Practical Approaches to Integrated Behavioral Health:
Special Considerations for Older Adults

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Objectives

At the completion of this activity, participants will be able to:

• Describe models and approaches used to integrate behavioral health and primary care.

• Identify practical, time-effective methods to meet the behavioral health needs of older adults in an integrated setting.

• Identify specific considerations in planning, implementing or evaluating integrated behavioral health and primary care in community settings.
Definition of Integrated Care

The care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

(SAMHSA-HRSA Center for Integrated Health Solutions, 2016)

www.integration.samhsa.gov
Behavioral Health Integration in Primary Care
Based on Survey of 348 Federally Qualified Health Centers (FQHC)

Core Components of Successful Integrated Models

Lardier, Jones & Perez, 2011
| Philosophy & Setting                      | Team-based, population based health approach  |
|                                         | Improve efficacy & efficiency of primary care |
|                                         | Share pods, office centrally located, exam rooms |
|                                         | Routine part of care                           |
| Behavioral Health Consultants (BHCs)    | Doctoral level psychologists                   |
|                                         | LCSWs, MHCs, LMFTs and other master’s level clinicians |
| BHCs’ Interventions                    | Functional improvement vs symptom reduction    |
|                                         | CBT, ACT & SFBT; Psychoeducation & coping skills |
| BHCs’ Qualities                        | Accessible (on demand, warm handoffs)         |
|                                         | Generalist (sees all patients)                 |
|                                         | Highly productive (average 8-10 pts per day)   |
|                                         | Educator (provide formal & informal training)  |
| Nature of Visits                        | < 30 minutes                                   |
|                                         | Episodic care                                  |
|                                         | 10-15% long term                               |
Collaborative Care (Raney, 2015)

- A specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.
- Collaborative Care is:
  - Team-driven collaboration and Patient-centered
  - Evidence-based and practice-tested care
  - Measurement-guided treatment to target
  - Population-focused
- Leverages capacity of psychiatry to address BH problems of moderate severity in primary care setting.
- “Care Manager” facilitates proactive engagement and treatment adjustment.
- Operationalizes measurement-based treatment to target; population-based care; and accountable care.
Key Resources for Integrated Behavioral Health

- SAMHSA-HRSA Center for Integrated Health Services (CIHS)
- Behavioral Consultation and Primary Care
  [https://www.behavioralconsultationandprimarycare.com/](https://www.behavioralconsultationandprimarycare.com/)
- University of Washington Advancing Integrated Mental Health Solutions – AIMS Center
  [https://aims.uw.edu/](https://aims.uw.edu/)
- Department of Veterans Affairs VISN2 Center for Integrated Healthcare
  [https://www.mirecc.va.gov/cih-visn2/clinical_resources.asp](https://www.mirecc.va.gov/cih-visn2/clinical_resources.asp)
- University of Massachusetts Center for Integrated Primary Care
  [http://www.umassmed.edu/cipc/](http://www.umassmed.edu/cipc/)
Mental Health Challenges Among Older Adults

• Prevalence among older adults:
  – Any mental disorder (including dementias): 20-22%
  – Depression: estimates range from 10-38%
  – Anxiety: estimates range from 3.5-10%

• Older adults with mental health diagnoses are 2.5 times more likely to be in long term nursing facilities

• The number of older adults receiving mental health diagnoses has doubled in the past 30 years.

• Depression kills older men, who have the highest suicide rate of any demographic group.
Special Considerations in providing BH Services to Older Adults

• Intervention should consider the older adult’s
  – age, gender, cultural background, preferred language, degree of health literacy;
  – prior experience with mental health providers;
  – Resiliencies and usual means of coping with life problems.

• Approaches to care should
  – recognize that many older adults adapt successfully to life transitions;
  – recognize individual processes of adaptation to changes in physical, psychological and social functioning and functional limitations;
  – support continued personal and interpersonal growth;
  – Be based on accurate individualized assessment of abilities, strengths and vulnerabilities.

• BH clinicians must be aware of their own responses to working with older adults.

American Psychological Association, 2014
Behavioral Health in Primary Care

• Anxiety and depression are underdiagnosed among older adults in primary care settings.
• Up to 37% of older adults seen in primary care have depression symptoms.
• Older adults are more likely to engage with behavioral health care if integrated in primary care.
• Assessment, differential diagnosis and treatment of comorbid conditions is improved.
• Treating mental health in primary care is challenged by competing priorities of comorbid conditions.
Anxiety in Older Adults

• Anxiety and dementia may interact.
• Anxiety symptoms may present idiosyncratically among older adults.
• Age-related stressors include:
  – caregiver stress;
  – financial problems;
  – caring for grandchildren and other extended family;
  – intergenerational family communication and conflict;
  – disability and loss of function.
• Fall risk interacts with anxiety.
Treating Anxiety

• Evidence base for:
  – Cognitive Behavioral Therapy (CBT)
  – Relaxation training
  – Acceptance and Commitment Therapy (ACT).

• To reduce fall risk and associated anxiety:
  – Use cognitive coping skills;
  – Evaluate orthostatic hypotension, vision and hearing impairments, cognitive function, ADLs, environmental risks;
  – Include balance-strengthening exercises or activities in care plan.
Grief and Loss Among Older Adults

• In addition to death or separation from loved ones and friends, can also include loss of specific belongings, animals, roles, independence, health, financial well-being, functional abilities and range of activities.

• Common grief – a fundamental and necessary emotion
  – Affects 50% of individuals experiencing a loss (death)
  – Depression-like experience with feelings of grief and loss predominant
  – Gradually diminishes over a period of up to 24 months
  – Some aspects of grief may persist for years

• Resilient grief: milder; 30-35% of individuals

• Assist with the natural process of diminishing emotional intensity by identifying, articulating and respecting emotions.

• Help individual consider ways to honor cherished memories and legacy.

• Expand focus on other relationships and activities.
Depression and Grief

• Approximately 15% of individuals have complex, severe or chronic grief reaction to loss.
• May evolve into depression or trigger major depressive episode
• Assess for suicide risk, monitor depression symptoms
• Provide regular supportive grief counseling
• Tools for coping and acceptance from CBT and ACT are often useful
• Initiate depression treatment if MDE criteria are met; or if > 6 months with no reduction of grief intensity; social isolation; or anhedonia
• If individual has pre-existing depression or PTSD (including traumatic loss): address as primary and incorporate work on grief/loss.
Depression in Older Adults

- 16 percent of women and 11 percent of men age 65 and older experience symptoms of depression.
- Major Depressive Disorder is slightly less prevalent among older adults, but is more strongly associated with negative outcomes:
  - Medical comorbidity
  - Increased risk of dementia
  - Cognitive deficits
  - Increased suicide risk
  - Increased overall mortality
- Increased risk of persistent mild cognitive impairment and dementia
- Negative impact on outcome of medical comorbidities
Depression - Risk Factors

• Aging-related risk factors for depression:
  – Medical illness
  – Disability, loss of functional abilities
  – Cognitive decline
  – Social isolation
  – Loss and other negative events

• Depression increases risk of these same factors (reciprocal interaction)
Diagnosing Depression: Older Adults

- 40-60% of depression goes undiagnosed in elderly
- Under diagnosis associated with misconceptions and stigma of the disease by patients and caregivers; patient education is key
- Work with PCP to rule out physical causes
- Always assess for suicidality
- Key symptoms among older adults:
  - Sleep disturbance and fatigue
  - Psychomotor retardation
  - Hopelessness about the future
  - Poor memory & concentration
  - Slower processing speed and executive function (e.g. reasoning, problem solving, planning)
  - Anhedonia often more prominent – “Depression without sadness”
Depression is a serious concern for older adult patients because it is associated with:

A. Very high risk of suicide among older men.
B. Strong association between depression and recurring experience of loss.
C. Depression negatively affects outcomes of comorbid medical conditions.
D. All of the above.
Pharmacologic Treatment of Depression in Older Adults

- “Start low, go slow” ➔ “Start low, stay low”
- Consider any comorbidities and concomitant medications
- First line SSRIs, SNRIs: sertraline, citalopram, escitalopram, desvenlafaxine
  - Better pharmacokinetic profile
  - Fewer drug-drug interactions
  - No anticholinergic or sedative effects

- Patient Education
  - Can improve both depression and anxiety
  - Gradual response over 2-6 weeks
  - In 1 week, sleep & appetite may improve; longer for mood, energy and negative thinking.
  - Take medication as prescribed.
  - Early side effects may improve; contact provider if they persist.
  - If one SSRI does not produce improvement, another might; inform your provider if no change.
  - Continue medication at least 6 months, even if you feel better; contact provider before discontinuing.

James, L. & O’Donohue, W., 2009
Treatment for Depression

• Behavioral and interpersonal approaches in therapy especially useful for older adults if medication is poorly tolerated due to interactions or side effects.

• Evidence base for:
  – Cognitive Behavioral Therapy (CBT)
  – Behavioral Activation
  – Acceptance and Commitment Therapy (ACT).
Behavioral Activation (1)

• Explain rationale for patient behavior change:
  “When we feel down or ill, we sometimes stop doing many activities that we used to like to do. This can make depression worse. Research has shown that depression can be improved when we increase activities that provide enjoyment or sense of accomplishment.”

• Acknowledge difficulty of depression and that sometimes no activities feel enjoyable. Strategically take small steady steps even if activities initially feel difficult or awkward instead of pleasurable. Words to describe this:
  “Act first, feel later; Act according to plan, not feeling.”

• As abilities change with age, functional limitations can be seen as insurmountable barriers. The manner or extent of participation in previous activities may need to change due to functional limitations. Use problem-solving approaches and CBT to work with this.
Behavioral Activation (2)

• Select activities that:
  – Are likely to increase pleasure or sense of accomplishment;
  – They used to enjoy; or they already do but would like to do more often;
  – Include elements of physical exercise and social interaction, setting goals that are realistic for the individual.
  – Are realistic considering the person’s resources.

• Follow up may include:
  – Track and monitor to help them notice progress.
  – Use solution-focused strategies / problem-solving as needed to resolve barriers.
  – Reinforce positive behavior change.
  – Reset goals as needed when a goal is accomplished, or if barriers are encountered.
  – Strengthen or refine active behavior using stimulus control (cues/reminders) and positive reinforcement (consequences/rewards).
  – If needed, address communication skills for engaging or being assertive with significant others.
Age-Related Behavioral Issues: Self-management of chronic disease

• Use the “Two-minute Test” to assess patient’s capacity to engage effectively in self-care:
  – Open-ended question about their success in managing their chronic condition; “What’s it like for you to manage your diabetes?”
  – If > 2 minute response, reinforce and encourage, building on strengths;
  – If < 2 minute response, ask open-ended question: “What do you most want to talk about in our visit today?”
  – Engage in problem-solving with patient to address their top priority.
  – In the conversation, find opportunities to link stress coping back to effective chronic disease management.
  – Set a realistic and attainable goal to constructively cope with stress/distress.
  – Continue in follow-up visits.
Age-Related Behavioral Issues: Insomnia

- Over half of older adults report chronic sleep difficulties
- Insomnia affects quality of life and increases risk of
  - accidents and falls;
  - obesity, diabetes, hypertension;
  - cardiovascular disease and stroke;
  - depression, substance abuse;
  - overall mortality
- 63-72% of elders attributed insomnia to nocturia
- Sleep medications diminish in effectiveness over time and lead to problematic drug/drug interactions and side effects.
- For older adults, by far the safest treatment is cognitive and behavioral interventions.
Treating Insomnia – Sleep Hygiene

• Avoid caffeine 6-8 hours before bedtime.
• Avoid nicotine and alcohol 2 hours before bedtime.
• Reduce/eliminate use of sleep medication.
• Exercise regularly, but not within 2 hours of bedtime.
• Maintain regular sleep schedule and avoid naps.
• If a nap is essential, limit to 20 minutes.
• Make the bedtime environment conducive for sleep.
• Create a routine to begin winding down at least 60 minutes before bedtime, and **minimize use of electronic screens during this time**.
• A light bedtime snack can help, but avoid snacks when wakeful in the night.
Treating Insomnia – Stimulus Control

- Stimulus control is based on the behavioral principle that conditioned antecedents increase likelihood of conditioned behavior.
- Stimulus control procedures to treat insomnia help ensure the bed and bedroom are conditioned triggers for sleep, not wakefulness.

1. Go to bed only when sleepy (but get up at the scheduled time).
2. If awake in bed for more than 15-20 minutes, get up, leave the room and do not return until feeling drowsy. Engage in calm, soothing activity until signs of drowsiness/reduced concentration.
3. Use bed for sleep and sex only. No TV, phone/tablet, reading or eating in bed.
Age-Related Behavioral Issues: Improving Medical Adherence

• Taking a pill is a behavior which is amenable to functional analysis.
• Ask, “What might get in the way of taking this medication?”
• Potential barriers include:
  – Patient beliefs
  – Patient access
  – Patient tolerance
  – Organization, memory
  – Patient support (spouse or caregiver)
  – Patient confidence and collaboration
• To resolve barriers, use motivational interviewing, cognitive coping skills, problem-solving, communication skills, patient education.
Age-Related Behavioral Issues: Managing Mild/Moderate Dementia

• Actively work to slow progression with medication, nutrition, vitamin supplement, cognitive activity, language therapy.

• Behavioral intervention can help with:
  – Functional behavior, Activities of Daily Living (ADLs)
  – Caregiver skills and communication
  – Agitated or uncooperative behavior
  – Behavioral activation to reduce depression

• SSRI and SNRI medications are effective for patients with dementia and anxiety or depression.

• Address caregiver stress.
Other Age-Related Behavioral Issues

• End of Life Concerns
  – Encourage patients and family members in actively planning the direction of care, transitions and wishes at end of life.
  – Suggest the use of an advanced directive.
  – Seek a cultural guide if you are not from the same cultural background as your patients.

• Caregiver stress
  – Family caregivers may experience stress and disruption of their own well-being and social activities and are at risk for increased mortality, coronary heart disease and stroke.
  – Grandparents parenting grandchildren may cause similar stress, although context and details differ.
  – Integrated BH providers can advocate for primary and secondary prevention and support programs at your hospital, clinic or community.
Reducing and Managing Caregiver Stress

- Provide brief education about specific illness or disability and accessing a range of care and support services.
- Help the individual identify specific stressors and demands of caregiving.
- Strengthen communication and problem-solving skills.
- Brief education on emotion regulation, stress response and coping.
- Teach specific coping skills such as self-talk and diaphragmatic breathing.
- Give explicit permission for self-care and explore thoughts and feelings about self-care.
- Set realistic goals for self-care activities, especially those that increase social interaction and support.
- Identify and strengthen positive meanings about caregiving (value-based action).
Question:

Caregiver stress may be reduced by:

A. Increasing knowledge and skills needed to access specific resources.
B. Strengthening self-care.
C. Strengthening caregiver’s awareness of value-based action.
D. All of the above.
How to assist:
Especially for Older Adults

• Support memory by putting plans/recommendations in writing.
• Be concrete and specific, and take a slower pace.
• Use accommodations for visual and hearing impairments.
• Always consider potential impact of medication interactions on cognitive and behavioral functioning, and consult as needed.
• Cultural, spiritual and religious values are often of high importance for older adults; recognize and encourage the importance of values as a source of strength and resilience.
• Grief and loss processes may be multiple and ongoing, and apply to loss of loved ones and friends, specific belongings, animals, roles, independence, health, financial well-being, functional abilities and range of activities.
• Mild cognitive impairment may be exacerbated by depression or anxiety, and cognitive function may improve with appropriate treatment.
Build on protective factors common among older adults.

- The ability to regulate emotions appears to improve with age.
- In some cultures, older adults are accorded special honor and respect, and may have a leadership role in family or community.
- Problem-solving abilities are strengthened by a wealth of life experience and knowledge.
- Many older adults have deeply held values, founded on a lifetime of experience. Both MI and ACT approaches can be especially helpful when they are used to help the individual take value-based action.
When working with older adult patients, it is important to consider:

A. If any accommodations are needed for sensory impairment.
B. Their strongly held values.
C. Potential medication interactions.
D. All of the above.
References


