepy
  - Get out of bed if not sleeping

- Improved: nighttime awakenings, sleep latency, quality, and efficiency, anxiety and depressive symptoms
Reminiscence and Life Review

- **Pot and colleagues (2010):** 50 to 90yrs with SSD; 12 two-hour sessions vs. control group which watched a successful aging video
- Discuss life experiences, sensory recall, etc.
  - Houses the individual lived in or smells from one’s past
  - Significant improvement in depressive symptoms relative to control group
    - Not anxiety- both groups improved
- Meta-analysis: reduced depressive symptoms in those with SSD (d-0.37) (Bohlmeijer et al., 2003)
“Exergame” Intervention

• **Rosenberg et al. (2010):** 12 week Nintendo Wii Sports in older adults with SSD (three 35 minute sessions a week; no control group).
  • Depressive symptoms significantly declined
  • Reduction maintained at 24-week follow-up
    • 37% of participants’ symptom scores declined by 50% or more
  • Anxiety scores declined across the intervention, but not significantly
The Silver Song Club
A health promotion example

- Coulton et al. (2015): 14-week 60+ yrs choral intervention (90-minute rehearsals) vs. a normal activity control group

- 6 months: had significantly improved mental-health related quality of life scores (Mean difference= 2.35)

- Cost effective
Social activities - easy to implement, high impact

(Forsman et al., 2011)

<table>
<thead>
<tr>
<th>Type of intervention</th>
<th>Number of participants in comparison (depression/quality of life/functional level/positive mental health/life satisfaction)</th>
<th>Depression</th>
<th>Quality of life</th>
<th>Functional level</th>
<th>Positive mental health</th>
<th>Life satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical exercise</td>
<td>237/296/53/185/0</td>
<td>-0.10 (-0.36 to 0.16)</td>
<td>-0.33 (-0.83 to 0.17)</td>
<td>-2.40 (-8.16 to 3.36)</td>
<td>0.03 (-0.67 to 0.73)</td>
<td>Not estimable</td>
</tr>
<tr>
<td>Skill training</td>
<td>318/72/0/64/0</td>
<td>-0.12 (-0.56 to 0.32)</td>
<td>-0.28 (-0.76 to 0.20)</td>
<td>Not estimable</td>
<td>-0.55 (-1.07 to -0.04)</td>
<td>Not estimable</td>
</tr>
<tr>
<td>Reminiscence</td>
<td>145/18/35/44/126</td>
<td>-0.24 (-0.62 to 0.13)</td>
<td>-0.01 (-7.50 to 7.48)</td>
<td>0.03 (-5.35 to 5.41)</td>
<td>-0.47 (-1.34 to 0.40)</td>
<td>-1.02 (-2.02 to -0.02)</td>
</tr>
<tr>
<td>Social activities</td>
<td>167/178/0/141/26</td>
<td>-0.41 (-0.72 to -0.10)</td>
<td>-6.40 (-10.38 to -2.42)</td>
<td>Not estimable</td>
<td>-1.02 (-2.02 to -0.02)</td>
<td>-1.40 (-1.65 to -1.15)</td>
</tr>
<tr>
<td>Multicomponent</td>
<td>387/756/62/120/124</td>
<td>-0.16 (-0.41 to 0.10)</td>
<td>-0.09 (-0.24 to 0.06)</td>
<td>Not estimable</td>
<td>-1.30 (-2.86 to 0.26)</td>
<td>-0.12 (-0.75 to 0.51)</td>
</tr>
<tr>
<td>Heterogeneity ($Q_b$)</td>
<td>$Q_b = 5.50, p &gt; 0.05$</td>
<td></td>
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<tr>
<td>Any type of psychosocial intervention</td>
<td>1254/1320/150/554/276</td>
<td>-0.17 (-0.31 to -0.03)</td>
<td>-0.19 (-0.34 to -0.05)</td>
<td>-0.26 (-0.60 to 0.07)</td>
<td>-0.24 (-0.47 to -0.00)</td>
<td>-0.64 (-1.52 to 0.23)</td>
</tr>
</tbody>
</table>

The effect sizes for social capital and cost outcomes were not estimable for most of the intervention categories and are therefore not presented in the table. A significant $Q_b$ indicates that differences in effect between intervention categories are significant. Statistically significant estimates are marked in bold.
Mind-Body
Tai Chi

- **Lavretsky et al. (2011):** adults 60+ with MDD who only partially responded to escitalopram (Lexapro); 10 week tai chi intervention vs. 10 week health education group
  - Reduction and remission in depressive symptoms
  - improved health-related quality of life
  - decreased inflammation (C-reactive protein)

- Also associated with improved cognitive abilities like delayed recall (Lam et al., 2012)
Meditation

- **Lavretsky et al. (2013)** Dementia caregivers with mild depressive symptoms
- Kirtan Kriya vs. listening to relaxing music for 12 minutes a day for 8 weeks
- 65% showed 50% reduction in depressive symptoms (vs. 31%)
- 43% improvement in telomerase activity (vs. 3.7%)
Conclusions and Future Directions
Conclusions

Pharmacotherapy
- efficacy in preventing recurrence of depression
- yet antidepressants and benzodiazepines are associated with a number of negative side-effects for older adults

Psychotherapy
- reduces the incidence of depressive and anxiety disorders
- therapy sessions are lengthy and may require travel to a therapist.

Psychosocial
- promoting mental health
- more indicated and selective studies are needed to show whether psychosocial prevention can reduce incidence of disorder
Limitations

Few studies consider prevention of new incidence over time

Studies need an adequate follow-up period

Very large samples required to detect differences when rate of conversion to disorder is low

Most studies have limited racial and socioeconomic diversity
Future Directions

• A better understanding of risk factors can enable us to target the most vulnerable

• **Disabilities, mobility and cognitive capabilities & resiliencies, wisdom, and strength**
  
  • Patient centered outcomes research
    
    • Making informed health care decisions, outcomes that matter to patients
  
  • Values and preferences of older adults
Future Directions

• How to reach rural elderly?

• Innovations in technology
  • Reach elders with mobility, transportation, or economic difficulties
  • Allow individuals to work at own pace
  • Shared globally
  • Inexpensive
  • Reusable

• Downside: crisis assistance and ethical concerns
Future Directions

• Can prevention use biomarkers to target etiology of mental disorder?

• Need for interventions that can be carried out by more than just mental health specialists!
  • Work through primary care physicians or social services
  • Lay counselor approach in low- and middle-income countries (Dias et al., 2019)
<table>
<thead>
<tr>
<th>Negative Valence Systems</th>
<th>Positive Valence Systems</th>
</tr>
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<tbody>
<tr>
<td>• Loss</td>
<td>• Reward responsiveness</td>
</tr>
<tr>
<td>• Fear</td>
<td>• Reward learning</td>
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<table>
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<tr>
<th>Cognitive Systems</th>
<th>Systems for Social Processes</th>
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<tbody>
<tr>
<td>• Attention</td>
<td>• Attachment</td>
</tr>
<tr>
<td>• Working memory</td>
<td>• Social communication</td>
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</tbody>
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<tr>
<th>Arousal/Regulatory Systems</th>
<th>Sensorimotor Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arousal</td>
<td>• Motor actions</td>
</tr>
<tr>
<td>• Circadian Rhythms</td>
<td>• Habit</td>
</tr>
</tbody>
</table>
Helpful Reviews & Reports


• Kim et al. (2017). Cognitive stimulation as a therapeutic modality for dementia: a meta-analysis. Psychiatry Investigation, 14, 626-639


Thank you!

• Questions?

• leggetta@med.umich.edu
References


• Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/


