WELCOME
to the

Geriatric Mental Health in Primary Care ECHO

January-June 2025

Funding Statement

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Series Learning Objectives

- Describe the role of Primary Care in assessing at least one mental health condition
- Describe the role of Primary Care in treating at least one mental health condition

Series Sessions

Date	Session Title
1/23/2025	Social Isolation/Loneliness
2/27/2025	Substance Use Disorder
4/24/2025	Depression
5/22/2025	Anxiety
6/26/2025	Serious Mental Illness

Core Panel

- Brian Rosen, MD, Staff Physician, Outpatient Psychiatry, Dartmouth Health
- Courtney Stevens, PhD, Licensed Clinical Psychologist, Dartmouth Cancer Center
- Ellen Flaherty, PhD, APRN, AGSF, Vice President, Geriatric Center of Excellence, Dartmouth Health
- Lora Gerard, Program Leader, Northern New England Geriatric Education Center, Geriatric Center of Excellence, Dartmouth Health
- Meredith Kolodze, DSW, LICSW, Program Manager Specializing in Older Adults, NAMI
- Renee Pepin, PhD, Research Lead Geriatric Center of Excellence, Dartmouth Health

Social Connectedness and Aging

Renée Pepin, PhD

Connecting

- Who are you
- Where are you from

BACKGROUND: Key Definitions

- *Social isolation:* the objective lack of (or limited) social contact with others.
- *Loneliness:* the perception of social isolation or the subjective feeling of being lonely.
- *Social connection:* an umbrella term that encompasses the structural, functional, and quality aspects of how individuals connect to each other.

BACKGROUND: Context of Aging

- Late life can be filled with many changes. Older adults and their families may be dealing with:
  - changes in physical functioning
  - changes in body and senses
  - changes in living situation
  - changes in finances
  - changes in social circles

BACKGROUND: Social Connectedness and Mental Health

- Low social connectedness is associated with poor physical and mental health outcomes, including higher rates of mortality and cognitive decline
- Social Connectedness is strongly associated with depression and anxiety
- There is a bidirectional relationship between depression and loneliness
- Low social connectedness can lead to or exacerbate depressive and anxiety symptoms
- Depression and anxiety can lead to low social connectedness
- Common underlying factors can contribute to both mental health and social connectedness simultaneously

Social Connectedness Screening: UCLA 3-Item Loneliness Scale

1. How often do you feel that you lack companionship?
   - Hardly Ever
   - Some of the Time
   - Often
2. How often do you feel left out?
   - Hardly Ever
   - Some of the Time
   - Often
3. How often do you feel isolated from others?
   - Hardly Ever
   - Some of the Time
   - Often

Anne, 69 yo Female (UCLA = 6)

Married, strong relationship with 4 children, 8 grandchildren

Retired teacher

Very chatty and upbeat. Initially, reports she is “fine” and “always with family”, with additional probing discloses that she doesn’t have any friends and misses her co-workers and students. She feels a lack of purpose and doesn’t know who she is anymore.

Greg, 81 yo Male (UCLA = 8)

Caregiver for wife, lives with wife, strained relationship with daughter

Retired IT manager

Reserved but tearful. Reports feeling overwhelmed, feels alone, and doesn’t want to stress his wife.

Rebecca, 73 yo Female (UCLA = 6)

Single, lives alone with cat in senior housing

Retired

Uses a wheelchair, focused on chronic medical conditions. Doesn’t feel “lonely”, always has been a loner and she mostly keeps to herself. Reports she is unlikely to join in with community activities.

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Loneliness is Identified

Something Happens

Enhancing Social Connectedness: Intervening

- Validate the valid (emotions are always valid)
  - Affirm that feelings of loneliness are reasonable
  - Validate related feelings of sadness, emptiness, and longing
- There are things we can do to improve connectedness [be careful about how it is introduced]
  - Do not force people to be positive, look on the bright side, etc.
  - But, it is not inevitable and there are things we can do to maximize social connectedness

Enhancing Social Connectedness: Intervening

- Tailor to the individual
  - What is getting in the way of connectedness?
  - How much/what type of connection is desired?
- What aspects of social connectedness are not feasible right now?
  - How can the environment be modified to support activities?
  - How could can activities be modified so they are safe and doable?

Enhancing Social Connectedness: Intervening

- Build on resources/strengths
  - If you can solve a problem – do that
    - Address the underlying issue (e.g., hearing, transportation)
  - Leverage Technology
  - Recommend additional intervention
    - Group-based programing
    - Community-building
    - Friendly visiting
  - Recommend Clinical Care

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Opinion | The Life Span of Loneliness - The New York Times

Video Presentation

WELCOME to the

Geriatric Mental Health in Primary Care ECHO

Session 2, Substance Use Disorder
February 27, 2025

Substance Use and Older Adults

Stuart Lewis, MD FACP

Associate Professor of Medicine

Geisel School of Medicine at Dartmouth

CONFLICTS:

None to Report

Not Today's Topic, But….

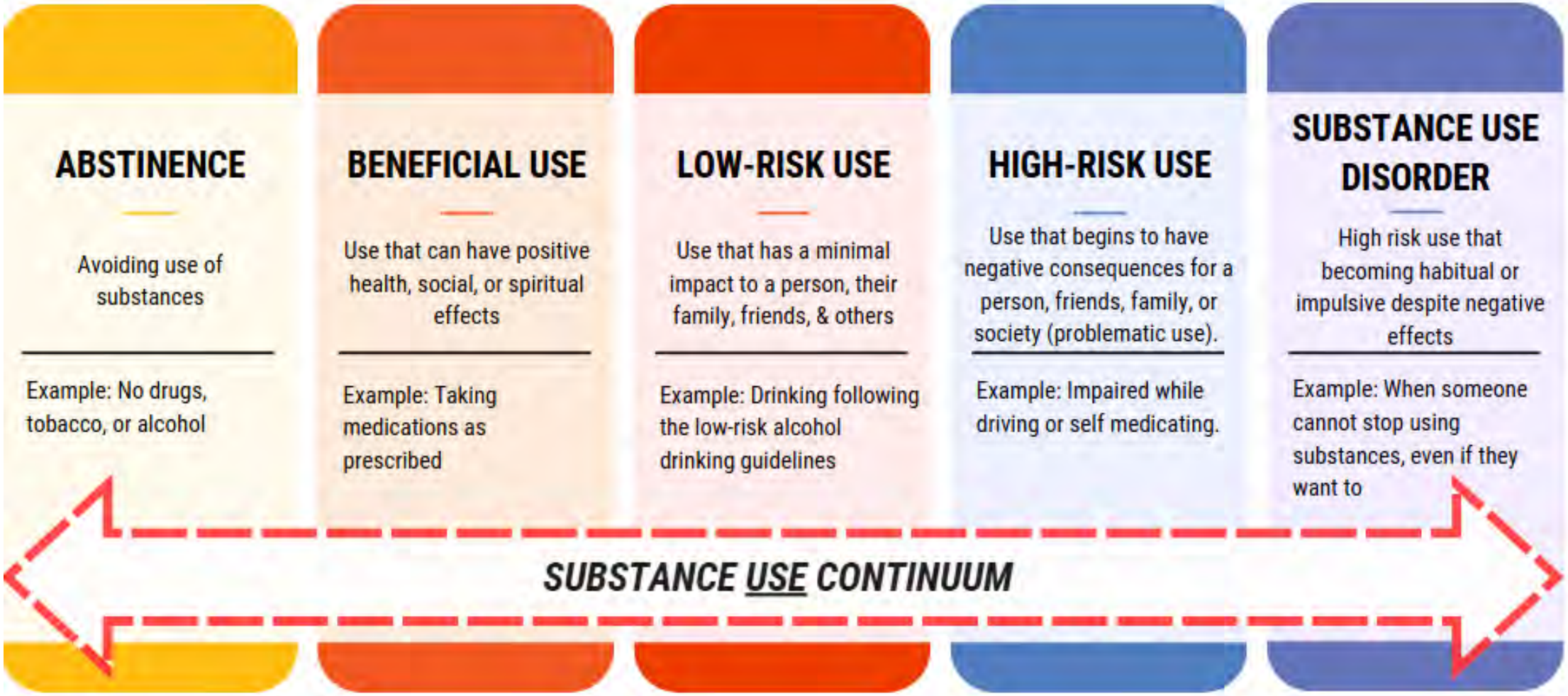
CDC estimates that **38%** of all alcohol-related deaths in 2020 and 2021 were in people ages 65 or Older

Learning Objectives

- Be Familiar With the Continuum of Substance Use in Older Adults
- Be Familiar With the Prevalence and Harms of Substance Use in Older Adults
- Understand Why It Might Be Difficult to Recognize Substance Use in Older Adults

What's A Substance?

Alcohol	Sedatives
Caffeine	Hypnotics and Anxiolytics
Cannabinoids	Stimulants
Hallucinogens	Tobacco
Inhalants	Opioids
Other Unclassified Substances	

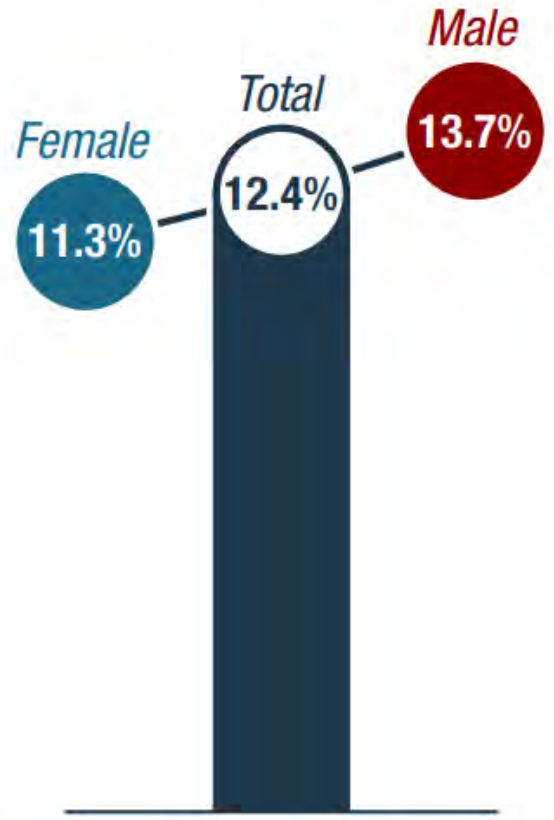

ABSTINENCE
Avoiding use of substances
Example: No drugs, tobacco, or alcohol
BENEFICIAL USE
Use that can have positive health, social, or spiritual effects
Example: Taking medications as prescribed
LOW-RISK USE
Use that has a minimal impact to a person, their family, friends, & others
Example: Drinking following the low-risk alcohol drinking guidelines
HIGH-RISK USE
Use that begins to have negative consequences for a person, friends, family, or society (problematic use).
Example: Impaired while driving or self medicating.
SUBSTANCE USE DISORDER
High risk use that becoming habitual or impulsive despite negative effects
Example: When someone cannot stop using substances, even if they want to
SUBSTANCE USE CONTINUUM

CIGARETTE SMOKING

Percentage using in past month

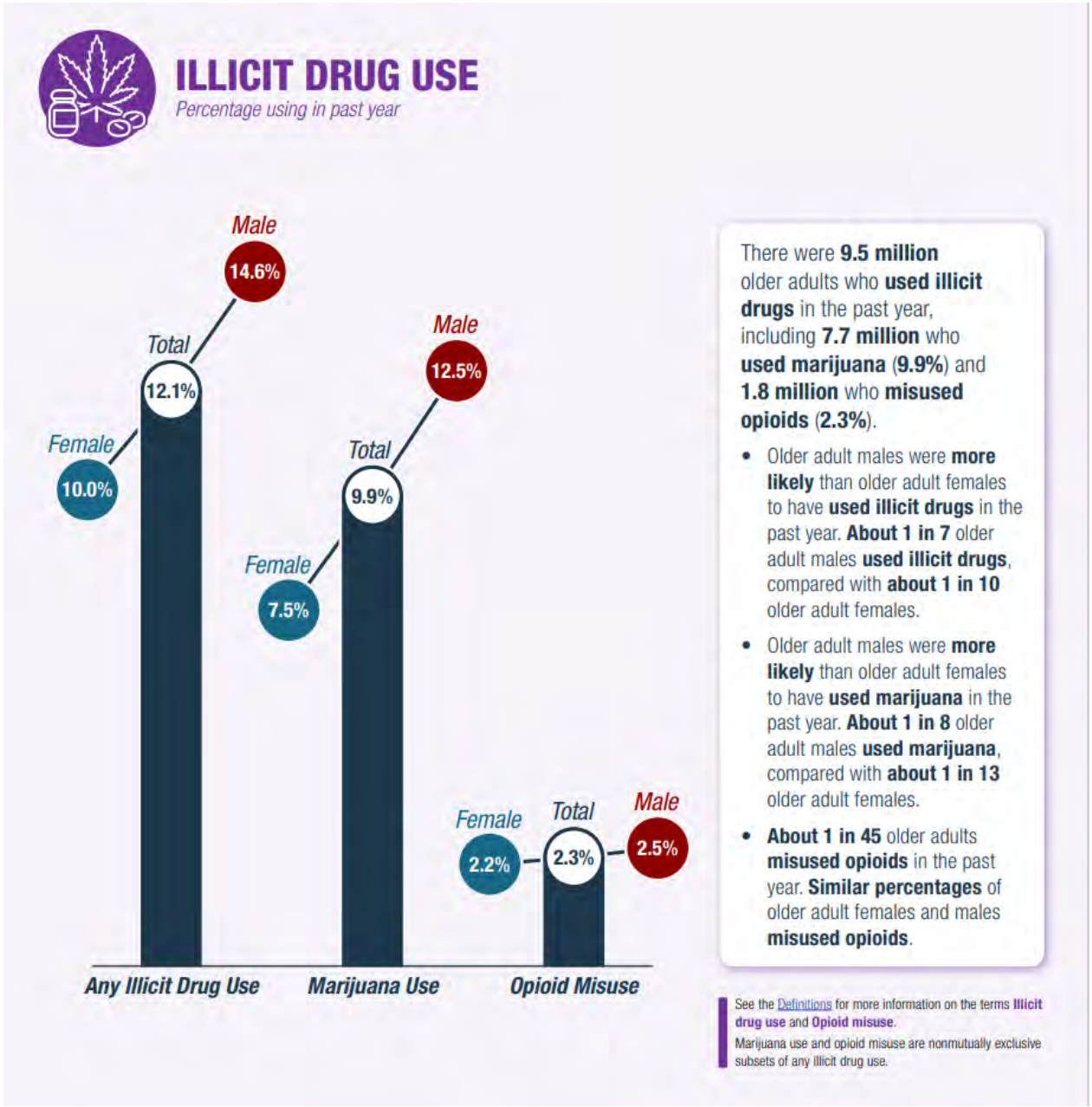
About 9.7 million older adults, or **nearly 1 in 8**, **smoked cigarettes** in the past month.

- Older adult males were **more likely** than older adult females to have **smoked cigarettes**. Percentages were **13.7%** for older adult males and **11.3%** for older adult females.



Numbers (Millions): **Cigarette Smoking:** *Females:* **4.7M**, *Males:* **5.0M**

Substance Abuse and Mental Health Services Administration. (2024). Behavioral health among older adults: Results from the 2021 and 2022 National Surveys on Drug Use and Health (SAMHSA Publication No. PEP24-07-018). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/older-adult-behavioral-health-report-2021-2022



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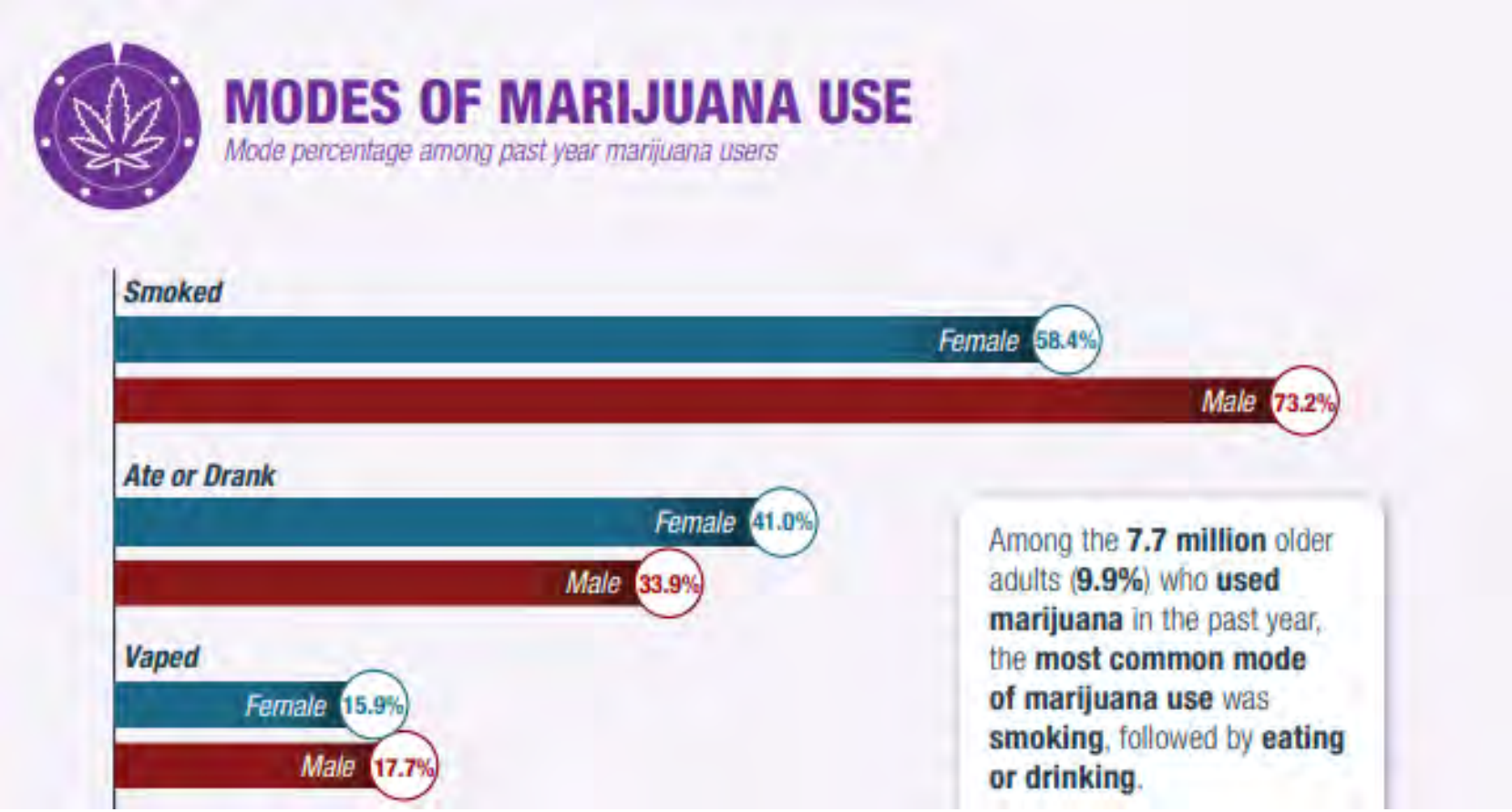

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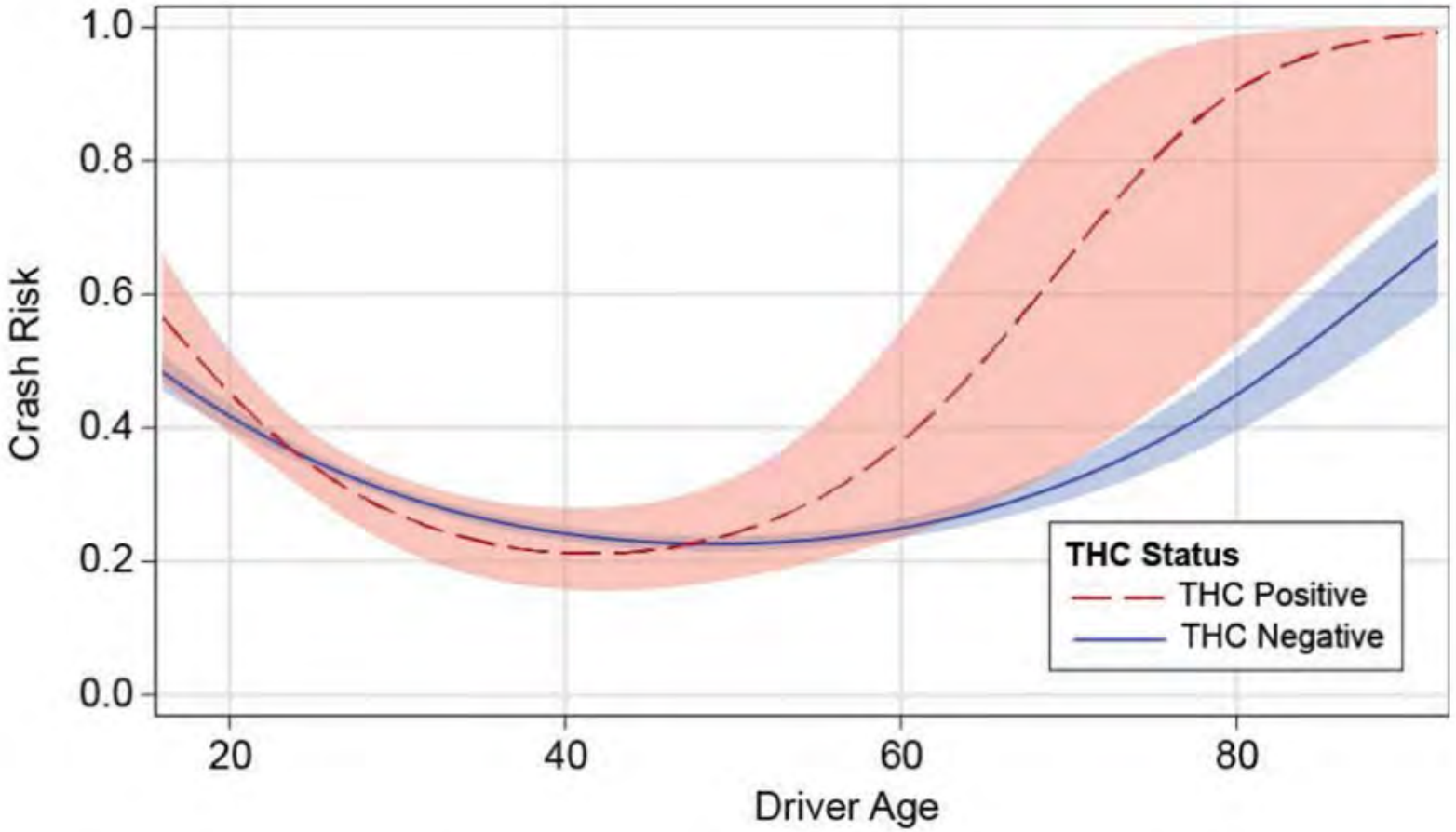


Fig. 1. Crash risk as a function of driver age and THC category.

Johnson MB, Mechtler L, Ali B, Swedler D, Kelley-Baker T. Cannabis and crash risk among older drivers. Accid Anal Prev. 2021 Mar;152:105987. doi: 10.1016/j.aap.2021.105987. Epub 2021 Feb 4. PMID: 33549974.

Cannabinoid Use FAR Outpaces ANY Evidence of It's Benefits*

*Except as add on to usual care for highly emetogenic chemotherapy

Opioid Use Disorder 2013-2018 in Adults over 65

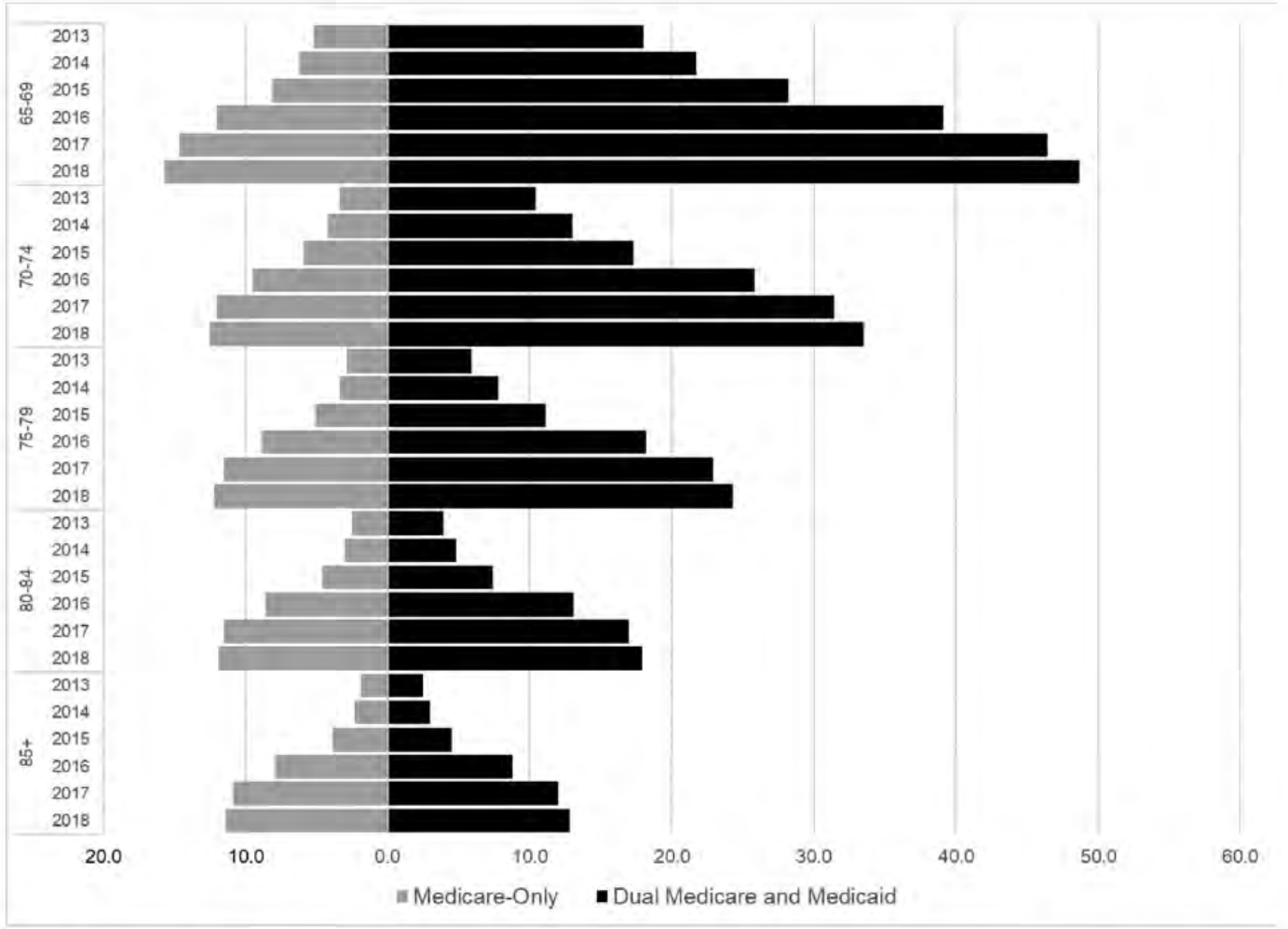
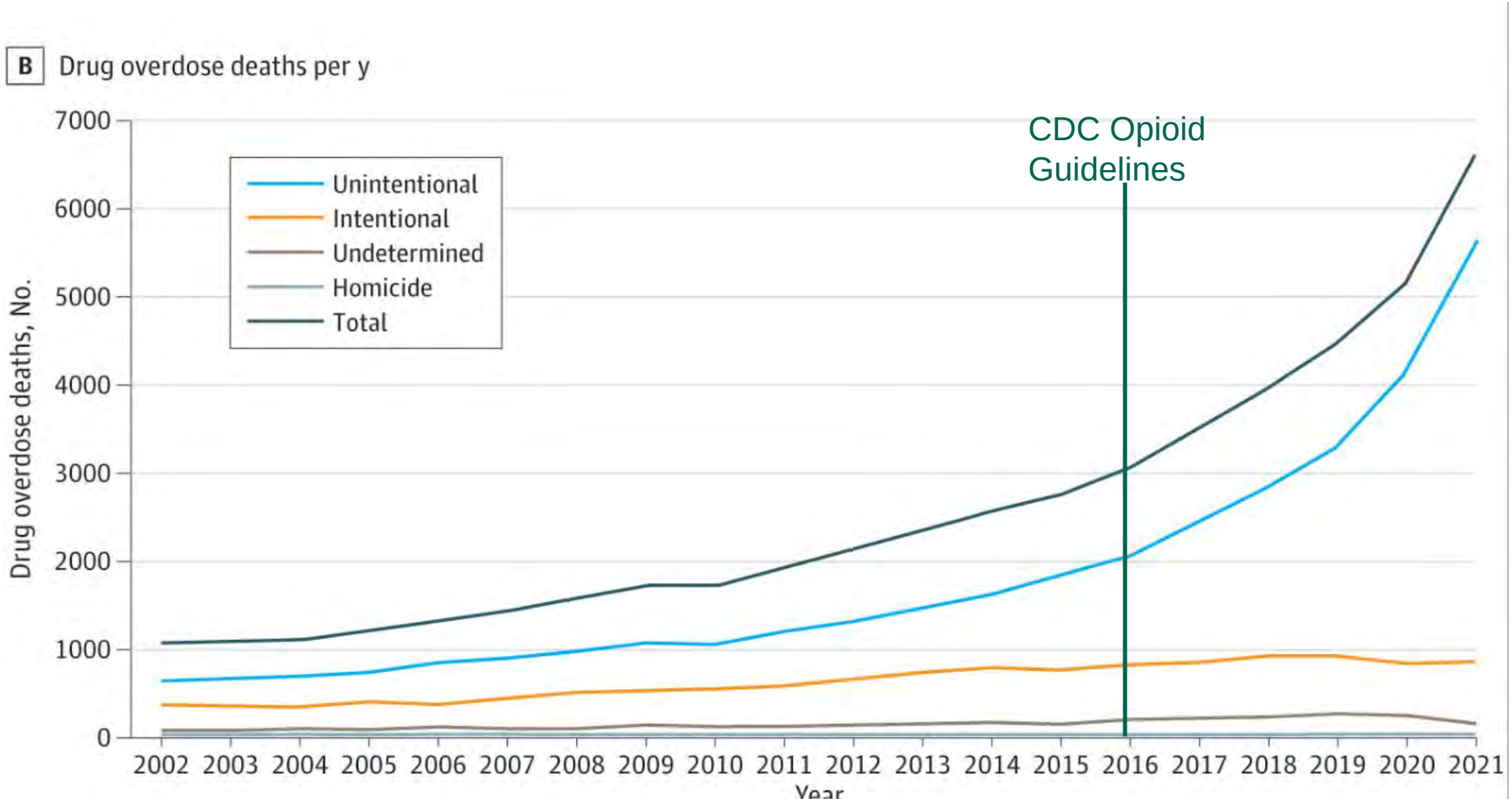


Figure 1. Estimated opioid use disorder prevalence per 1,000 Medicare beneficiaries by age and dual eligibility status, 2013–2018.

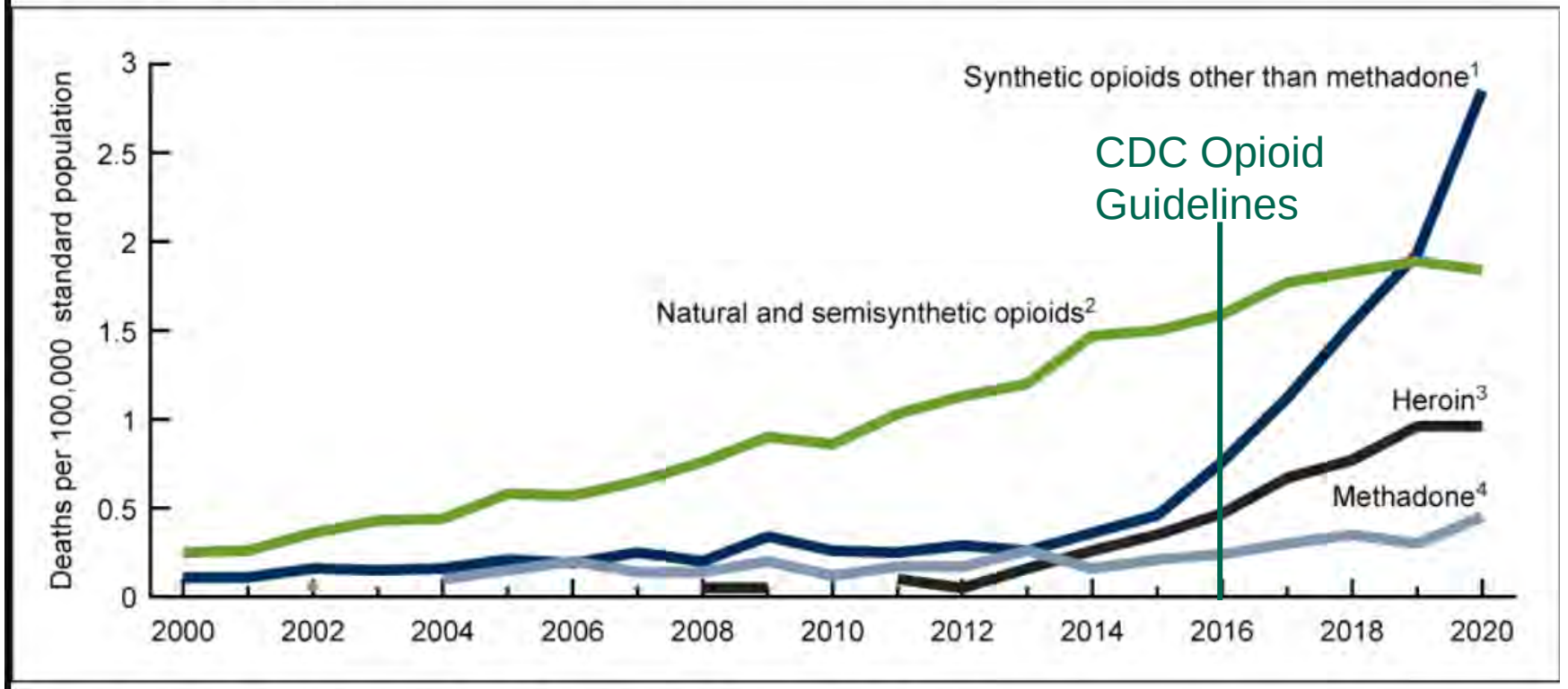
Note: All differences are statistically significant ($p \leq 0.001$).

Shoff C, Yang TC, Shaw BA. Trends in Opioid Use Disorder Among Older Adults: Analyzing Medicare Data, 2013-2018. Am J Prev Med. 2021 Jun;60(6):850-855. doi: 10.1016/j.amepre.2021.01.010. Epub 2021 Mar 31. PMID: 33812694; PMCID: PMC8154702.



Humphreys K, Shover CL. Twenty-Year Trends in Drug Overdose Fatalities Among Older Adults in the US. *JAMA Psychiatry*. 2023;80(5):518-520. doi:10.1001/jamapsychiatry.2022.5159

Figure 4. Age-adjusted rate of drug overdose deaths involving opioids for adults aged 65 and over, by type of opioid: United States, 2000–2020



[1]Significant increasing trend from 2000 through 2020, with different rates of change over time; $p < 0.05$.
[2]Significant increasing trend from 2000 through 2017, with different rates of change over time, and stable trend from 2017 through 2020; $p < 0.05$.
[3]Significant increasing trend from 2011 through 2017, and stable trend from 2017 through 2020; $p < 0.05$.
[4]Significant increasing trend from 2004 through 2020; $p < 0.05$.
NOTES: Drug overdose deaths are identified using the *International Classification of Diseases, 10th Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Drug overdose deaths involving opioids are identified by specific multiple-cause-of-death codes: heroin, T40.1; natural and semisynthetic opioids, T40.2; methadone, T40.3; and synthetic opioids other than methadone, T40.4. Deaths involving more than one opioid category are counted in both categories. Data are missing for years in which the number of deaths does not meet National Center for Health Statistics standards of reliability. Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db455-tables.pdf#4.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Kramarow EA, Tejada-Vera B. Drug overdose deaths in adults aged 65 and over: United States, 2000–2020. NCHS Data Brief, no 455. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: https://dx.doi.org/10.15620/cdc:121828

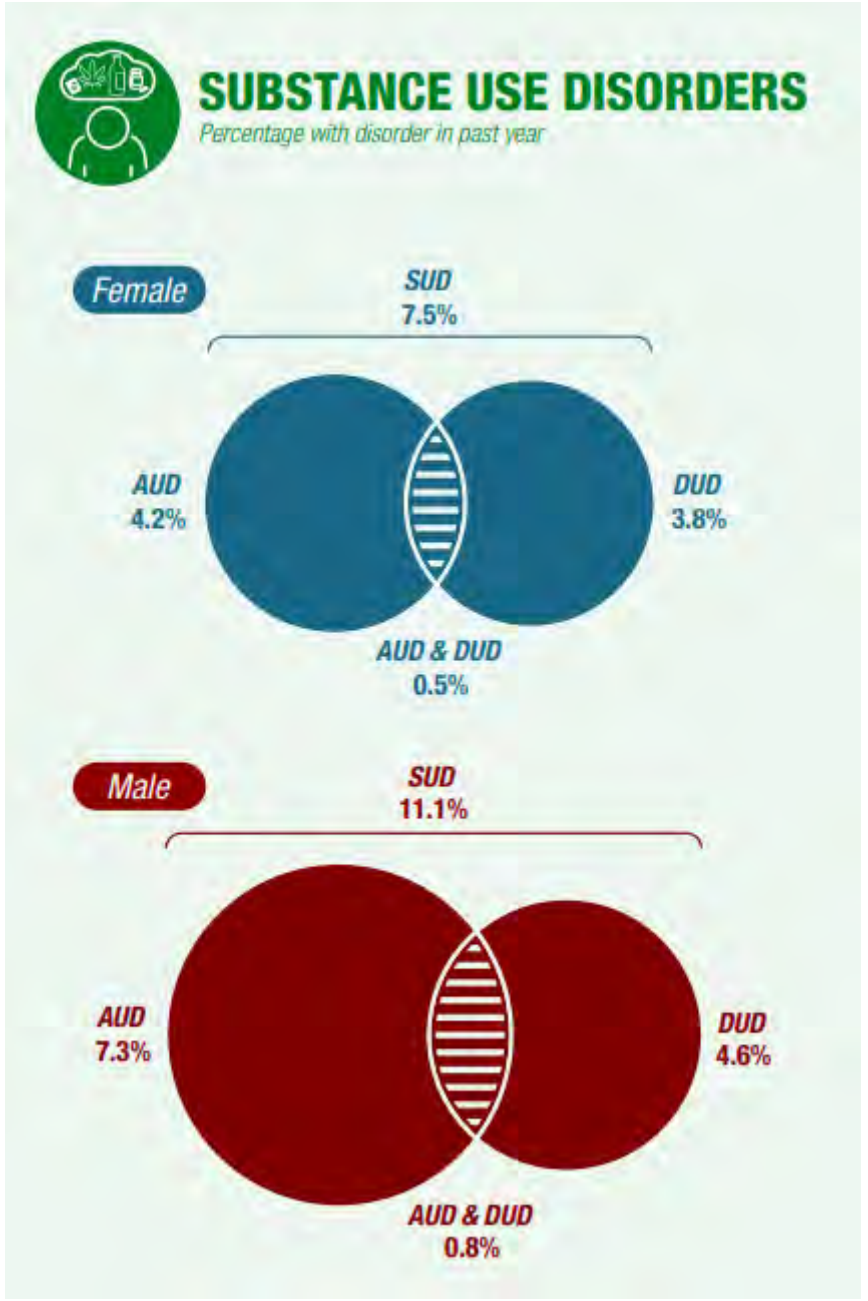


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Table 1. Use of DSM-5 Criteria for the Diagnosis of Substance-Use Disorder in Older Adults.*

DSM-5 Criterion	Application of Criterion for Older Adult
Substance taken in greater amount than intended	Older adult may be impaired using the same amount taken when younger
There is persistent desire or unsuccessful effort to cut down or control use	Older adult may not realize use is problematic, especially with long-term use
There is excessive time spent to obtain, use, or recover from the substance	Same
There is craving for the substance	Same
Repeated use leads to inability to perform role in the workplace or at school or home	Role impairment is less pertinent; older adult may be retired and may be living alone
Use continues despite negative consequences in social and interpersonal situations	Same
Valued social or work-related roles are stopped because of use	Effect of substance use on social roles is less obvious if older adult is no longer working
Repeated substance use occurs in potentially dangerous situations	Same; older adult may be at increased risk for impaired driving
Substance use not deterred by medical or psychiatric complication	Same; medical consequences can be serious, including confusion, falls with injury, and psychiatric symptoms
Tolerance develops: increasing amount is needed to obtain effects	Symptomatic impairment may occur without an obvious need for increasing the amount
Withdrawal syndrome occurs or patient takes substance to prevent withdrawal	Withdrawal syndrome can occur with more subtle symptoms such as confusion

* DSM-5 denotes *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition.

Lehmann SW, Fingerhood M. Substance-Use Disorders in Later Life. *N Engl J Med*. 2018;379(24):2351-2360. doi:10.1056/NEJMra1805981

Table 2. Signs of Possible Problematic Substance Use in Older Adults.

Psychiatric symptoms: sleep disturbances, frequent mood swings, persistent irritability, anxiety, depression
Physical symptoms: nausea, vomiting, poor coordination, tremors
Physical signs: unexplained injuries, falls, or bruises; malnutrition; evidence of self-neglect, such as poor hygiene
Cognitive changes: confusion and disorientation, memory impairment, daytime drowsiness, impaired reaction time
Social and behavioral changes: withdrawal from usual social activities, family discord, premature requests for refills of prescription medications

Lehmann SW, Fingerhood M. Substance-Use Disorders in Later Life. *N Engl J Med*. 2018;379(24):2351-2360. doi:10.1056/NEJMra1805981

Substance Use Sign?	Or……?
Memory problems or confusion	Cognitive issues, depression, vitamin deficiencies, thyroid issues, polypharmacy, hearing loss
Increase isolation	Depression, hearing loss, vision loss, cognitive issues,
Increased falls	Vitamin deficiencies, parkinson's disease, arthritis,
Difficulty managing daily tasks	Cognitive issues, depression, vitamin deficiencies, polypharmacy
Mood changes	Cognitive issues, depression, vitamin deficiencies ,thyroid issues, polypharmacy
Skipping health appointments	Cognitive issues, depression
Unsteady gait	Vitamin deficiencies, Parkinson's disease, arthritis, stroke, obesity
Unexplained injuries	Sleep disorders, hearing loss, vision loss, balance disorders
Excessive drowsiness or low energy	Sleep apnea, thyroid issues, depression
Drastic weight changes	Cancer, thyroid disease, obesity
Medication mismanagement	Cognitive issues, depression, vitamin deficiencies ,thyroid issues, polypharmacy
Slurred or slow speech	Stroke, other neurological problems, polypharmacy, thyroid issues, depression

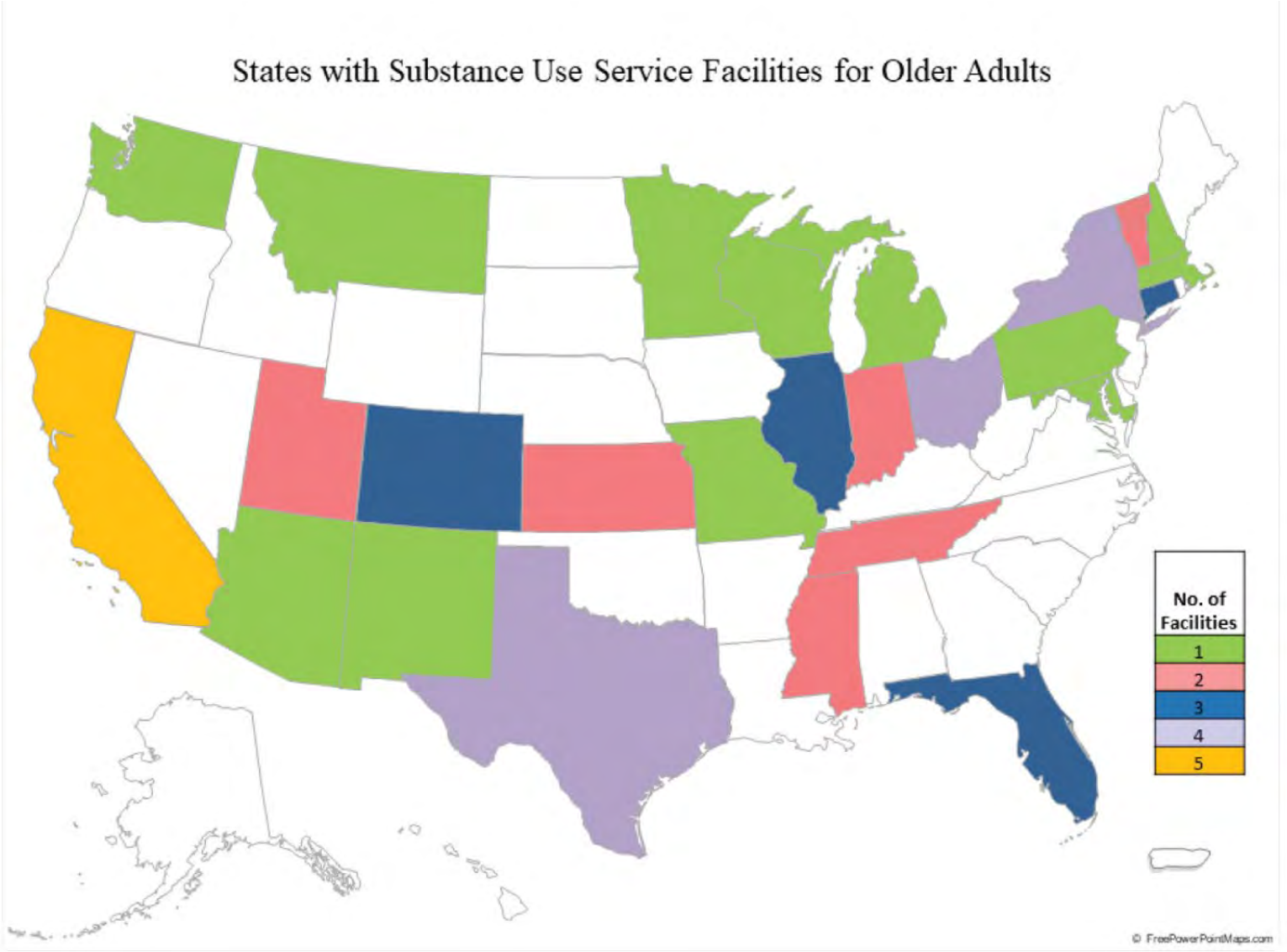
Substance Use is Often Not Recognized by Health Care Providers

Mental health concerns:
Co-occurring mental health issues like depression and anxiety can be intertwined with substance use, making diagnosis complex.

Healthcare provider bias:
Some healthcare professionals may not actively screen for substance use in older patients, assuming it is not a relevant concern.

Stigma Gets in the Way….

If You Don't Consider Substance Use – You Will Never Recognize It



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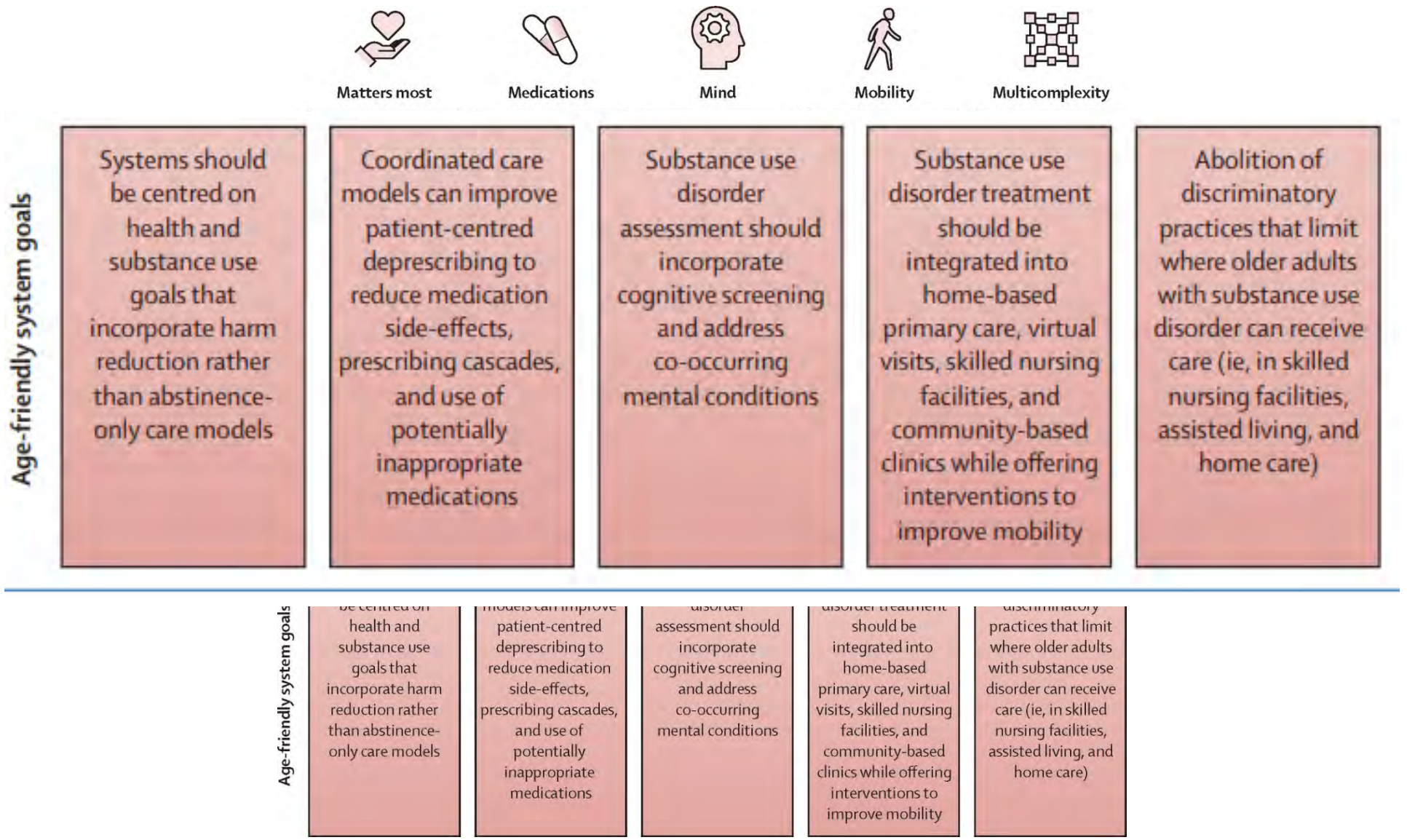
The “M”s of Substance Use



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Session 3, Depression, April 24, 2025

Depression in the Geriatric Population

Brian Rosen, MD, MSPH

Assistant Professor of Psychiatry

Dartmouth Health

Defining the Problem

What is Depression in Older Adults?

- Major depressive disorder
  - Early Onset
  - Late Onset Depression
- Persistent depressive disorder (dysthymia)
- Substance/medication-induced depressive disorder
- Depressive disorder due to a medical condition

DSM 5: Major Depressive Disorder

- Major Depressive Episode: Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or **(2) loss of interest or pleasure**.
  - Depressed most of the day, nearly every day as indicated by subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful)
  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by subjective account or observation)
  - Significant weight loss when not dieting or weight gain (e.g., change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
  - Insomnia or hypersomnia nearly every day
  - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - Fatigue or loss of energy nearly every day
  - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
  - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Late Life Depression

- Late life depression (LLD) is depression in older adults (“Geriatric Depression”)
  - “Late onset depression” = first onset of a depressive episode after age 60
    - Accounts for one-half of all episodes in older adults
    - Typically occurs in the context of a loss or medical illness
    - May be the harbinger of a neurocognitive disorder
  - “Early onset depression” = first onset of a depressive episode before age 60
    - “Endogenous depression”

Clinical Presentation of Late Life Depression

- Symptoms less common in the elderly
  - Low self-esteem
  - Guilt
  - Low mood
- Symptoms more common in the elderly
  - Somatic
  - Apathy
  - Anorexia and weight loss/food refusal
  - Psychomotor disturbances
  - Suicidal behavior (often abrupt and impulsive)
  - Psychosis
  - Care resistance/refusal

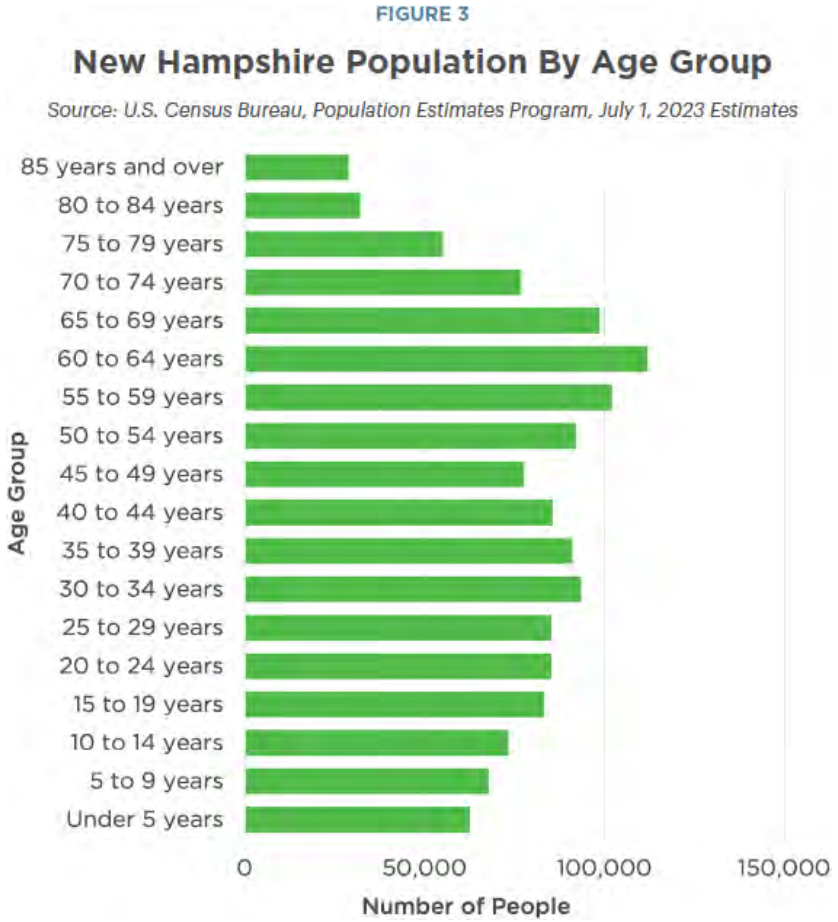
How Common is It

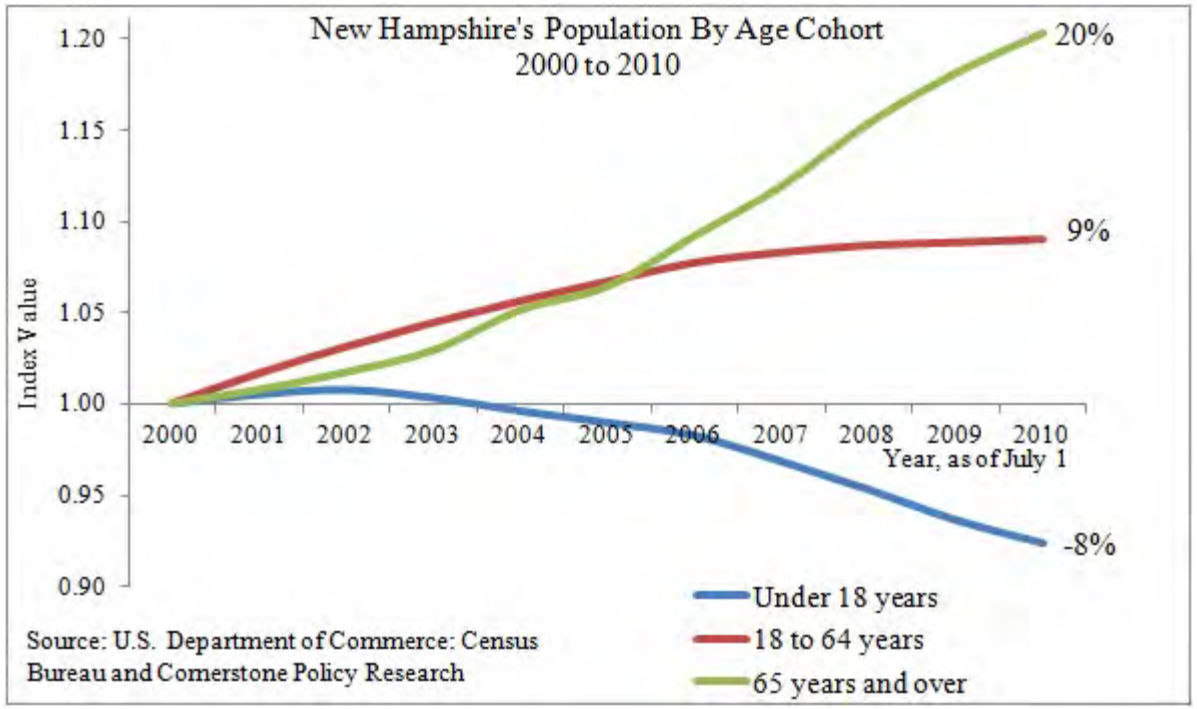
Epidemiology of Late Life Depression

- Prevalence of depression in community dwelling elders is ~2-15%
- Older adults hospitalized for medical illness or receiving home health have a 12% prevalence
- Prevalence in elders with MI, CVA, or cancer is >40%
- Prevalence in elders in nursing homes/long term care facilities is as high as 50%
- Overall prevalence of depression in the elderly is likely lower than younger groups but the incidence may be similar
- Undiagnosed in 50% of cases?

Biological
Psychological
Social

Demographic Shifts





[New Hampshire Policy Points 2025: Population and Demographics - New Hampshire Fiscal Policy Institute]

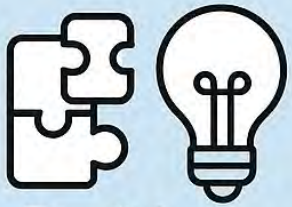
Evaluation in the Geriatric Patient

- History (+ collateral) and physical (neurological evaluation!)
- Scales (PHQ-9, QIDS, GDS, MoCA)
  - Useful to reduce stigma (increases capture)
  - Helpful to track changes over time
  - Helpful to use to convince patients they're better!
  - MoCA useful to determine if there's any cognitive impairment (cognitive profile is important - executive functioning, processing speed, attention are most impaired in LLD)
- Laboratory assessments (CBC w/ differential, CMP, UA, Utox, vitamin D, TSH, +/- B12/folate, RPR, HIV)
- Neuroimaging (+/- utility, useful if suspect primary CNS pathology, severe vascular burden, or neurocognitive disorder)
- PSG (OSA is a big depression mimic/contributor in the elderly)

Treatment

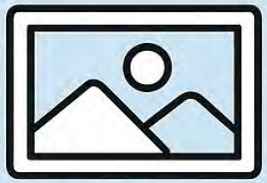
Cognitive Behavioral Therapy

Identifying and changing negative thinking and behavior patterns



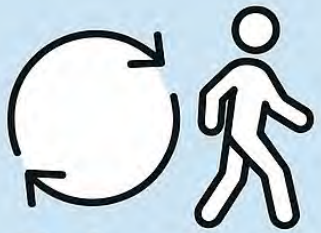
Problem-Solving Therapy

Developing skills to effectively manage life challenges



Reminiscence Therapy

Recalling past experiences and reflecting on their meaning



Behavioral Activation

Increasing engagement in positive and rewarding activities

Psychopharmacology

- All antidepressants equally effective at initially treating LLD*
  - What medication should I start first… It Depends!
- An adequate trial is 8 weeks at a therapeutic dose (increase dose at 6 weeks)
  - Must ensure adherence!
- Begin with ½ starting adult dose and increase as tolerated
- Make one change at a time

Choosing a medication

- Safety profile (e.g. orthostasis, overdose risk, QT interval) – Beers Criteria, STOPP, START
- Pharmacokinetic profile (e.g. absorption, distribution, metabolism, elimination)
- Pharmacodynamic profile (e.g. sensitivity to effects and side effects)
- Drug-drug interaction profile (e.g. CYP induction/inhibition)
- Tolerability (e.g. sedation, EPS, anticholinergic burden)
- Salutary effects (e.g. sedation, anxiolysis, activation, appetite stimulation, etc)

Treatment Resistant Geriatric Depression Differential Diagnosis

- SEPTICMD
  - Substances (abuse? withdrawal?)
  - Enough (dose too low? trial too short?)
  - Psychosis
  - Therapeutic Issues (transference? counter-transference?)
  - Iatrogenic (side effects? chemotherapy? interferon? hormones?)
  - Characterological
  - Medical Issues (hypothyroidism, OSA, pain, neurodegenerative, vascular, inflammation)
  - Diagnosis (wrong? comorbidities?)

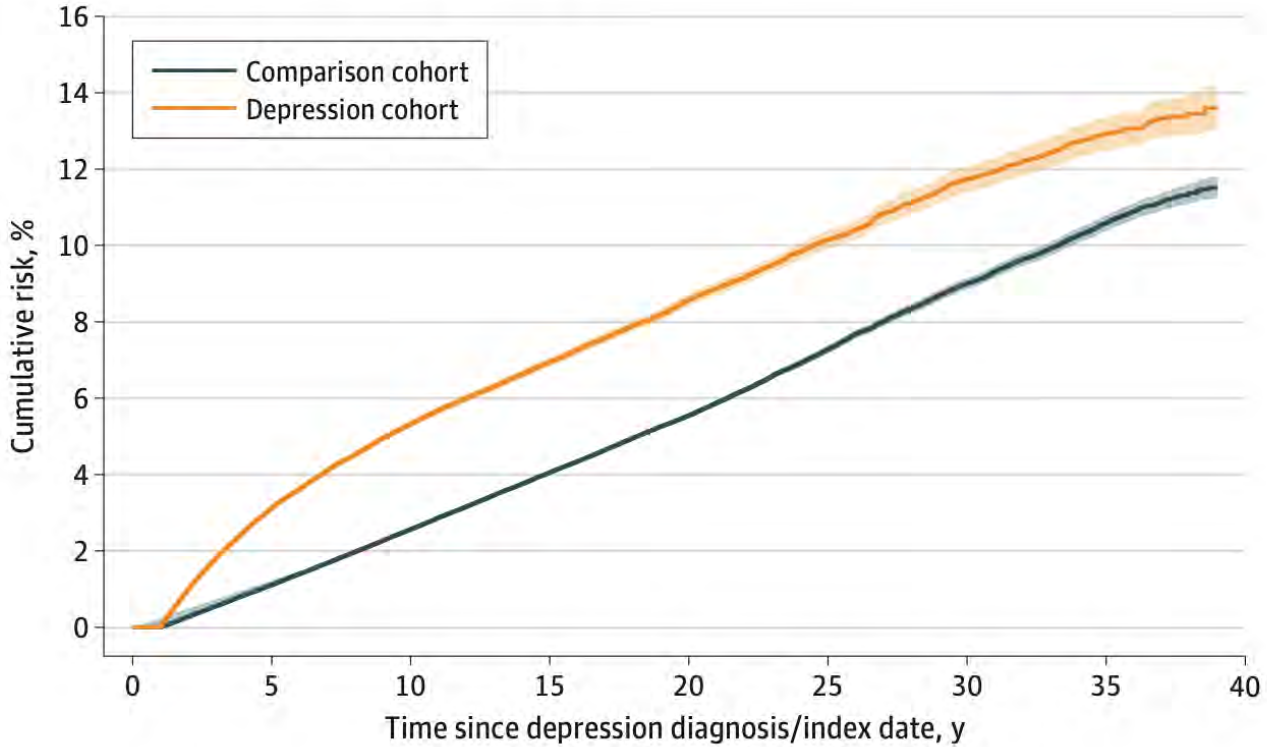
Treating Treatment Resistant Depression

- Treatment resistance is failure of more than 2 antidepressants
- Optimum Study (2023) – Demonstrating the importance of augmenting with aripiprazole or Wellbutrin.
- Consideration of interventional approaches
  - Transcranial Magnetic Stimulation
  - Electroconvulsive therapy
  - Esketamine (although no geriatric specific data exists)

Impact of LLD

- Depression is Dangerous!
  - Increases risk of suicide
  - Worsens medical comorbidities and reduces overall quality of life
  - Worsens functional status/reserve
  - Worsens cognition
  - Increases utilization of healthcare
  - Increases risk for problematic alcohol and drug use
  - Increases hospital LOS
  - Increases overall cost of care
- Depression is an independent risk factor for developing dementia (AD and VD) and LLD may be a dementia prodrome

Figure 1. Cumulative Incidence of Dementia for Individuals With Depression Diagnoses and Members of the Matched Comparison Cohort, 1980 to 2018



No. at risk								
Comparison cohort	1 190 302	882 944	534 344	286 315	123 605	33 844	19 095	7678
Depression cohort	246 499	168 402	95 296	48 305	19 211	4498	2409	931

Elser, et al JAMA Neurology July 25, 2023

Older adults often don't get the care they need for mental health

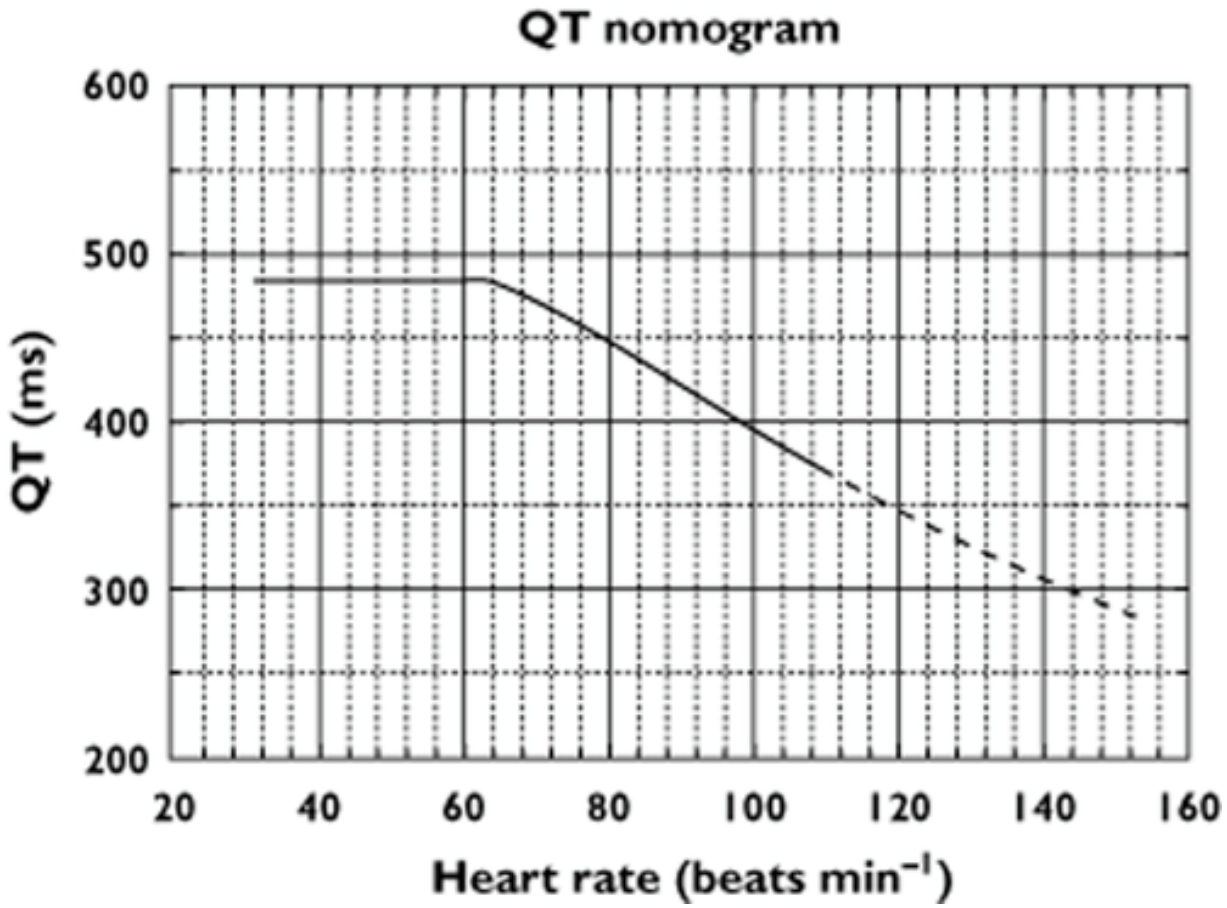
- Older adults often don't get the care they need for mental health
  - Do not seek help for depression.
  - Think symptoms are a normal part of getting older.
  - Feel stigma or shame about feeling depressed.
  - Do not appreciate that treatment can help
- Older adults may also face barriers to treatment, including:
  - Difficulty getting care because of costs, problems with transportation, or a lack of mental health services.
- Healthcare professionals may not adequately diagnose or treat depression in older adults.
  - May confuse the symptoms with physical illness
  - Do not appropriately screen

Special Topics

Citalopram and the FDA

- FDA released a black box warning for citalopram in 2011 citing risk of QTc prolongation and Torsade de Pointes and that the maximum daily dose should not exceed 40 mg
- The maximum recommended dose of citalopram is 20 mg per day for patients older than 60 years of age
- Citalopram should be discontinued in patients who are found to have persistent QTc measurements greater than 500 ms

QT Nomogram



Isbister and Page, BJCP 2012

4 Things To Know About Depression & Older Adults

Depression is a common problem among older adults, but it is not a normal part of aging. It can affect the way you feel, act, and think.

1. **Depression can be treated.**
   It's important to seek help early on.

2. **Signs and symptoms of depression vary.**
   For some older adults with depression, sadness may not be their main symptom.

3. **Friends and family can help offer support.**
   They can help watch for symptoms and encourage treatment.

4. **Living a healthy lifestyle can help reduce feelings of depression.**
   This may include eating a balanced diet and being physically active.

To learn more, visit **www.nia.nih.gov/depression**.

NIH National Institute on Aging

Questions?

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WELCOME
to the

Geriatric Mental Health in Primary Care ECHO

Session 4, Anxiety, May 22, 2025

Anxiety and Older Adults

Brian J. Rosen, MD

Goals

Recognize	Recognize how anxiety presents differently in older adults.
Screen	Screen for anxiety using age-appropriate tools.
Understand	Understand medical mimics and differential diagnoses.
Initiate	Initiate first-line treatment and know when to refer.

Is This Common?

Anxiety is a common illness among older adults, affecting as many as 10-20 percent of the older population, though it is often undiagnosed.

Prevenance varies based on housing setting

Significant heterogeneity in presentation and cultural norms makes this difficult to study

Hidden Epidemic

Older adults often don’t recognize their symptoms as anxiety — or if they do, they may not feel comfortable bringing it up.

Many have lived with anxiety for decades and assume it’s just part of who they are.

Anxiety is frequently missed by clinicians, especially in the context of:

- Chronic medical illness
- Polypharmacy
- Major life events (e.g., bereavement, illness, caregiving)

Untreated anxiety in older adults is linked to:

- Cognitive decline
- Increased disability
- Poorer physical health
- Reduced quality of life

Common Types of Anxiety

- Generalized Anxiety Disorder
- Specific Phobias
- Social Anxiety Disorder
- Panic Disorder

Generalized Anxiety Disorder (GAD)

Characterized by chronic, excessive worry about multiple concerns (health, finances, family) that is hard to control.

GAD is frequently seen in older patients and may present with more somatic symptoms (fatigue, muscle tension, poor sleep) than in younger adults

One of the most common anxiety disorders in later life, though many cases go untreated.

Social Anxiety Disorder

Anxiety marked by intense fear of social or performance situations.

Older adults may become extremely anxious about being judged or embarrassed, sometimes due to age-related concerns.

This can lead to avoiding social engagements, worsening isolation.

Specific Phobias

Persistent irrational fears of specific objects or situations.

Common Phobias: Fear of falling, Fear of illness or death, Medical procedures or appointments

This can lead to avoiding social engagements, worsening isolation.

Panic Disorder

Involves recurrent panic attacks – sudden episodes of terror accompanied by physical symptoms like chest pain, palpitations, shortness of breath, dizziness, etc.

Panic disorder is less common in late life than in younger populations

However, it does occur and can be misinterpreted as a medical emergency (e.g. heart attack) in older adults.

How Anxiety Presents in Older Adults

Somatic complaints (GI distress, chest tightness, breathlessness)

Sleep disruption

Cognitive complaints (“my memory is worse”)

Avoidance of social interaction or activities

Less likely to report worry explicitly

Often masked by comorbidities

Diagnosis in Primary Care: Recognition and Challenges

Somatic Symptom Overlap

Under-reporting and Stigma

Attribution to Life Stressors

Cognitive Impairment

Multiple Medications and Conditions

Screening Tools for Primary Care

GAD-7: validated in older adults, but cutoff ≥5 may be more sensitive

Geriatric Anxiety Inventory (GAI) – if more time is available

Consider combining with PHQ-9

When It’s Not Just Anxiety

Rule out:

- Medication side effects (e.g. bronchodilators, antidepressants)
- Early cognitive impairment
- Physical illness (PE, arrhythmia, hyperthyroidism)

Anxiety often *coexists* with:

- Depression
- Dementia
- Substance use

First-Line Treatment Options

Psychoeducation – normalize, not minimize

CBT – effective even via telehealth

Mindfulness & relaxation

Exercise, routine, social connection

First-Line Treatment Options

SSRI (citalopram, escitalopram, sertraline)

SNRI (duloxetine, venlafaxine)

Buspar

AVOID Benzodiazepines

Monitoring & Follow-up

Set clear symptom targets (sleep, function, socialization)

Use GAD-7 over time (track progress)

Reassess every 2–4 weeks early on

Watch for SE of medication therapy

When to Refer

Severe symptoms with suicidal ideation

Comorbid psychosis, trauma, or substance use

No response to SSRI/SNRI + non-pharmacologic therapy

Diagnostic uncertainty (e.g., new-onset anxiety + cognitive decline)

Key Takeaways

Anxiety is common but often atypical in older adults

Screen with GAD-7, think function not just “worry”

Prioritize CBT, SSRIs, social connection

Avoid benzos

Collaborate with caregivers and check for cognitive change

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WELCOME to the

Geriatric Mental Health in Primary Care ECHO

Session 5, Serious Mental Illness, June 26, 2025

Older adults and serious mental illness

Lisa A. Mistler

Associate Professor of Psychiatry

Dartmouth-Hitchcock Health

Overview

- Definition of SMI
- Specific needs of older adults with SMI
- Programs designed to meet those needs
- Specific tips

Project ECHO series

- Social connectedness and aging
- Substance use and older adults
- Depression in the geriatric population
- Anxiety and older adults

Definition of Serious Mental Illness (SMI)

DSM5 diagnosable mental disorders leading to significant impairment in functioning

Schizophrenia, schizoaffective disorder, bipolar illness, treatment-resistant major depressive disorder

Risk factors and complications in older adults

Demographic differences in rates of psychological distress	Racial/ethnic Income Gender
Disruptive effects of sub-clinical levels of distress	Social isolation, loneliness, depression. Large percentage receiving mental health care not associated with diagnosable mental disorder
Link between mental health and physical health	↑ functional impairment associated with ↑ depression symptoms
Psychological distress associated with economic disadvantage	Disrupted employment Underinsurance

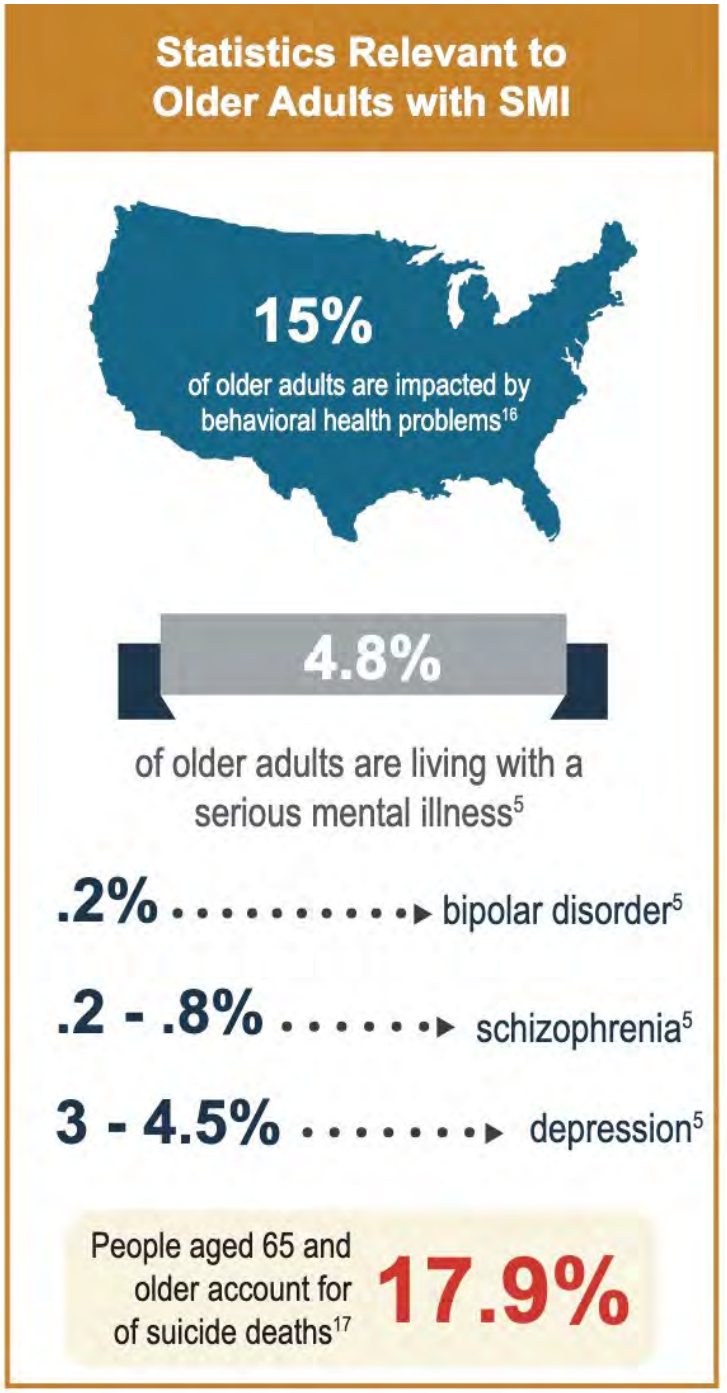
Revised definition of Serious Mental Illness (SMI)

DSM diagnosable mental disorders leading to significant impairment in functioning

Schizophrenia, schizoaffective disorder, bipolar illness, treatment-resistant major depressive disorder

Older adults with one or more other disorders may fit the definition of SMI if the disorders result in functional impairment

How common is SMI in older adults?



Source: SAMHSA 2019

- **Older adults with SMI may have:**
- ↑ rate of comorbid health conditions
- ↓ life expectancy
- Financial difficulty
- Cumulative effects of neuroleptics/change in metabolism
- Lifestyle
- Substance misuse
- Potential cognitive impairment
- ↑ rates of hospitalization

More likely in older adults with SMI

- Impaired independent living skills
- Poor social skills
- Minimal social support
- Limited medical and psychiatric self-management skills


It's
Complicated

Treatment considerations

Higher prevalence of comorbid physical health problems and substance use disorder in older adults with SMI

Difficult to disentangle overlapping symptoms

Requires integrated approach

Features of integrated models of care

- Co-location or embedded services
- Collaborative care
- Person-centered care
- Whole-person approach
- Improved access and outcomes
- Reduced stigma

Evidence-based models of social skills training

HOPES- Helping older people experience success

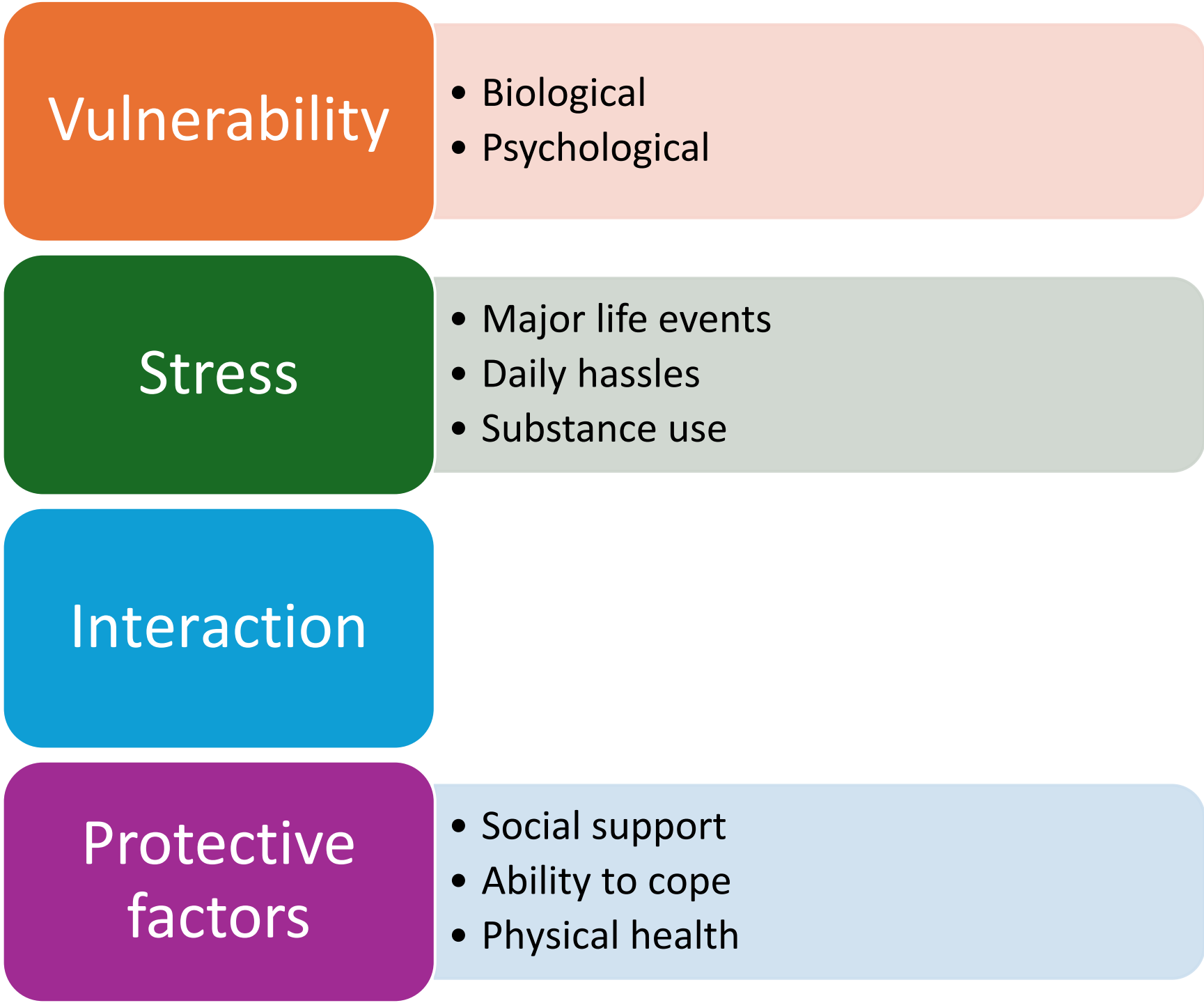
CBSST- Cognitive behavioral social skills training

Evidence-based models of illness self-management

HARP- Health and recovery peer program

I-IMR- Integrated illness management and recovery

Stress-vulnerability model



I-IMR comprises 4 evidence-based practices:

- Psychoeducation
- Behavioral tailoring
- Relapse prevention
- Coping skills

I-IMR modules

- Recovery
- Brain-body connection
- Practical facts (mental and physical health)
- Healthy lifestyles
- Using medication effectively
- Social support
- Managing stress
- Managing physical and mental health
- Relapse prevention
- Self advocacy

Tips

Screen	Screen for common disorders, but be suspicious
Have	Have a high threshold for attributing symptoms to psychiatric diagnosis
Email or call	Email or call their psychiatric clinician

Tips

Ask about

Ask about substances

- “Do you ever need just a “little something” to help you sleep?”
- “Wow. I bet you could drink 8 cups of coffee a day.”

Normalize

Normalize hallucinations

- “Some of my patients hear someone calling their name or see something out of the corner of their eye.”

Treat

Treat delusions seriously and kindly

- “It sounds like you’re really afraid that someone’s breaking in at night.”

Key takeaways

When daily function is affected by symptoms, consider subclinical diagnoses

Integrated care is the gold standard

Emphasize collaboration and shared decision making

Thank you!

- Q and A
- Case discussion

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