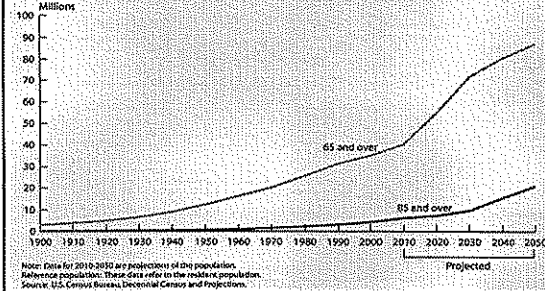


Mental Health Care for Older Adults in Primary Care

University of Iowa
March 29, 2006

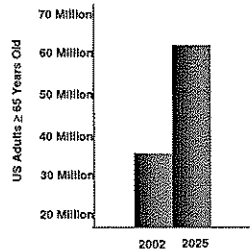
Martha L. Bruce, Ph.D., M.P.H.
Professor of Sociology in Psychiatry
Weill Medical College of Cornell University

Number of people age 65 and over, by age group, selected years 1900-2000 and projected 2010-2050



Why Focus on Geriatric Mental Health?

- ♦The number of Americans over the age of 65 is expected to grow to 62 million by 2025
- ♦The number of older adults suffering from mental disorders will rise at a similar, if not faster, growth rate
- ♦18-28% of elderly population has significant psychiatric symptoms
- ♦Between 7,218,000 and 11,228,000 older adults will have significant psychiatric symptoms by 2010



Top 10 Recommendations of White House Conference on Aging Delegates

1. Reauthorize the Older Americans Act within the first six months following the 2005 White House Conference on Aging
2. Develop a coordinated, comprehensive long-term care strategy by supporting public and private sector initiatives that address financing, choice, quality, service delivery, and the paid and unpaid workforce
3. Ensure that older Americans have transportation options to retain their mobility and independence
4. Strengthen and improve the Medicaid program for seniors
5. Strengthen and improve the Medicare program
6. Support geriatric education and training for all healthcare professionals, paraprofessionals, health profession students, and direct care workers
7. Promote innovative models of non-institutional long-term care
8. Improve recognition, assessment, and treatment of mental illness and depression among older Americans
9. Attain adequate numbers of healthcare personnel in all professions who are skilled, culturally competent, and specialized in geriatrics
10. Improve state and local based integrated delivery systems to meet 21st century needs of seniors

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Good Mental Health is the Foundation for Overall Health, Quality of Life and Independence

Factors that increase risk of depression:

- Medical Illness (cardiovascular disease)
- Disability
- Cognitive Decline
- Social Isolation
- Loss And Other Negative Events
- Genetic Vulnerability

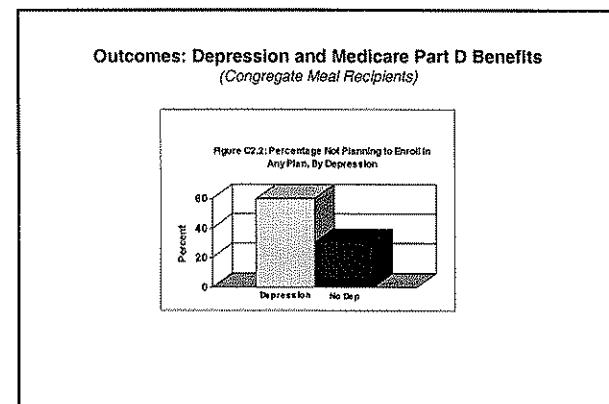
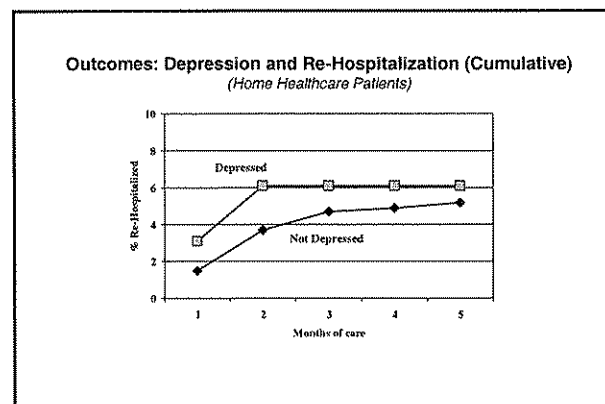
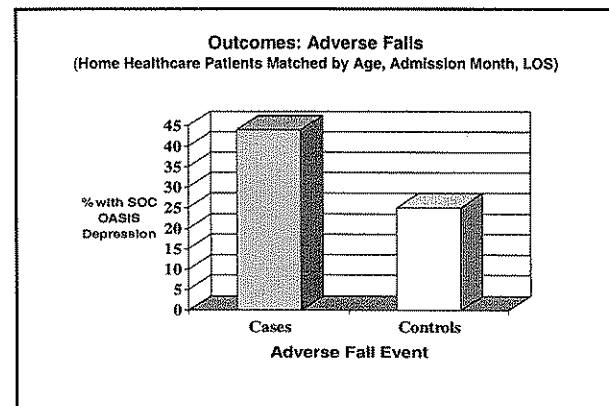
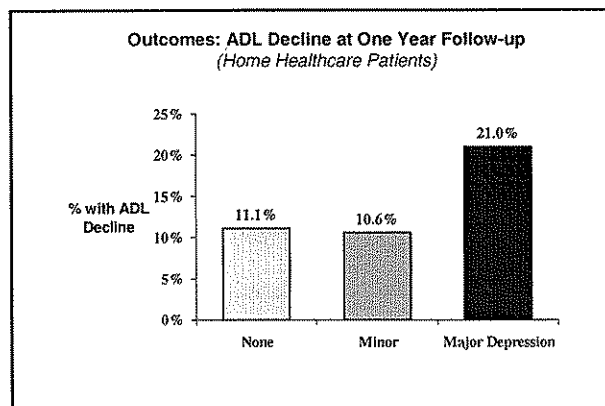
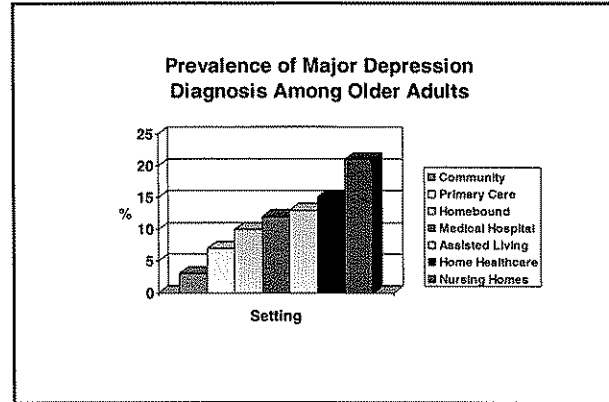
Depression increases the risk of:

- Medical Illness
- Disability
- Social Isolation
- Cognitive Decline
- Loss Of Independence
- Relocation/Institutionalization
- Suicide And Deaths From Other Causes

Severe Mental Illness Does Not Protect From Aging-Related Losses

*Residents of "Adult Homes" with
History of Mental Illness:*

- Chronic Medical Conditions (diabetes, hypertension)
- Declining Self-Care abilities
- Declining Outside Interests
- Loss of Parents, Siblings
- Decline in Decision Making abilities



What Is the Evidence Base for Geriatric Mental Health?

Depression

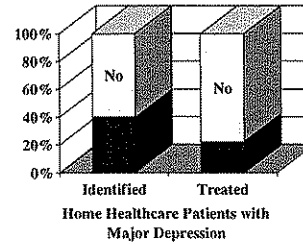
- **Treatment:** Efficacious medication and psychotherapy treatments for mild to moderate depression
 - NIH research on complex depressions (severe, psychotic features, bipolar, executive dysfunction)

• **Primary Care:**

- Detection and Screening
- Collaborative Care Models
- Care Management Models
 - PROSPECT
 - IMPACT
 - PRISM-E

Outreach Models

Depression Remains Typically Overlooked and Untreated



Primary Care can collaborate with MH Specialty to:

Improve Mental Health Assessment

1. Counsel Patients about Depression
2. Include Diagnostic Assessments
3. Provide Treatment and Care Management

Training in Depression Screening

- Geriatric Depression Facts (video)
- Depression Assessment (video)
- Tool Kit
- Field Practice
- Reminders and Boosters



First: What is Major Depressive Disorder?

A syndrome of 5+ symptoms lasting \geq two weeks

- **Symptoms must include:**
 - Depressed or sad mood
 - OR
 - Decreased interest or pleasure in activities
- **Other symptoms include:**
 - Significant changes in appetite or weight
 - Sleep disturbances
 - Restlessness or sluggishness
 - Fatigue or loss of energy
 - Lack of concentration or indecision
 - Feelings of worthlessness or inappropriate guilt
 - Thoughts of death or suicide

Facts: Depression Is Caused By:

- **Multiple factors interacting with each other.**
 - Genetics
 - Medical illness (especially cardiovascular)
 - Psychological trauma.
- **Depression can occur without any obvious stressful event.**
- **Depression is a Biological Illness**




Non-Depressed Brain

Depressed Brain

Reprinted with permission from Mark George, MD, Biological Psychiatry Branch, Division of Intramural Research Programs, NIMH, 1997

Challenges in Assessing Depression

- **Belief that depression is:**
 - A "normal" and therefore an acceptable part of aging
 - A "normal" response to illness, disability, isolation
 - A reflection of poor moral character
 - Not treatable
- **Symptoms overlap with medical illness & treatments**
 - Misattribution of physical symptoms to depression
 - Misattribution of depression symptoms to medical illness
- **Masked by:**
 - "Atypical symptoms"
 - Anxiety, worry,
 - disability,
 - pain,
 - cognitive impairment





Training in Depression Screening (Home Healthcare Nurses)

Assessment Approach must:

- Add as little as possible burden or time
- Be similar to assessments
- Not stigmatize depression
- Rely on nurses' knowledge and clinical judgment

Use the Two-Item Screen as a platform

- Training in making them sensitive with older adults
- Follow-up questions ONLY when clinically relevant

Two Item Screen In the Context of Physical Assessment


- 1 - Depressed mood (e.g., feeling sad, tearful)

"How has your mood been in the past couple of weeks?
 Have you been feeling depressed or down? How about sad or blue?"
- 2 - Loss of Pleasure or interest in Usual Activities



"In the past week, have you found yourself losing interest
 in your activities [that you are able to do]?"

If Yes to either question, ask:

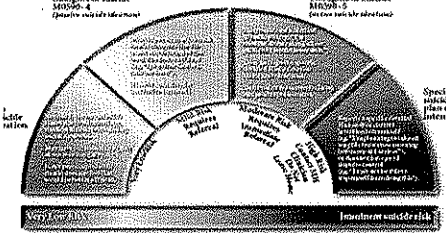
- "How long have you been feeling this way?"
 - Two weeks or more?
- "How much of the day?"
 - Much of the day (not just transient thoughts)?




Training Video

Suicide Risk Assessment



*Always follow individual agency procedures for suicidal patients.



Interacting with Depressed Patients

REASSESS symptoms at each visit. If symptoms persist after a month of treatment, contact physician


REASSURE patients that being depressed is not their fault

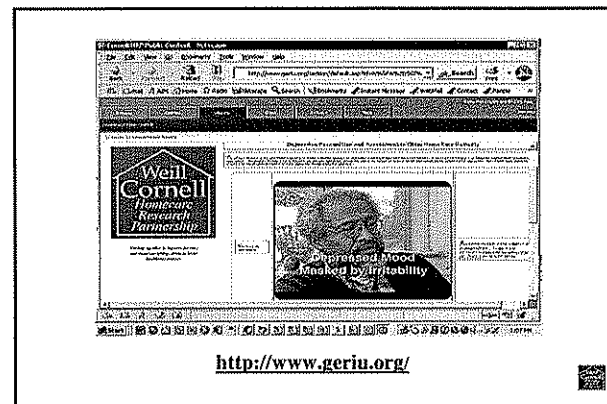
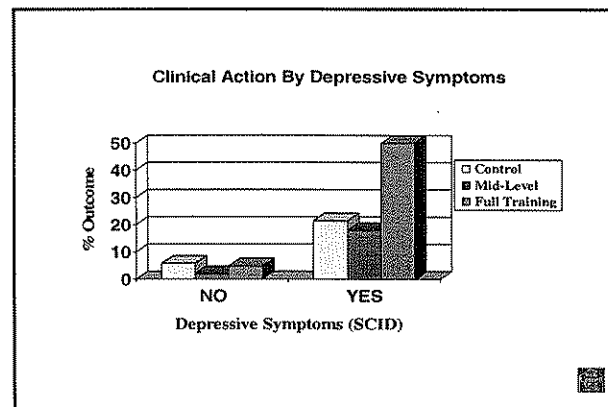
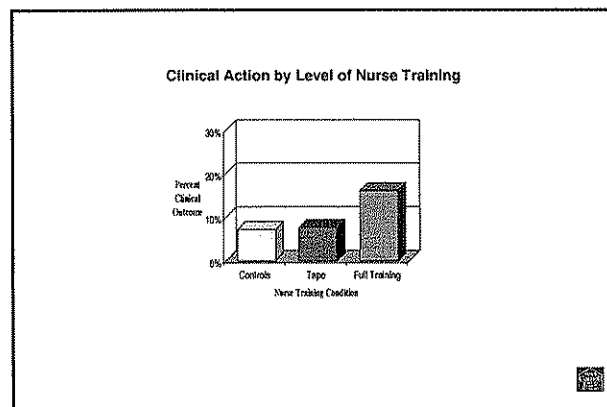
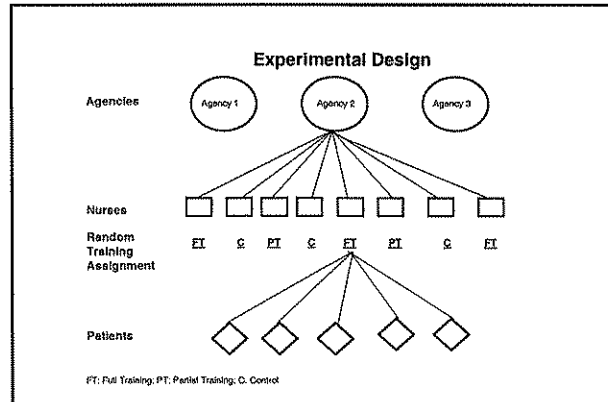
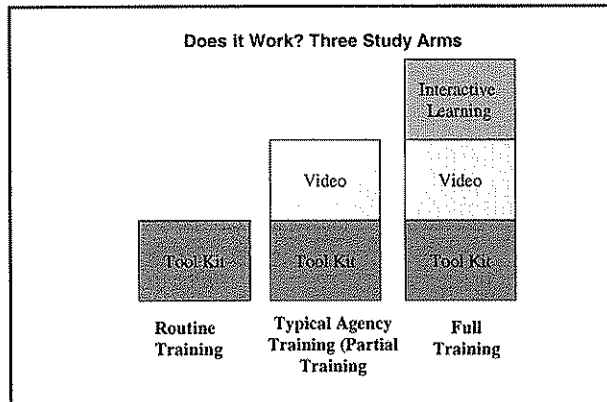
SUPPORT patients by reassuring them that they can always call on you or other health care provide for help and support

ENCOURAGE patients to engage in activities that are pleasant to them and that they are still able to do

REMINd patients that depression is treatable, but it takes time

REMAIN positive -- yet matter of fact -- yourself





Depression is treatable

- ◆ Antidepressants as effective in older patients as younger patients (*Reynolds et al, 2003, JAMA*)
- ◆ Psychotherapy also as effective in older patients as younger patients (*Araan & Cook, 2002 Biol. Psych.*)

Psychotherapy for late-life depression

- ◆ 27 RCTs to date (Mackin & Areán, 2003; Areán & Cook, 2003)
- ◆ Cognitive Behavioral Therapy
- ◆ Interpersonal Therapy
- ◆ Problem Solving Therapy
- ◆ Brief Dynamic Therapy
- ◆ Reminiscence Therapy
- ◆ Bibliotherapy

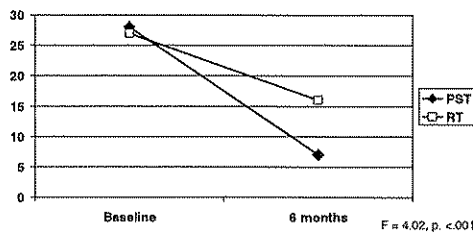


Common Adaptations

- ◆ Longer session times.
- ◆ More sessions.
- ◆ "Say-it, show-it, do-it"/ "Cue and Review"
- ◆ Relying on past experiences to enhance learning.
- ◆ Involving significant others.

Problem Solving Therapy versus Reminiscence

(Areán et al, 1994)



Access barriers (Alvidrez & Areán, in press)

- ◆ Common concerns about psychotherapy
 - Stigmatization;
 - Fear of mental health settings;
 - Being pressured to divulge personal information;
 - Too time intensive;
 - Working with a therapist from a different background.
- ◆ Strategies to make therapy more helpful
 - Using a medical model of psychiatric disorders;
 - Collaborating with the therapist ;
 - Integration in to low-stigma settings.

Barriers to Mental Health Referral Among Older Adults Participating in Home Delivered Meals

Sirey et al., preliminary data

Evidence Based Systems of Care for Depression in Primary Care



3rd Generation Depression System Change Interventions

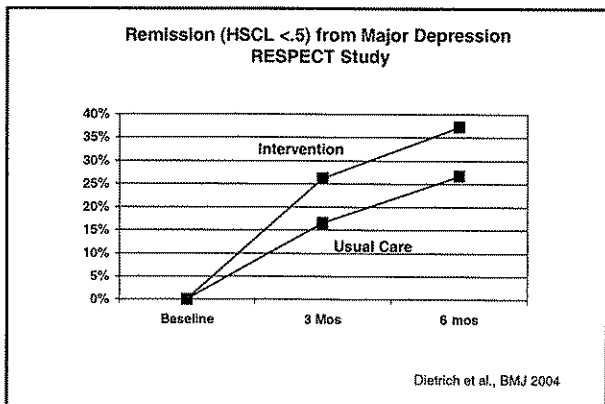
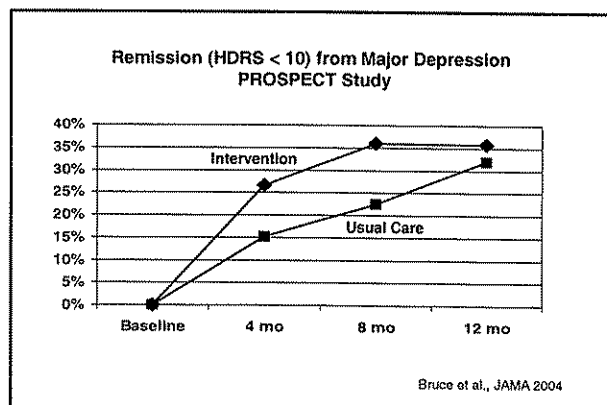
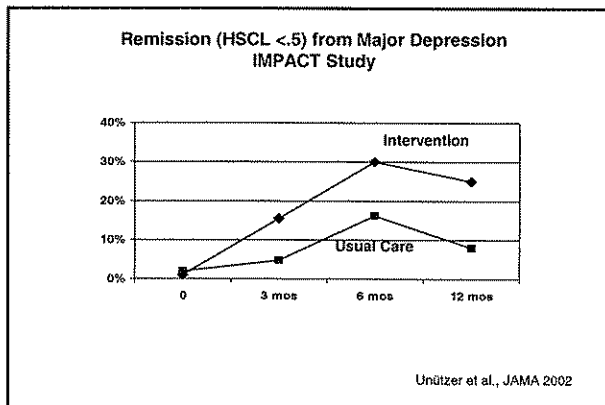
Change	IMPACT	PROSPECT	RESPECT
	Depression Specialist	Depression Specialist	TCM
Care Mgmt	On-site	On-site	Off-site
Patient Education	Yes	Yes	Yes
Psychiatric supervision	Face to face	Face to face	Telephone
Psychotherapy supervision	Telephone	Face to face	N/A
Rx algorithm	Yes	Yes	No

Managing Any Other Chronic Disease

Monitor Depressive Symptoms
 Educate Patient and Family
 Monitor Adherence
 Monitor Side Effects
 Provide Support

Managing Antidepressants is Like.....

Consult or Refer to Agency/Outside Specialist As Needed



- Cultural and Ethnic Diversity
- **Little evidence** that prevalence of mental illness varies
 - especially taking into account
 - Setting
 - Medical burden and disability
 - Socioeconomic environment
 - Immigration and social networks
 - **Lots of evidence** that access to quality mental health care varies
 - for example:
 - "Impacted" Adult homes disproportional ethnic minorities
 - Black HC patients half as likely to be treated for depression
 - **Insufficient understanding** of definitions of "quality" care
 - Evidence of racial/ethnic variation in
 - Treatment preferences (prayer)
 - Attitudes and beliefs about mental illness and treatment
 - Family involvement
 - Preferred types of providers

Thank you

Questions?