MENTAL HEALTH WEEKLY
Essential information for decision-makers

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In This Issue...

The resurgence in COVID-19 infection nationally has left mental health provider organization administrators facing a difficult decision. Should they make vaccination mandatory for their employees, even though the end result could worsen an already difficult challenge in retaining qualified staff?
. . . *See top story, this page*

Academic partners see benefit in collaborative training
. . . *See page 3*

From the Field
Digital apps: One piece of whole-person mental health care
. . . *See page 5*

Suicide-attempt traits in seniors, younger adults examined
. . . *See page 7*

SAMHSA announces 26 suicide prevention grant awards
. . . *See page 8*

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Debate on vaccine mandates leaves mental health providers conflicted

The resurgence of COVID-19 cases brought on by the potent Delta variant has left mental health provider organizations facing a dilemma they recently thought they wouldn't have to address: Should they require their staff members to be vaccinated?

One might assume that for a helping profession committed to keeping its patients as safe as possible, the decision to require employees to be vaccinated against the worst effects of the virus would be a no-brainer. But in the face of severe labor shortages that were prominent even before the pandemic, many behavioral health organizations are responding to vaccine hesitancy in their ranks with hesitancy of their own.

Bottom Line...
For many mental health provider agencies, the decision on whether to mandate COVID-19 vaccination for staff members pits public health concerns against the reality of workforce shortages.

Leaders of both the National Association for Behavioral Healthcare (NABH) and the National Council for Mental Wellbeing told *MHW* last week that recent discussions with members have highlighted how conflicted many leaders are over this issue.

"Folks are nervous about doing it," National Council President and CEO Chuck Ingoglia, M.S.W., said of mandating staff vaccinations. "They have already been wrestling with workforce shortages."

See **Vaccine** page 2

Large settlement with insurer signals federal emphasis on enforcing parity

This month's announcement of more than $15 million in settlement payments from UnitedHealthcare and its behavioral health subsidiary may be less significant for the amount paid than for what this development might signal about stepped-up monitoring and enforcement of parity compliance.

Bottom Line...
Landmark agreements with UnitedHealthcare over alleged discriminatory practices could be just the first of significant parity enforcement actions involving the U.S. Department of Labor.

The Aug. 11 announcement from the U.S. Department of Labor and the New York State Office of the Attorney General is noteworthy in several respects. It is believed to be the first parity enforcement action announced jointly by the federal government and a state agency. Also, it comes with assurances that the federal Labor Department will remain active in asserting a monitoring role that many say it has had for years but has not always maximized.

"I think it is significant that the Department of Labor is being more aggressive and is working directly with the states as well," David Lloyd, senior policy advisor at The Kennedy Forum, told *MHW*. "That is important, given how insurance is regulated."

See **Settlement** page 4

Vaccine from page 1

"We polled our leadership team, and we've taken a position of strongly encouraging vaccination but not mandating," said NABH President and CEO Shawn Coughlin. In what has become a politically charged dialogue around vaccination, serious concerns remain in the community of behavioral health systems that if vaccine mandates are imposed, a considerable number of people will simply choose to leave their jobs rather than be subject to a requirement, Coughlin indicated.

Centerstone takes the step

Coughlin said that as of last week, he had not heard of any NABH members that had decided to impose a vaccination mandate for staff. But one of the nation's most prominent community-based behavioral health providers, a member of the National Council, announced this month that all staff members will need to submit documentation of a completed COVID-19 vaccine by Nov. 1.

Centerstone, which maintains operations in Tennessee, Indiana, Illinois and Florida, made the announcement in an email to all staff on Aug. 12. "As a leadership team, we believe our shared organizational values (respect, expertise, integrity and empowerment) call us to take a proactive stand to protect the health of our employees and the patients who trust and depend on us for their care," the email states.

Any Centerstone staff member with a title of director or above will have to submit proof of COVID-19 vaccination by Oct. 1, with all other employees having another month beyond that to submit their documentation. No categories of employees are exempt from the requirement, but Centerstone states that it will consider providing reasonable accommodations to unvaccinated employees who cannot receive the vaccine for medical or religious reasons. Inclusion of such exemptions is generally considered essential for ensuring that a workplace's policies do not come into conflict with laws such as the federal Americans with Disabilities Act (ADA).

In explaining to staff the rationale for its policy, Centerstone mentions research showing that patients with behavioral health disorders are at higher risk of contracting COVID-19, and that the available vaccines remain the safest and most effective way to prevent virus transmission and to minimize the severity of illness if the virus is contracted.

In follow-up comments on the organization's policy, Centerstone Director of Corporate Communications Robert Lambert told *MHW*, "The internal reaction to the announcement has been generally positive and supportive. More than 42% of our 3,800 staff members had voluntarily submitted documentation of their completed COVID-19 vaccination prior to the adoption of this requirement. We are already seeing that percentage increase as people are moving ahead with documenting that they've already been vaccinated."

Regarding Centerstone's deadlines for documentation, Lambert said, "We feel this timeline is generous and provides employees with time to make informed decisions."

He added that in many of the communities Centerstone serves, new COVID-19 cases have reached record highs, with hospitals experiencing strain in their capacity to treat patients. This has necessitated taking the step to require vaccination, he said.

The National Council's Ingoglia said that when COVID-19 infection rates were comparatively low back in the spring, almost none of the several member providers he talks to in a typical week were considering a vaccine mandate. The Delta variant has now fueled renewed interest in the topic, but uncertainty remains — particularly when many providers are reporting staff vacancy rates in the 15 to 20% range, he said.

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Publishing Editor Valerie A. Canady
Contributing Editor Gary Enos
Copy Editor James Sigman
Production Editor Douglas Devaux
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For its own staff office, the National Council is requiring proof of vaccination for any employees who want to work in the office when it reopens on a limited basis in early September.

"The staff is absolutely comfortable with it," said Ingoglia, who added that by last March 90% of the National Council staff had already received the vaccine. Employees also are subject to other requirements, including an indoor mask mandate in the District of Columbia.

'As a leadership team, we believe our shared organizational values (respect, expertise, integrity and empowerment) call us to take a proactive stand to protect the health of our employees and the patients who trust and depend on us for their care.'

Centerstone email to staff

State mandates imposed

In a handful of states, some behavioral health workers will not have a choice regarding vaccination if they want to remain employed in that state. The California Department of Public Health on Aug. 5 announced that health care workers who provide services or have the potential for exposure to patients in health care facilities must be vaccinated no later than Sept. 30. Included in the definition of health care facilities are acute psychiatric hospitals and residential substance use and mental health treatment facilities.

Rob Fuller, partner in the health care consulting firm Nelson Hardiman, told *MHW* that programs that operate solely at an intensive outpatient or outpatient level of care would not fall under this requirement. However, "if you are indoors in a general acute-care setting or have long-term residents or regular overnight patients, then you're covered," Fuller said.

California's requirement includes limited exemptions from the vaccine mandate for legitimate medical or religious reasons. A worker would have to submit a physician's letter stating that the employee qualifies for a medical exemption, but the letter would not have to specify the medical condition that justifies the exemption. Fuller says the religious exemption is defined narrowly, and therefore it will be difficult for many individuals to qualify under that.

California's order leaves it to employers to decide how to address individuals who have not been vaccinated and don't have an exemption. If a reasonable accommodation for a particular worker cannot be made, termination of employment would appear to be a valid option, Fuller said.

He said he is advising clients to use the same ADA track when considering accommodations, regardless of whether the employee's exemption is based on medical or religious grounds. Also, he believes employers should hold off on any terminations until the Food and Drug Administration moves from the present emergency use authorization of the COVID-19 vaccines to full approval of the vaccines, which is expected soon.

NABH's Coughlin said the emergency authorization status was certainly a factor in the association leadership's decision not to recommend vaccine mandates for members. Yet he added that even when full approval is granted, workforce shortage concerns in the industry will likely be more prominent a factor in convincing leaders to shy away from calling for mandates.

"Even in states with high vaccination rates, this is still a concern," Coughlin said. •

Academic partners see benefit in collaborative training

Partners in a mental health workforce development initiative in central New York believe greater collaboration among mental health disciplines can help improve quality of care to the underserved while also easing a shortage of clinical professionals in the region. An initiative funded by the federal Health Resources and Services Administration (HRSA) is establishing a multidisciplinary training program designed to improve services for high-need populations.

Bottom Line...
Planners of a federally funded workforce training project hope to build teams of mental health professionals who will be more inclined to work together to assist the underserved.

Participants in the training initiative include Syracuse University academic departments that cover social work, counseling and psychology, as well as Upstate Medical University's psychiatry faculty. It is hoped that the trainees who choose to stay in the central New York area post-training will maintain close contact with one another and build greater opportunities for collaborative patient care.

"There is no substitute for relationships and networking," Carrie J.

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Smith, professor and the interim chair of Syracuse's School of Social Work, told *MHW*. "We want to build a cadre of professionals who have had this experience."

The HRSA grant that is supporting the initiative totals $1.24 million over four years. Smith said organizers of the project hope to train 20 students a year, or 80 over the life of the grant, in this interdisciplinary effort.

Approach to fieldwork

Smith said Syracuse students in social work, counseling and psychology will work together in community-based organizations as part of their field practicum work. There will be joint training in various modalities of treatment, as well as in strategies for working effectively with high-need populations in the community.

As in many communities, "Here our needs are severe," Smith said. "We have extreme poverty, high substance use rates, homelessness. All of these have been exacerbated by COVID, of course."

Those involved with the initiative believe interdisciplinary training will offer students a firm grounding in how community-based care can be optimized to improve outcomes for historically underserved populations.

While the trainees will be exposed to the benefits of collaborative care, it is also important to note that their supervisors in the various disciplines at the field practicum sites will also be encouraged to work more closely together — a practice that is not always fully implemented in a typical behavioral health provider organization. "We often get on automatic pilot in the way we do things," Smith said.

She added, "These disciplines are related but distinct. There can be obstacles to greater interaction. This is an opportunity for our students to work together."

The project will offer scholarships for trainees and also will create opportunities for research in collaborative care, organizers say.

Focus on the underserved

This initiative will be designed to leverage what is known about removing barriers to care at the community level, Smith said. "There is a growing recognition of the importance of the use of technology to address the community's needs," she said. "Many individuals face a transportation shortage, or a lack of a facility proximate to them."

'These disciplines are related but distinct. There can be obstacles to greater interaction.'

Carrie J. Smith

The Onondaga Nation Native American reservation also will be an area of focus for the initiative, Smith said, thanks to a close relationship between the tribe and the Upstate Medical University child psychiatrist who is working on the project. "This is a great opportunity to deliver services there," she said.

Project organizers are optimistic about the opportunities closer collaboration can afford to trainees. "I think it will be a wonderful opportunity for our clinical mental health counseling students whose training is very focused," Derek X. Seward, chair of counseling and human services in Syracuse's School of Education, said in a Syracuse University News article.

The academic disciplines at Syracuse that are involved in this project are housed at the university's Falk College of Sport and Human Dynamics (social work), the School of Education (counseling) and the College of Arts and Sciences (psychology).

Seward added in the Syracuse article, "This project will provide more richness and training around working in interdisciplinary teams, which they normally don't get until they begin their field experiences. Most licensed counselors practice in interdisciplinary settings, so this early exposure to other mental health professionals will serve our students well."

Smith said the students who participate in this initiative will not be required to commit to staying in the central New York area post-training. But that becomes the case for many anyhow, she said, and a positive experience in the field during training certainly would do nothing to discourage them from staying. •

Settlement from page 1

UnitedHealthcare, United Behavioral Health (UBH) and Oxford Health Insurance will pay more than $15.6 million to resolve claims by the government and private litigants in cases in which it denied payment for mental health services or reimbursed services at rates lower than those for general medical care. These practices were alleged to be in violation of New York's state parity law, adopted in 2006, and the federal Mental Health Parity and Addiction Equity Act of 2008.

In announcing the settlements, which resolve all investigations and litigation around these matters, U.S. Secretary of Labor Marty Walsh said, "Protecting access to mental health and substance use disorder treatment is a priority for the Department of Labor and something I believe in strongly as a person in long-term recovery. This settlement provides

Continues on page 6

FROM THE FIELD

Digital apps: One piece of whole-person mental health care

by Caroline Carney, M.D.

COVID-19 has put a spotlight on public conversations around mental health and substance use disorders like never before. Over the last 18 months, society has begun to acutely understand the importance of behavioral health, while recognizing and seeking to reduce long-standing stigmas.

Prior to the pandemic, researchers revealed that mental health disorders such as major depression, bipolar disorder, schizophrenia and obsessive-compulsive disorder were top causes of disability around the world. Since the start of the pandemic, the number of people experiencing loneliness and isolation, contributing factors to mental illness, soared. One recent report, for example, suggests that 36% of all Americans — including 61% of young adults and 51% of mothers with young children — feel "serious loneliness." Loneliness has also been implicated as an independent contributor to mortality, especially in elders.

The greater awareness of the importance of mental health and wellness will continue to break down stigmas and encourage those who need help to seek treatment. Attention to and support of mental health has increased, particularly by employers. Preventative measures to keep people as healthy and productive as possible are more and more recognized as important as physical health preventative measures.

At the same time, however, it's already challenging for many people to access the mental health care they need. In addition to those who had existing mental health needs prior to the pandemic, more people than ever now are in need of services that are limited in availability.

Can digital apps bridge the gap?

Many Americans currently live in "behavioral health deserts," where they have little or no access to mental health care. In fact, nearly 120 million Americans live in mental health provider shortage areas, where they have no or only fragmented care.

Even for those with access to mental health care, it's not unusual to wait weeks to get an appointment. That wait time may get longer; by 2025, it's estimated there will be a shortage of about 250,000 mental health professionals.

So, we now face a clash between too few providers and an increasing need for mental health care. As a result, many people are embracing new mental health digital technologies to try to care for themselves. And the industry is reacting to that demand: There's an enormous number of new mental health self-care apps on the market, and many are easy to access around the clock.

While these apps can be helpful, as providers it's crucial to understand their limitations too and how patients may interact with these tools. Many apps have not been studied as much as traditional therapies such as cognitive behavioral therapy and medication management and might not be the only or right support or treatment. As with any course of treatment, it is critical to build the patient-provider relationship to ensure patients get the right kind of mental health support for their unique needs.

Digital technology alone isn't enough

All of the mental health apps on the market make it easier for anyone to access a variety of forms of mental health care, but they can also be confusing. Often, mental health apps are just stand-alone technologies that aren't connected to the rest of the patient's overall health care journey — and that may or may not be appropriate depending on the individual's needs.

Even the best digital tools can't completely take care of people with complex mental health conditions. Which is why technology alone doesn't adequately address the needs of serious mental illness.

Instead, what might work best is a combination of digital technology plus the support of a comprehensive care team, including behavioral health providers. Technology can help providers screen an individual and direct the person to the right level of care.

New opportunities for whole-person care

Digital solutions work best when part of a holistic, person-centered approach to care. Ideal digital mental health tools will provide patients with greater access to self-care plus encourage a seamless, real-time relationship between patients and providers.

In the best of circumstances, the technology should send information to the primary care providers about the patient's mental health status in between visits. That information should allow providers to reach out to patients with early interventions if they see something that raises concerns.

Some health care organizations also are beginning to use technology to close the loop between physical health and mental health. One important use of

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technology is to connect primary care doctors with behavioral health providers to support evidence-based behavioral health practices. This is sometimes referred to as "collaborative care."

Collaborative care is a well-established practice that supports access to higher quality of care and helps to control costs. New technologies can make it easier for screening and monitoring a patient's response to treatment while supporting integration into medical records with patient support through app-based assignments and reminders.

Likewise, digital health tools that combine self-help with the support of a care team can help patients better engage in their own health through mindfulness-based activities and therapeutic supports.

In most cases, mental health apps work best when used in combination with the support and guidance of trusted health care providers in a collaborative care team. When used in this way, they can address more than just mental or physical health — they can improve care for the whole person. This overall, holistic approach to health is an exciting transformation in care delivery.

Caroline Carney, M.D., a board-certified internist and psychiatrist, serves as the chief medical officer for Magellan Health and Magellan Rx Management.

Continued from page 4

compensation for many people who were denied full benefits and equitable treatment."

Two practices under fire

The complaints against UnitedHealthcare and their associated health plans involve two practices that the government agencies said ran afoul of federal and state parity protections. One involved United's practice of reducing baseline reimbursement rates for out-of-network mental health services delivered by psychologists or master's-level clinicians by as much as 35%, while not imposing such sweeping payment reductions for out-of-network general medical care. This was resulting in mental health patients bearing an inequitable burden for the cost of these services, according to the government agencies.

"The reimbursement issue is important; it is an issue we often see," Lloyd said.

The other practice involved UBH's use of its Algorithms for Effective Reporting and Treatment (ALERT), a program it applied to claims data in order to identify clinical risk, utilization and outlier cases for outpatient treatment. The Labor Department alleged that UBH violated the federal parity act and breached its fiduciary duty to members of plans under the Employee Retirement Income Security Act by using the algorithms in a discriminatory fashion to deny claims or issue adverse benefit determinations for outpatient mental health care.

As part of the overall settlement, $2.5 million will go into a Labor Department ALERT fund to resolve federal claims and $1.1 million will go into a New York ALERT fund to resolve state claims. United also has agreed not to issue any adverse benefit determinations or claim denials via use of the ALERT program. It is allowed to establish a different concurrent review program for outpatient mental health services, and it also can continue to use ALERT for purposes that include care coordination, disease management and the identification of waste and fraud by a plan member or provider, according to the settlement.

'For generations there has been discrimination in this space. It didn't just disappear with passage of the parity act in 2008.'

David Lloyd

United has publicly stated that the issues resolved in the settlement involve business practices it no longer uses. The company also has faced numerous legal challenges in recent years over its handling of claims for substance use disorder treatment, through use of internally derived guidelines that often conflict with widely accepted level-of-care standards in the addiction treatment industry.

The total settlement amount encompasses claims from both private and government litigants, as well as penalties imposed by the federal government and New York state. Lloyd said government litigation and private actions are both important pieces of the puzzle in parity enforcement.

More actions to come

Lloyd said that as part of the Consolidated Appropriations Act in Congress last December, new requirements for more detailed reviews of parity compliance were imposed on insurers. It is believed that the settlements announced this month could signal stepped-up activity by the Labor Department in overseeing insurer practices and taking action when necessary.

The department's acting assistant secretary for the Employee Benefits Security Administration also suggested this in a press briefing

earlier this month. "You should expect to see more investigations," Ali Khawar was quoted as saying in a Bloomberg Law report. "We have taken a look at our existing inventory of cases and have sent out a number of letters asking for plans and issuers to provide their nonquantitative treatment limitation analyses, and that work is ongoing right now. There are other investigations that are open, and I predict it will be a very active issue for us for years to come."

Lloyd said many of these issues have plagued individuals with mental health needs for a long time. "For generations there has been discrimination in this space. It didn't just disappear with passage of the parity act in 2008," he said.

He suggested progress eventually will be measured not in the amount of fines imposed against insurers but in seeing these companies move away from discriminatory practices. "Hopefully plans will be doing what they should be doing," Lloyd said.

In her public comments as the settlements with United were announced, New York Attorney General Letitia James emphasized the timeliness of offering redress to consumers. "In the shadow of the most devastating year for overdose deaths and in the face of growing mental health concerns due to the pandemic, access to this care is more critical than ever before," James said in an Aug. 11 news release. "United's denial of these vital services was both unlawful and dangerous — putting millions in harm's way during the darkest of times." •

Suicide-attempt traits in seniors, younger adults examined

While subjective suicidal intent was higher compared to a young group, older adults who are suicidal were less likely to fulfill criteria for major depression and several other mental disorders, compared to younger adults, according to new research published Aug. 9 in the *American Journal of Geriatric Psychiatry*.

In the article, "Clinical characteristics in older, middle-aged and young adults who present with suicide attempts at psychiatric emergency departments: a multisite study," the researchers set out to study age-group differences in clinical characteristics in older, middle-aged and younger adults with actual suicide attempts.

Suicide rates are particularly high among people 70 years and older, the researchers stated. A previous suicide attempt is a strong risk factor for subsequent suicide, and the relationship between nonfatal and fatal attempts is particularly pronounced in the oldest segment of the population. For every late-life suicide death, it is estimated that approximately four older adults make nonfatal attempts; the corresponding figure in younger populations is around 25.

The study was led by Stefan Wiktorsson, Ph.D., of the University of Gothenburg in Sweden, and colleagues.

Study method

The researchers characterized suicidal behavior with the Columbia Suicide Severity Rating Scale and the Suicide Intent Scale. Symptoms associated with suicide were rated with the Suicide Assessment Scale. Patients self-rated their symptoms with the Karolinska Affective and Borderline Symptoms Scale. The researchers conducted the study at three Swedish university hospitals.

A total of 683 participants who presented with self-harm at psychiatric emergency departments were selected for the study, and they were divided into three age groups: younger (18–44), middle-aged (45–64) and older (65 and older) adults.

Results

Three-quarters of the older patients lived alone, a proportion larger than that of either of the other two age groups. Serious physical condition/disability was noted in two-thirds of the older adults. As anticipated, this proportion was higher compared to both younger and middle-aged patients, the researchers stated.

Half of the 65+ group fulfilled criteria for major depression, compared to three-quarters in both the middle-aged and young groups. Anxiety disorders and alcohol and substance use disorders were also less prevalent in the 65+ group, while serious physical illness was more common.

Ongoing contact with psychiatric services was noted in 41% of those in the older group, a proportion half that of the youngest group. One-quarter of the older adults had contact with primary care for mental health issues. Antidepressants were prescribed at the time of the attempt in half of the older adults, compared with three-quarters of the middle-aged group and two-thirds of the younger group.

The study indicated that slightly less than half of the older adults had a previous history of suicide attempt, a proportion lower than what was reported in the two other age groups. Very few of the older adults reported past history of nonsuicidal self-injury, whereas such episodes were noted in almost one-quarter of the middle-aged group and almost two-thirds of the younger group. Poisoning was employed as a single method at the index episode in three-quarters of the older adults.

Assessment interference

While older adults with a suicide attempt showed higher suicide intent than young adults, they had lower scores on all ratings of psychiatric symptomatology, according to

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the study. Low ratings might interfere with clinicians' assessments of the needs of older adults with intentional self-harm, the researchers indicated. The researchers suggested that clinicians pay attention to medical morbidity in older patients and their living situation, as well as other sources of vulnerability not examined in this study that may be relevant for individualized approaches.

Cognitive impairment or fatigue in the aftermath of the attempt might impact on self-ratings in the older group. It remains to be elucidated whether "age-friendly" rating scales might result in a higher symptom level. Another consideration is that the responses of the older adults might be colored by feelings of self-stigma and shame to a larger degree than those of their younger counterparts. Certain symptoms (e.g., somatic symptoms) may be culturally more acceptable and less stigmatizing for older individuals than the traditional mood/anxiety symptoms.

The researchers added that the findings highlight the need for understanding how clinical characteristics of nonfatal suicidal behaviors in older persons differ from those of their younger counterparts. •

Briefly Noted

SAMHSA announces 26 suicide prevention grant awards

The Substance Abuse and Mental Health Services Administration (SAMHSA) on Aug. 6 released 26 grant awards totaling $17.8 million to help communities prevent suicide during the COVID-19 pandemic, according to a SAMHSA press release. The Emergency Response for Suicide Prevention Grants program helps states, tribes and communities advance efforts to prevent suicide and suicide attempts among adults 25 and older in order to reduce the overall suicide rate and the number of suicides in the United States. Recipients of the funding will assist at-risk people by providing such services as:

- rapid follow-up of adults who have attempted suicide or experienced a suicidal crisis after discharge from emergency departments and inpatient psychiatric facilities,
- providing training for community and clinical service providers and systems serving adults at risk,
- working across state and community departments and systems to implement comprehensive suicide prevention and
- suicide screening and assessment, as well as appropriate clinical treatment services required as a result of the assessment.

This funding was provided by the Coronavirus Response and Relief Supplemental Appropriations Act, 2021. The 26 grant recipients are receiving up to $800,000 each.

Coming up...

The **New York Association of Psychiatric Rehabilitation Services Inc.** is holding its 39th annual conference, "United in Hope, Together for Justice, Wellness for All," virtually **Sept. 21, 23, 28 and 30**. For more information, visit **https://www.eventbrite.com/e/united-in-hope-together-for-justice-and-wellness-for-all-tickets-163080673685**.

The **New Jersey Association of Addiction and Mental Health and Addiction Agencies Inc.** is holding its 2021 fall conference, "No Going Back: Moving Forward in a New Paradigm," virtually **Oct. 13**. Visit **https://www.njamhaa.org** for more information.

The **American Academy of Child & Adolescent Psychiatry** is holding its 68th annual meeting (and second virtual meeting) **Oct. 18–30**. For more information, visit **https://aacap.confex.com/aacap/2021/meetinginfo.cgi**.

In case you haven't heard...

Nearly half (48%) of U.S. teens are concerned about experiencing social anxiety in transitioning back to "normal" life, according to a new survey released Aug. 11 by the Morgan Stanley Alliance for Children's Mental Health. The survey polled a nationally representative group of 516 U.S. teens ages 15–19 to gather insights regarding the impact of the COVID-19 pandemic on mental health. Following a year that included remote learning and disruption of daily life, 47% of teens expressed concern about falling behind in school and 43% reported they are concerned about mental health challenges as a result of the pandemic. Additionally, as many as one-third of teens are anxious about returning to in-person learning. Two-thirds of U.S. teens feel hopeful they will adapt and rebound from the pandemic, the survey found. According to the study, 64% of Black teens and 52% of Hispanic teens (vs. 44% of white teens) expressed concern about experiencing social anxiety following the COVID-19 pandemic. Despite the issues facing teens, 42% have increased the number of conversations with others about mental health.