



Practice guide

Integrated behavioral
health care for older adults

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Part 1

Introduction

The goal of this resource is to provide primary care practices with actionable, evidence-based guidance on the nuances of integrated care for the behavioral health needs of older adults. Behavioral health integration (BHI) can help provide additional support for complex patients, in addition to decreased levels of burnout and burden for physicians.

For more general guidance on BHI, please refer to the BHI Collaborative's [BHI Compendium](#). For other topic-specific best practices, please refer to the American Medical Association's strategic practice guides ([psychopharmacology](#), [substance use disorder](#), [suicide prevention](#)), or any of the [BHI Overcoming Obstacles webinars](#).



What is behavioral health integration (BHI)?

BHI is widely accepted as the result of primary care (or other care settings) and behavioral health physicians and other clinicians, working together with patients and families, using a systematic approach to provide patient-centered care.

Who is included in the term “older adults”?

When using the term “older adults,” it is referring to adults aged 65 and older.

Why is BHI relevant to the care of older adults?

Changes to physical health can be a normal part of aging, but this is not true of symptoms such as insomnia, low mood, increased suicidal

thoughts, memory impairment, and increased substance use or misuse.

The percentage of the population in the United States that consists of older adults (65+) is expected to exceed the percentage of the population that is children (77.0% to 76.5%) for the first time by 2034.¹ Approximately 20% of adults that are over the age of 65 will experience a mental health concern.² Factors such as ageism, stigma, and lack of identification lead to older adults being written off as having a natural reaction to illness or life changes instead of something that should be further investigated. This patient population also tends to keep their concerns to themselves and may be reluctant to seek help or may even self-identify their symptoms as a normal part of aging. Additionally, our healthcare system is already stretched to meet the need of this population. Not only are there already shortages of primary care physicians and psychiatrists, but also those physicians with specialization in caring for older adults—geriatricians and geriatric psychiatrists.^{3,4}

Creating a treatment pathway (i.e., screening to treatment) for behavioral health concerns when caring for older adults in a primary care setting (both urban and rural) is of utmost importance and highlights the importance of **integrated behavioral health care**.

1. Bureau UC. An aging nation: Projected number of children and older adults. Census.gov. October 8, 2021. Accessed April 15, 2023. <https://www.census.gov/library/visualizations/2018/comm/historic-first.html>.

2. Older adults living with serious mental illness. samhsa.gov. May 2019. Accessed April 15, 2023. <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf>.

3. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. aamc.org. June 2020. Accessed April 15, 2023. <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf>.

4. About geriatric psychiatry. aagponline.org. Accessed April 15, 2023. <https://www.aagponline.org/families-caregivers/about-geriatric-psychiatry/>.

Part 2

Identification of the need

This section will identify the prevalence of the most common behavioral health conditions and symptoms seen in the primary care setting in adults over the age of 65:

- *Depression and anxiety*
- *Substance misuse and substance use disorders (SUDs)*
- *Suicidal ideation and death by suicide*
- *Neuropsychiatric symptoms of dementia*

While older adults are additionally impacted by conditions such as bipolar disorder and schizophrenia spectrum illnesses, taking care of this population is more nuanced and beyond the scope of this guide.

This section will also identify how to go about first screening for, and then further diagnosing, these conditions utilizing history gathered, collateral information, possible medical tests, and more.



Key conditions and symptoms

Depression and anxiety

Late-life depression is a major depressive episode that occurs in adults over 65 who have no prior history of a Major Depressive Disorder (MDD). Up to 15% of older adults are impacted by MDD, which can include both late-life depression as well as depression that has occurred earlier in life.⁵ MDD is often triggered by other chronic health issues, loneliness, and grief. Because older adults often have a range of other comorbidities, mental health conditions are not always the most obvious component to treat and can also be difficult to recognize. Older adults with MDD do not always present with typical symptoms of depression but are more likely to present instead with somatic symptoms, functional changes, and/or cognitive difficulties, leading to both underdiagnosis and under-treatment.⁶

Anxiety disorders include Generalized Anxiety Disorder (GAD), Social Phobia, Specific phobias, Panic Disorder, Obsessive Compulsive Disorder (OCD), and Post Traumatic Stress Disorder (PTSD). They may be written off as a normal part of aging in older adults or can be mistaken for physical health conditions since they often manifest with symptoms of physical illness such as gastrointestinal or cardiac symptoms. While 10–20% of older adults experience an anxiety disorder,⁷ half of older adults in the community have some symptoms of anxiety.⁸

Substance misuse and substance use disorders

Substance misuse and substance use disorders (SUDs) include drugs such as cocaine, heroin, marijuana, alcohol, prescription medications including opiates and benzodiazepines, over-the-counter (OTC) medications, and supplements. While the rate of substance use disorders is reported as 0.2–1.9% of older adults,⁹ almost 20% of older adults misuse prescription drugs, over-the-counter medication, or alcohol, often unintentionally.¹⁰

As we age, what medications and substances do to our bodies and how our bodies interact with medications and substances changes, making substance misuse very dangerous and potentially deadly for older adults even at small amounts. Chronic medical conditions and chronic prescription or OTC medication use provides an additional risk for those who use other substances. Data from 2018 shows that 87.5% of older adults take at least one prescription medication, and 39.8% have polypharmacy, or take five or more prescription medications daily.¹¹ Substance misuse can impact how daily medications are able to treat chronic illnesses and can lead to increased adverse side effects such as hypotension and/or adverse events such as falls and increased ER visits.

5. Depression in late life: Not a natural part of aging. [aagponline.org](https://www.aagponline.org). October 27, 2022. Accessed May 3, 2023. <https://www.aagponline.org/patient-article/depression-in-late-life-not-a-natural-part-of-aging/>.

6. Tampi RR, Tampi DJ. The assessment of depression among older adults. *Psychiatric Times* March 20, 2022. Accessed May 3, 2023. <https://www.psychiatrictimes.com/view/the-assessment-of-depression-among-older-adults>.

7. Anxiety and older adults: Overcoming worry and fear. [aagponline.org](https://www.aagponline.org). October 27, 2022. Accessed May 3, 2023. <https://www.aagponline.org/patient-article/anxiety-and-older-adults-overcoming-worry-and-fear/>.

8. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-011%20PDF%20508c.pdf

9. Substance Abuse and Mental Health Services Administration. Treating Substance Use Disorder in Older Adults. Treatment Improvement Protocol (TIP) Series No. 26, SAMHSA Publication No. PEP20-02-01-011. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

10. SAMHSA—Get Connected: Linking Older Adults with Resources on Medication, Alcohol, and Mental Health. HHS Pub. No. (SMA) 03-3824. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2019.

11. National Center for Health Statistics. Health, United States, 2018. Hyattsville, MD. 2019. f



KEY DEFINITIONS

Substance misuse: Term used for prescription medications used other than prescribed¹²

Substance use: Term used to cover illicit substances

Substance use disorder: Defined as “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems”¹³

Polypharmacy: Taking 5 or more medications

Excessive polypharmacy: Taking 10 or more medications

Potentially inappropriate medications (PIMs): Use of a medication when the potential risk outweighs the potential benefit

There are many barriers for older adults to address a substance misuse or SUD including myths that older adults don’t have substance use issues, or if they do, it’s too late to get them help or older adults don’t benefit from treatment (ageism), lack of realization on the individual level that their substance misuse is a problem, lack of awareness by the caregiver or family, financial insecurity, limited access to transportation, normalization of substance misuse, and more.¹⁴ In treating substance misuse and SUDs, it is important to use **person-first and non-stigmatizing language**.

Suicidal ideation and death by suicide

Physicians in primary care and nonpsychiatric care settings see ~77% of people who die by suicide within the 12 months prior to death.¹⁵ 17.9% of all deaths by suicide are by adults above the age of 65. Men experience the highest rate of completed suicide, while women have the highest rate of attempted suicide.

Older adults tend to more carefully plan than children, with 1 in every 4 attempts resulting in completed suicide, versus 1 in every 200 children. A 2017 study showed that the most common method for death by suicide in men above the age of 50 is with firearms, and those that used firearms were more likely to be non-Hispanic, white, married, lack a college education, living outside of the Northeast, and are experiencing relationship problems.¹⁶

Cognitive changes, dementia and resulting neuropsychiatric symptoms

Many illnesses that impact the brain from a neurological standpoint additionally affect mood, behavior, and can lead to other psychiatric symptoms including but not limited to insomnia, suicidal ideation, and psychosis. The most common neuropsychiatric disorder is dementia, with the most common dementia being Alzheimer’s dementia.



KEY DEFINITIONS

Dementia is an umbrella term utilized for diseases with brain changes that impact memory, language, executive functioning and interfere with daily living.

Examples of dementia include **Alzheimer’s disease**, **Lewy body dementia**, **Vascular dementia**, **Frontotemporal dementia**, and dementia from other neuropsychiatric diseases such as **Huntington’s disease**, or **Creutzfeldt-Jakob Disease**.

The prevalence of all dementias is projected to be about 14 million people by 2060.¹⁷ According to the **Alzheimer’s Association**, while a vast majority of dementia diagnoses are made by primary care physicians (PCPs), ~40% reported discomfort in making

12. Words matter - terms to use and avoid when talking about addiction. National Institutes of Health. November 29, 2021. Accessed May 3, 2023. <https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>.

13. Substance Use Disorders. In: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision: DSM-5-TR*. American Psychiatric Association Publishing; 2022:543-546.

14. Substance Abuse and Mental Health Services Administration. Treating Substance Use Disorder in Older Adults. Treatment Improvement Protocol (TIP) Series No. 26, SAMHSA Publication No. PEP20-02-01-011. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

15. Mann JJ, Michel CA, Auerbach RA. Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review. <https://ajp.psychiatryonline.org/>. February 18, 2021. Accessed May 3, 2023. <https://doi.org/10.1176/appi.ajp.2020.20060864>.

16. Choi, N. G., DiNitto, D. M., Marti, C. N., Kaplan, M. S., & Conwell, Y. (2017). Suicide means among decedents aged 50+ years, 2005–2014: Trends and associations with sociodemographic and precipitating factors. *The American Journal of Geriatric Psychiatry*. <http://doi.org/10.1016/J.JAGP.2017.06.001>

17. Alzheimer’s Association. 2023 Alzheimer’s Disease Facts and Figures. *Alzheimers Dement* 2023;19(4). DOI 10.1002/alz.13016.

a dementia diagnosis, and ~50% of PCPs reported not feeling adequately prepared to care for individuals with dementia.¹⁸

It is important to differentiate dementia from other reversible causes of dementia and psychiatric conditions such as depression, acknowledging that subsequent symptoms seen in dementia often include depression, increasing substance use, worsening anxiety, suicidal ideation, and possibly psychosis. Additionally, neuropsychiatric illnesses such as [Parkinson's Disease](#), and other medical conditions like stroke or heart attack can put someone at risk for developing a behavioral health condition due to impact on the brain. For example, 40% of older adults with Parkinson disease develop major depressive disorder (MDD), as do 25% of older adults post-stroke.¹⁹



WATCH OUT

Older adults who are members of racial/ethnic and other minority groups, including LGBTQ older adults²⁰ and women,²¹ are at higher risk for developing behavioral health concerns. A known problem in skilled nursing facilities is bullying of older LGBTQ adults, which can lead to older adults feeling pressure to hide their identities and not feel comfortable sharing their identity with other residents and staff members. This further reaffirms the importance of [improving cultural competency](#) and understanding how older adults can draw on their cultural heritage to improve their own health and well-being. This is even more crucial to understand as the population over the age of 65 shifts towards growing percentages of racial and ethnic minority populations.²²

Screening and diagnosis considerations

Many older adults present with symptoms that may contribute to, be a sequelae of, or not even be related to a behavioral health condition. Because of the degree of overlapping and confounding factors in the care of older adults, it is crucial to assess for a variety of conditions including both behavioral health and physical illnesses.

It is important to note there are significant overlaps between risk factors and key symptoms for behavioral health conditions of older adults, necessitating consideration of multiple conditions co-occurring. Evidence-based screening tools can be sent ahead of time to be self-administered, completed in a waiting room, or administered by a medical assistant (MA).



TIP

See [Appendix B](#) for a table summarizing key risk factors, symptoms, differential diagnoses, screening tools, further medical testing, and other considerations for working towards diagnosing MDD, anxiety disorders, substance misuse/SUD, suicidal ideation (SI), and cognitive decline.

Screening tools are just that—tools to assess for a variety of symptoms in a more targeted and efficient manner. They do not give a behavioral health diagnosis, as these conditions are clinical diagnoses that necessitate further questioning from a clinician as well as utilizing the information from the tool, patient interview, collateral information, mental status examination, other medical tests, and more. There are additional considerations that are particular to the older adult population, which may impact the scoring of a screening tool, and should be further assessed.

18. Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures. *Alzheimers Dement* 2023;19(4). DOI 10.1002/alz.13016.

19. Conroy SK, Brownlowe KB, McAllister TW. Depression Comorbid With Stroke, Traumatic Brain Injury, Parkinson's Disease, and Multiple Sclerosis: Diagnosis and Treatment. *Focus (Am Psychiatr Publ)*. 2020 Apr;18(2):150-161. doi: 10.1176/appi.focus.20200004. Epub 2020 Apr 23. PMID: 33162852; PMCID: PMC7587873.

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21. Shutte, K., Lemke, S., Moos, R. H., & Brennan, P. L. (2014). Age-sensitive psychosocial treatment for older adults with substance abuse. In I. Crome, L.-T. Wu, R. Rao, & P. Crome (Eds.), *Substance use and older people*. West Sussex, UK: Wiley-Blackwell.

22. Older adults living with serious mental illness. *samhsa.gov*. May 2019. Accessed April 15, 2023. <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf>.



SPECIAL CONSIDERATIONS

Physical health changes: Chronic and serious illness along with new medical diagnoses lead to increased risk of behavioral health disorders. Some illnesses commonly cause brain chemistry changes and may lead to late-life behavioral health conditions, including but not limited to stroke, cancer, traumatic brain injury (TBI), and neuropsychiatric diseases such as Parkinson’s disease.

Bereavement and grief: Grief is one’s response to loss and bereavement is the period of coping with said loss. As we age, loss becomes a part of our lives and experiencing grief is a normal part of this, though it can begin to expand outside of normal grief and into an illness that requires medical attention, such as prolonged grief disorder, or a major depressive disorder.

Cognitive changes: Typical age-related changes include some word-finding difficulties, sometimes forgetting names, making occasional errors with Instrumental Activities of Daily living (IADLs). More severe changes may be a dementia diagnosis or an underlying mental illness. Cognitive changes also highlight the importance of partnering with a patient and their family or caregiver as a care team.

Sensory impairments: Loss of vision or hearing can be mistaken for numerous health conditions, including behavioral health concerns. Regular screening is often attainable, but items such as glasses or hearing aids are not always covered by insurance and may be a financial burden for a person.

Disability and reliance on caregivers: Age-related changes to the body include muscle atrophy and decreasing bone density, which can impact coordination and balance. Reflexes slow, ambulation may slow and necessitate an assistive device. About 35% of older adults report being disabled in some capacity.²³ With aging and disability additionally comes small losses in independence, such as driving, and subsequent reliance on others, which can substantially impact a person’s mental health.

Changes in environment: As the population ages, the percentage of older adults transitioning to living in an institutional setting grows—beginning at 1% of adults ages 65–74, to 3% of adults aged 75–84, and 9% of people aged 85 and older.²⁴ Adjustment disorder symptoms or symptoms of grief may be present, or may devolve into a major depressive episode.



KEY DEFINITIONS

Adjustment Disorder: The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s), causing marked distress and/or significant impairment, and does not meet criteria for another mental disorder.

Prolonged Grief Disorder: Persistent grief symptoms for over 12 months since another person’s death, including intense yearning for the deceased person and/or preoccupation with thoughts and memories of the deceased person, additional

emotional and behavioral symptoms, causing significant distress and/or impairment in functioning, and does not meet criteria for another mental disorder.

Social isolation: Having few social relationships or social contacts.

Loneliness: The subjective, individual feeling or sense of being alone, outside of social relationships.

Along with screening for specific behavioral health conditions (e.g., depression, anxiety, substance misuse), additional screening tools exist to help assess more holistic risk factors or contributing factors, such as:

- 1. Loneliness and social isolation:** It is important to assess a person’s current social network, which can give a sense of potential loneliness, social isolation, and even factors such as if someone has support for transportation or medication management.

23. Older adults living with serious mental illness. samhsa.gov. May 2019. Accessed April 15, 2023. <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf>.

24. Older adults living with serious mental illness. samhsa.gov. May 2019. Accessed April 15, 2023. <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf>.

- **Screening tools:** UCLA Loneliness Scale, The Campaign to End Loneliness Measurement Tool



WATCH OUT

Seventeen percent of adults 65 and older experience isolation.²⁵ Social isolation and loneliness profoundly impact older adults through both direct physiologic changes and indirect effects, which can lead to suicidal ideation (SI) and suicide attempts, cognitive decline, dementia progression, substance use, depression, and premature death.²⁶ 28% of adults over 65 live alone, with 45% being women above the age of 75.^{27,28}

The [Suicide Prevention Resource Center \(SPRC\)](#) lists risk factors of loneliness and social isolation as:

Social: Living alone, loss of significant other, family separation, few friends, being a caregiver for spouse

Psychological: Depression, anxiety, dementia

Physical: Poor health, serious illness, decreased mobility, loss of independence

Economic: Limited financial resources » Logistical: Loss of driver’s license, lack of transportation²⁹

2. Insomnia and sleep disturbance: May be a symptom of a behavioral health condition such as depression, substance use disorders, dementia, or other neuropsychiatric disorder.

- Screening tool: [PSQI](#)

3. Functional assessment: A functional assessment should include both assessing Activities of Daily Living (ADLs) and Instrumental Activities of Daily living (IADLs).

- Screening tools: [Katz](#), [Lawton IADL](#), [PASS](#), [FAQ](#)

4. Fall risk: May be a sequelae of a behavioral health condition such as a substance use disorder or a delirium.

- Screening tool: [STEADI](#)

5. Firearm safety: While firearms themselves may be politicized, discussion should always focus on the shared goal of risk reduction and ensuring safety for those in the house. One in three households in the US has a firearm,³⁰ so it is crucial to ask about firearm ownership and further assess safety.

- Clinical tool: The [3 A’s Framework](#)³¹ can help a clinician counsel regarding firearms in three steps: approach, assess, and act.

6. Elder abuse: Older adults are a vulnerable population, leaving them a target for elder abuse.

- Screening tool: [EASI](#)



PRACTICE SPOTLIGHT

Beachem Center for Geriatric Medicine

The Beachem Center for Geriatric Medicine is an interdisciplinary primary care setting at the Johns Hopkins Bayview Medical Center. There is a focus on whole-person care, with care coordination including a wide range of specialties, care providers, families, and in-home health care professionals. A clinical pharmacist is part of the team and works on medication management and titration, identifies possible medication interactions, and supports in medication reconciliation and opportunities for deprescribing. There is additionally a part-time staff therapist, and a part-time consultative geriatric-boarded psychiatrist that is co-located in the clinic. By having co-location and working within the same clinic, geriatricians can refer to the therapist and psychiatrist to work on common goals, such as anxiety surrounding colonoscopy, or to support with complex neuropsychiatric symptoms of dementia.

25. Connect2Affect. April 26, 2023. Accessed May 3, 2023. <https://connect2affect.org/>.

26. Reducing loneliness and social isolation among older adults. <https://sprc.org/>. July 2020. Accessed May 3, 2023. <https://sprc.org/wp-content/uploads/2022/12/Reducing-Loneliness-and-Social-Isolation-Among-Older-Adults-Final.pdf>.

27. Connect2Affect. April 26, 2023. Accessed May 3, 2023. <https://connect2affect.org/>.

28. Older adults living with serious mental illness. [samhsa.gov](https://www.samhsa.gov). May 2019. Accessed April 15, 2023. <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf>.

29. Reducing loneliness and social isolation among older adults. <https://sprc.org/>. July 2020. Accessed May 3, 2023. <https://sprc.org/wp-content/uploads/2022/12/Reducing-Loneliness-and-Social-Isolation-Among-Older-Adults-Final.pdf>.

30. Kravitz-Wirtz. Guns 101. BulletPoints Project. October 2020. Accessed May 3, 2023. <https://www.bulletpointsproject.org/guns-101/>.

31. How to counsel. BulletPoints Project. September 13, 2022. Accessed



Case study

Addressing needs via integrated care

What does behavioral health integration look like for supporting older adults? As discussed, the need for addressing behavioral health in primary care settings is crucial. Primary care physicians know their patients best and are often the best physicians to address all of their patient’s needs—including complex behavioral health conditions and symptoms. The step from talking about BHI to beginning to add integration into a practice workflow can be a big step.

For additional details on how to best design an integrative workflow, review the AMA’s “BHI Workflow Guide”. In this section, we will discuss the integrated care spectrum and apply the case to each level.

CASE OVERVIEW

Dr. B is a 68-year-old female (she/her), divorced, retired physician, domiciled alone, with a past medical history of osteoarthritis, heart failure with reduced ejection fraction (EF 40%), type 2 diabetes mellitus, obesity, and no known prior psychiatric history, who presents to her PCP with her son for increased irritability and “out of character” behavior at home.

After ruling out medical concerns and substance use, it appears that Dr. B has moderate to severe depression and a possible mild cognitive impairment, though this is difficult to assess with an active psychiatric condition and will need to be reassessed after resolution of her depression.

The following is the model spectrum for how care may be delivered to Dr. B:

Coordinated care		Co-location		Integrated care	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal collaboration	Basic collaboration at a distance	Basic collaboration on-site	Close collaboration on-site	Close collaboration	Full collaboration

Level 1: Care is delivered in separate facilities with separate systems; PCP may place a referral for Dr. B to see a psychiatrist, which Dr. B and her family will need to find and make an intake appointment with.

Level 2: Behavioral and non-behavioral health clinicians practice in separate facilities with separate systems; PCP refers Dr. B to a psychiatrist after evaluation, helps to set up an intake, and further conversation with the psychiatrist ensues regarding Dr. B’s care.

Level 3: Physicians and other clinicians practice in the same facility but not necessarily the same offices; PCP refers Dr. B to a psychiatrist two floors up in the same building. They know each other well and feel comfortable contacting each other regarding Dr. B’s health.

Level 4: Physicians and other clinicians practice in the same facility with some shared systems, such as scheduling and medical records; PCP refers Dr. B to a psychiatrist within the

same building and they can communicate via their EHR, along with their weekly multi-disciplinary rounds.

Level 5: Physicians and other clinicians are in the same facility with some shared space and identify delivery system challenges and implement system solutions together; PCP refers to a psychiatrist down the hall, who they then discuss with each other the following morning at group rounds in the shared team room.

Level 6: Physicians and other clinicians are in the same facility and share all practice space, functioning as one integrated team; Because Dr. B screened positive on some of the pre-appointment screening tests, Dr. B was able to be proactively scheduled with other team members on the same day as her PCP appointment. The PCP or MA introduce Dr. B to these team members, which may include a licensed clinical social worker working as a behavioral health specialist, a psychiatrist or other behavioral health specialists, on the day of the appointment.



RESEARCH SPOTLIGHT

Promoting Access to Collaborative Treatment through the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) trial^{32,33,34}

The **IMPACT trial** was one of the first trials looking at effectively treating depression of older adults in a primary care setting using the Collaborative Care Model. The **intervention** arm included each patient meeting with a depression care manager (DCM), a trained nurse, social worker or psychologist, who provided initial psychoeducation on depression, completed an initial assessment of symptoms, discussed behavioral changes such as behavioral activation, creating a structured schedule, and continued follow up with various treatment steps over the next 10–12 weeks, which may include medication management or a short course of psychotherapy. The DCM works with both the patient and the primary care provider to establish the treatment plan and additionally has weekly meetings with a supervising psychiatrist to discuss complex patients and patients who had not yet improved who may be indicated for the second step of treatment. A patient **registry** was created to track patient outcomes more easily and to facilitate treatment changes and adjustments when needed. Patients receiving collaborative care for treatment of their depression had a 50% rate or greater of improvement in depressive symptoms at 12 months, versus 19% receiving usual care.

32. Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. *JAMA*. 2002;288(22):2836–2845. doi:10.1001/jama.288.22.2836

33. Unützer J, Katon W, Williams Jr JW, et al. Improving primary care for depression in late life: the design of a multicenter randomized trial. *Med Care*. 2001;39:785-799.

34. Hegel MT, Imming J, Cyr-Provost M, et al. Role of behavioral health professionals in a collaborative stepped care treatment model for depression in primary care: Project IMPACT. *Fam Syst Health*. 2002;20(1):265-277.

Part 3

Treatment considerations

This section provides a holistic approach to considering treatment of behavioral health conditions and symptoms in older adults, including but not limited to medication management.

For more general tools and tips for prescribing, please access the AMA's [Psychopharmacology guide](#).

Behavioral health treatment of older adults is nuanced and requires a multimodal approach. There is no “one size fits all,” given the complexity of each individual.

More mild to moderate cases of behavioral health conditions or symptoms can be treated in the primary care setting. If physician practices find themselves wishing they had a behavioral health specialist to refer or talk through cases with, this may be an indication that BHI would be helpful to implement. Some types of integrated care models are more proactive in monitoring high risk cases for further psychiatric consultation, such as how a behavioral health specialist reviews patients to refer to the consulting psychiatrist in the Collaborative Care model (CoCM).

Regardless, a holistic approach to treatment of older adults is crucial, including but not limited to:

- Appropriate medication administration
- Behavioral activation
- Discontinuation of substances
- Firearm safety
- Healthy eating
- Neuromodulation such as electroconvulsive therapy (ECT)
- Outside referrals
- Physical activity
- Psychopharmacology
- Psychotherapy
- Relaxation, meditation, mindfulness
- Safety planning
- Sleep
- Social interaction and structure
- Vitamins



Appropriate medication administration

In addition to confirming the name, dose, and frequency of prescription, OTC, and herbal supplements being taken, it is crucial to ask about how medications are managed:

- Are they all kept in their own pill bottles and stored on the kitchen counter?
- Are they put in a pill box by a person who has a mild cognitive impairment?
- Do they utilize a pill box that a family member constructs but the patient takes the medications independently?

These are all crucial questions to assess if there is misuse of any medications or supplements. Many pharmacies will administer medications in bubble packaging, which can assist patients who take multiple medications to keep their medications sorted by time of day in which they take them.

As noted earlier, medication side effects or adverse reactions may lead to symptoms that mimic many behavioral health conditions and symptoms such as depression, sleep disturbance, anxiety, and cognitive side effects. A medication reconciliation is crucial in evaluating these medications.



WATCH OUT

Some medications can put patients at higher risk of Major Depressive Disorder or induce depression, including:³⁵

- Antihypertensive medications
- Anti-Parkinson medications
- Anticancer drugs
- Hormonal agents
- Benzodiazepines
- Corticosteroids
- Cimetidine



TIP

Be sure to assess OTC medications along with herbal supplements & natural remedies. In line with being culturally competent, it is important to remember that many older adults may utilize herbal supplements as a daily part of their health routine.



TIP

Keep an eye out for when your practice, hospital system, city, county, or state has medication take back days, and advertise this to your patients. The best way to reduce the risk of medication misuse is to no longer have them in the house if they are no longer being used.

Behavioral activation

Behavioral activation (BA) is a specific cognitive-behavioral therapy (CBT) tool that can be used separate from a full course of CBT. Some people have difficulty doing the things they want to do during the day, i.e., exercising, going to the grocery store, cleaning their room, due to excessive worries and/or changes in mood. Behavioral activation is a way to reduce avoidance and understand that activities can be completed despite negative thoughts or moods. The University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center aggregated the [evidence for BA](#). Trainings on BA and/or CBT can be found online ([AIMS Center, Beck Institute](#)), though are typically offered for a fee for both licensed and non-licensed clinicians.

Discontinuation of substances

The [National Institute on Alcohol Abuse and Alcoholism \(NIAAA\)](#) and the [Center for Substance Abuse Treatment \(CSAT\)](#) recommend older adults consume:

- No more than one standard drink per day or seven standard drinks per week.
- No more than two standard drinks on any drinking day or occasion (wedding, New Year's Eve, etc.)³⁶

Treatment of substance misuse and substance use disorders can positively impact the other aspects of a person's mental health—mood, cognition, fall risk, and more. Framing for cutting back on substance use should surround risk reduction, as opposed to focus on abstinence. This harm reduction technique will allow physicians to partner with the patient and help with making more long-term, meaningful changes.

Refer to the [AMA's Substance Use Disorder Treatment guide](#) (pages 7–8) or [ASAM](#) for a refresh on the levels of care for substance misuse and substance use disorders.

35. Neel AB. 10 Types of Medications That Can Make You Feel Depressed. <https://www.aarp.org/>. Accessed May 3, 2023. <https://www.aarp.org/health/drugs-supplements/info-02-2012/medications-that-can-cause-depression.html>.

36. Alcohol/Drug Abuse/Misuse. aagponline.org. November 1, 2022. Accessed May 3, 2023. <https://www.aagponline.org/patient-article/alcohol-drug-abuse-misuse/>.



PILOT HIGHLIGHT

Brief Intervention and Treatment for Elders (BRITE) Project^{37,38}

The [Florida BRITE Project](#) worked to identify adults aged 55 and older with non-dependent substance use and/or prescription medication issues using a [SAMHSA/CSAT](#) grant modeling [Screening, Brief Intervention & Referral to Treatment](#) (SBIRT) initiatives. BRITE counselors conducted outreach, screening and services and consisted of nurses, social workers, mental health counselors and certified addictions specialists. [Screening instruments](#) included a [prescreen](#), followed by questions on depression and suicide risk (using the [Short Geriatric Depression Scale \(S-GDS\)](#)), alcohol use, prescription and OTC medication use, and illicit drug use. SAMHSA Treatment Improvement Protocols [26](#) and [34](#) were modeled for the brief intervention and focused on health risk reduction including cutting back on substance use, as opposed to complete abstinence. Individuals were assessed at baseline, discharge, and 30-days post-treatment and data suggested that depression and alcohol severity scores decreased and medication misuse improved.



WATCH OUT

Older adults are at risk for diversion of substances, including forced diversion by others. This is especially true for controlled substances, as well as medications that have street-value such as gabapentin.

Older adults often experience chronic pain as a part of their comorbid medical conditions, and for those that have had a recent surgery, an opiate may have been prescribed as part of a short-term pain regimen. Long-

term opiate use is known to lower overall mood and can lead to depression, as can chronic pain. This is a tough nuance in caring for this population—ensuring that pain is adequately treated and that the risks of prescribing medications don't outweigh the benefits felt by the patient. For chronic pain, opiates may be a person's preferential pain treatment modality. The goal is to partner with the patient, to use multi-modal treatment, and to utilize harm-reduction by seeing if doses can be decreased if not fully weaned off.



TIP

Co-prescription of naloxone is a great harm reduction technique and is safe in older adults. It is important to ensure that the patient, caregiver, and other family members are also aware of how to use naloxone.

Firearm safety

Asking questions about firearm safety is an important public health assessment that primary care physicians should complete with patients.

Partnering with the patient to discuss firearm safety may include creating a [Firearm Life Plan](#), which acknowledges that the need for a firearm may change with time, as we age, as well as the patient's physical abilities, and make a plan for how to handle this.

Depending on a person's risk, the "Action" step of the [3 A's framework](#) can be utilized. Action from 3 A's framework includes: safer storage, temporary transfer of firearms, a mental health hold, or civil protective orders.³⁹ Additional support and resources for how to have discussions regarding temporary transfer of firearms can be found at [Lock2Live](#).

37. Schonfeld L, King-Kallimanis B.L., Duchene D.M., Etheridge R.L., Herrera J.R., Barry K.L., Lynn N. (2010). Screening and brief intervention for substance misuse among older adults: The Florida BRITE project. (eng). American Journal of Public Health, 100 (1), 108-14.

38. Schonfeld, L. Hazlett, R.W., Hedgecock, D.K., Duchene, D.M., Burns, L.V., and Gum, A.M. (2014). Screening, Brief Intervention, and Referral to Treatment for older adults with substance misuse. American Journal of Public Health. e-View Ahead of Print. DOI: 10.2105/AJPH.2013.301859

39. How to counsel. BulletPoints Project. September 13, 2022. Accessed May 3, 2023. <https://www.bulletpointsproject.org/how-to-counsel/>.

**TIP**

For additional information on firearm violence, risk factors, and how to best communicate with patients, access the AMA's module on "[The Physician's Role in Promoting Firearm Safety](#)" on the AMA Ed Hub™ or view this [AMA Update](#) on how to talk to patients about firearms.

Healthy eating

Nutritional needs can change throughout the life spectrum. [MyPlate](#) discusses some of the unique nutritional needs of older adults such as which nutrients to focus on (Vitamin B12, calcium, vitamin D, potassium), drinking plenty of liquids, and how to get enough fiber.

Neuromodulation such as electroconvulsive therapy (ECT)

Severe cases of depression which can include catatonia or psychosis are an appropriate indication for neuromodulation, especially if an older adult is having severe suicidal ideation or lack of oral intake.⁴⁰ Delusions that occur in MDD with older adults are typically somatically focused and may include thoughts that they are dying, their body is rotting, or that they have a severe physical illness. In such cases, neuromodulation such as ECT or transcranial magnetic stimulation (TMS) are appropriate, as is inpatient hospitalization.

Outside referrals

Some practices may be integrated with more than just behavioral health, possibly including occupational therapy (OT), physical therapy (PT), speech language pathology (SLP), or services such as palliative care, pain management, or more specialized addiction medicine or psychiatry services. Behavioral health OTs can be especially helpful in working with patients on behavioral activation, coping skills, creating a daily schedule and

structure, and OT can be helpful in supporting a person in their ADLs. SLP can be beneficial in working with patients with cognitive concerns such as word finding difficulties. PT can be beneficial for strengthening to help reduce fall risk. If a patient has limited mobility, they may qualify for home health services with these services. While it is important to recognize that not all patients have the time, transportation, or mobility to get to additional appointments, it is helpful to consider outside referrals when appropriate.

Physical activity

The [Move Your Way](#) campaign (U.S. Department of Health & Human Services) is part of the [Physical Activity Guidelines for Americans](#), which recommends that older adults get at least 150 minutes per week of moderate-intensity aerobic activity, which is anything that increases heart rate, at least two days a week of muscle-strengthening activity, and balance activities to reduce fall risk.⁴¹

Psychopharmacology

Given the changes in pharmacokinetics and pharmacodynamics as we age, prescribing psychoactive medications for older adults requires additional considerations and more intentionality.

- **Start low and go slow:** Older adults may be more susceptible to side effects and therefore may be more likely to discontinue a medication. By starting at even half of the typical starting dose, prescribers may avoid a person self-discontinuing a medication.
- **Titrate to effect:** While medications are often started at lower doses, they should be prescribed to efficacy as long as a person is tolerating the medication dose well.
- **Use an interaction checker and verify metabolism:** Given the degree of polypharmacy and excessive polypharmacy that older adults often incur, it can be helpful to ensure that a medication being prescribed will not interact with another medication. In that same vein, older adults often have changes to their hepatic and renal systems, which necessitates dose reductions depending on how a medication is metabolized.

40. Depression in late life: Not a natural part of aging. [aagponline.org](https://www.aagponline.org/patient-article/depression-in-late-life-not-a-natural-part-of-aging/). October 27, 2022. Accessed May 3, 2023.

41. Walk. Run. Dance. Play. What's your move? [Move Your Way®](https://health.gov/moveyourway). Accessed May 3, 2023.

- **Keep BEER's Criteria in mind:**⁴² All psychiatric medications find themselves on BEER's criteria, as PIMs. What is important is assessing which medications have a benefit that outweighs the potential risk. BEER's criteria can be helpful in ensuring anticholinergic burden does not get too high, which can greatly adversely impact older adults.
- **Be proactive in monitoring:** Because older adults are more susceptible to medication side effects including hyponatremia, pancytopenia, prolonging QTc interval, it is crucial to monitor labs and EKGs diligently.
- **Continuation of medications:** If after resolution of an acute episode of illness and subsequent taper of medication, the illness recurs, it is reasonable to continue these medications more long-term.



WATCH OUT

Many medications that are taken by older adults impact the serotonin system, such as anti-nausea medications (Zofran, Reglan), some antibiotics (Linezolid), OTC cough and cold medications (anything with dextromethorphan), opiate pain medications, and antimigraine medications (sumatriptan, Tegretol). When prescribing an antidepressant medication (SSRI, SNRI, TCAs, MAOIs), this may increase the risk of Serotonin syndrome.



WATCH OUT

Some medications necessitate drug levels to ensure both efficacy and to avoid toxicity (Lithium, valproic acid, nortriptyline). Levels of medications can additionally help with ensuring medication adherence.

Psychotherapy

Psychotherapy can be a first-line treatment in mild to moderate behavioral health conditions, which may include different modalities including but not limited

to cognitive behavioral therapy (CBT), interpersonal therapy (IPT), and acceptance and commitment therapy (ACT).⁴³ Any clinician can engage a patient in supportive psychotherapy, which includes active listening, empathy, positive reinforcement, and relies heavily on a good rapport with the patient. In many behavioral conditions, psychotherapy is used in conjunction with medication.

Relaxation, meditation, mindfulness

Relaxation skills such as deep breathing or grounding exercises are an easy and useful way to help with anxiety reduction.⁴⁴ Guided meditation, mindfulness exercises or relaxation techniques can be found through certain phone apps, online (e.g., YouTube), or practiced in therapy. These are useful coping skills for the patient to use to refocus on their body and out of their thoughts, worries, or mood.

Safety planning

Safety planning is an important treatment approach after assessing for suicide risk using the [Columbia Suicide Severity Rating Scale](#). A safety plan helps to identify the warning signs, create a list of coping strategies, distractions, supports, professional supports, and identify how to make the environment safer. Resources such as [My Safety Plan](#) support downloading or creating a safety plan template, which can then be printed out and made easily accessible for a patient and their family/caregivers.



WATCH OUT

Considerations for older adults that may increase safety risk include:

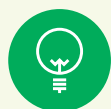
- Firearm ownership
- Living alone
- Limited social supports
- Mobility or transportation issues

Always consider making close follow-up with this population and assess how they will be getting to and from their appointments.

42. By the 2019 American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc*. 2019 Apr;67(4):674-694. doi: 10.1111/jgs.15767. Epub 2019 Jan 29. PMID: 30693946.

43. Depression in late life: Not a natural part of aging. *aagponline.org*. October 27, 2022. Accessed May 3, 2023. <https://www.aagponline.org/patient-article/depression-in-late-life-not-a-natural-part-of-aging/>.

44. Anxiety and older adults: Overcoming worry and fear. *aagponline.org*. October 27, 2022. Accessed May 3, 2023. <https://www.aagponline.org/patient-article/anxiety-and-older-adults-overcoming-worry-and-fear/>.

**TIP**

For additional strategies to identify and treat patients at-risk for suicide, check out the AMA's "[Suicide Prevention How-To Guide](#)."

**TIP**

The 988 Suicide & Crisis Lifeline is also available 24/7 and is a good resource—it can be reached by calling or texting 988, or by chatting <https://988lifeline.org/chat/>

Additional crisis lines are available for the LGBTQ population:

SAFE LGBT Elder Hotline:

For LGBT elders and caretakers.

1-877-360-LGBT (5428)

Confidential support and crisis response, available 24/7.

Trans Lifeline:

Staffed by transgender people, for transgender people.

1-877-565-8860 (United States)

Confidential, 24/7 crisis support

**PILOT HIGHLIGHT*****Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)⁴⁵***

The PROSPECT intervention⁴⁶ focused on adults over age 60 experiencing depressive symptoms, and included a clinical algorithm utilized by depression care managers, consisting of trained social workers, nurses, and psychologists, in collaboration with primary care physicians to help recognize depression, offer guideline-based treatment recommendations, monitoring symptoms of depression along with medication adherence and adverse side effects. Similar to IMPACT but with an additional focus on reduction in suicidal ideation and risk factors for suicide, the intervention arm saw significant reductions in suicidal ideation and depression severity.

45. Bruce ML, Ten Have TR, Reynolds III CF, et al. Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients: A Randomized Controlled Trial. *JAMA*. 2004;291(9):1081–1091. doi:10.1001/jama.291.9.1081

46. Mulsant BH, Alexopoulos GS, Reynolds 3rd CF, et al. Pharmacological treatment of depression in older primary care patients: the PROSPECT algorithm. *Int J Geriatr Psychiatry*. 2001;16:585–592. http://www.ncbi.nlm.nih.gov/htbin-post/Entrez/query?db=m&form=6&Dopt=r&uid=entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11424167&dopt=Abstract

Sleep

It is a myth that adults need less sleep as they age. While the need for sleep remains the same, older people do not sleep as deeply as younger people, which may impact their experience with sleep.⁴⁷ AAGP lists substance misuse (tobacco, caffeine, alcohol), poor sleep habits, illness (heart and lung disease, depression and dementia, chronic pain), and inactivity as the primary drivers of poor sleep.

- **Sleep hygiene:** Sleep hygiene is the habits that we partake in, often in the evening, which may disrupt sleep. They include but are not limited to screen time prior to sleep, late night meals, caffeine too late in the day, alcohol or tobacco use, and exercise in the evening.
- **Napping:** Naps may be disruptive to sleep at night. If napping occurs, it should be less than one hour and prior to 3p.m.
- **Inappropriate use of the bed:** The bed should be used for sleep and sex. Any other use such as working in bed or watching TV in bed conditions our brains that the bed is for something other than resting.
- **Cognitive behavioral therapy for insomnia (CBTi):** CBTi is an evidence-based, first line treatment for difficulties with sleep. It utilizes the principles of sleep hygiene along with cognitive-behavioral techniques to improve sleep efficiency, which looks at the amount of time that someone is in bed versus the amount of time someone is asleep while in bed.
- **Treatment of sleep disorders:** Poor sleep can be due to poor sleep quality from conditions such as obstructive or central sleep apnea (OSA, CSA), or restless leg syndrome (RLS). In these cases, referral to a sleep medicine physician and/or sleep study may be an appropriate plan.



TIP

Some insurance companies, including Medicare, may require a sleep study to be prescribed by a sleep medicine physician, and would necessitate referral to sleep medicine prior to a sleep study occurring.



WATCH OUT

If a patient or their bedpartner endorse that someone is kicking, punching, or moving excessively in their sleep, this may be an indication for a sleep study. [REM sleep behavior disorders are one of the early warning signs for Parkinson's disease.](#)

- **Psychopharmacotherapy:** Several medications are utilized to treat sleep, many of which are needed for short-term use while CBTi and changes to sleep hygiene are implemented. Medications are used to target either sleep onset or sleep latency and may include melatonin receptor agonists, benzodiazepine, and benzodiazepine receptor agonists.⁴⁸



WATCH OUT

Some prescription medications may cause insomnia, including steroids and medications used to treat Parkinson's disease.

47. Sleeping well as we age. aagponline.org. November 1, 2022. Accessed May 3, 2023. <https://www.aagponline.org/patient-article/sleeping-well-as-we-age/>.

48. Sleeping well as we age. aagponline.org. November 1, 2022. Accessed May 3, 2023. <https://www.aagponline.org/patient-article/sleeping-well-as-we-age/>.



Social interaction and structure

Retirement can cause a loss of structure or daily schedule to one's day, which can lead to changes in sleep patterns, losing one's identity, having excess free time, and more. Creating a daily schedule with activities can ensure that the patient is getting social interaction and staying engaged, which can lower risk for depression and possibly delay onset of dementia.⁴⁹ Part of maintaining brain health is to continue mentally challenging activities such as strategy games, learning a new skill, taking a class, or spending time volunteering.

Per Dr. Vivek Murthy's [U.S. Surgeon General's Advisory](#) related to loneliness & isolation, the national strategy to advance social connection contains 6 pillars:

1. Strengthen Social Infrastructure in Local Communities
2. Enact Pro-Connection Public Policies
3. Mobilize the Health Sector
4. Reform Digital Environments
5. Deepen our Knowledge
6. Build a Culture of Connection

In mobilizing the health sector, tips include integrating social connection into patient care, facilitating assessments into the EHR, and acknowledging social connection as a priority for health.⁵⁰

Vitamins

As we age, the way the body absorbs nutrients from food changes. Dietary supplements such as vitamins may be indicated. It's important to ask patients about vitamins when conducting a medication reconciliation. Some vitamin deficiencies may impact behavioral health symptoms, such as Vitamin D with mood. Vitamin B12 can impact gait stability and contribute to fall risk.

49. Stay mentally and socially active. Alzheimer's Disease and Dementia. Accessed May 3, 2023. https://www.alz.org/help-support/brain_health/stay_mentally_and_socially_active.

50. Murthy VH. O ur Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community. <https://www.hhs.gov/surgeongeneral/priorities>. May 3, 2023. Accessed May 3, 2023. <https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf>.

Part 4

Patient and caregiver engagement

This section will discuss ways to partner with patients as well as engage with any family/friends/caregivers.





Many behavioral health symptoms and conditions are stigmatized or may be viewed differently by different generations. Patients may not realize that their undiagnosed behavioral health condition is impacting their health, which is one of many reasons why speaking with a family member or caregiver, often referred to as a collateral informant, who can attest to the patient's mental state, is crucial. Also, knowing what language to use with patients and caregivers when talking about behavioral health conditions prior to discussing and starting medications, is also important.

There are many barriers to behavioral health treatment both inside and outside of the primary care setting, which highlights the need for the physician to partner with the patient to best address their needs. Barriers can include lack of knowledge on behavioral health conditions, or biases and stigma including generational differences and views on mental health such as symptoms indicating a weakness or having a “pull yourself up by your bootstraps” mentality.

The [Age-Friendly Health Systems Initiative](#) is an initiative and movement to help all aspects of the healthcare delivery system deliver age-friendly care. The initiative focuses on the unique healthcare needs of older adults and uses the [4M Framework](#), focusing on what matters, medication, mentation and mobility. This framework empowers both patients and physicians to communicate most effectively with older adults and focus on the

topics that are most relevant to each individual patient. Additional ways to practice age-friendly care can include how age-friendly a physical office environment is. This can include availability of handicap parking, use of ramps, elevators that accommodate space for mobility devices, wheelchair accessible waiting rooms, patient rooms and bathrooms, utilizing chairs in the waiting room without wheels and that have arms, and having patient materials and resources that have large-font options.

The [E4 Center: Center of Excellence for Behavioral Health Disparities in Aging](#) focuses on engagement, education, and empowerment for equity in the behavioral health care of older adults. They host a substantial number of [webinars and education on demand](#) including how to assess for what matters most to older adults, [strategies for implementing trauma-informed care](#), [addressing chronic pain](#), and more. One way to partner with your patient is to ensure you're using language that is inclusive and free of age bias.

Ageism refers to “the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age.”⁵¹ Ageism can have great impact in the healthcare setting, ranging from how clinic team members treat older adults to how aging-friendly a practice environment is, which affect opportunities that older adults may have to experience healthy aging.⁵² Not only do healthcare setting biases

51. Ageing: Ageism. World Health Organization. March 18, 2021. Accessed May 3, 2023. <https://www.who.int/news-room/questions-and-answers/item/ageing-ageism>.

52. Ageing and health. World Health Organization. October 1, 2022. Accessed May 3, 2023. <https://www.who.int/news-room/fact-sheets/detail/ageing-and-health>.



impact healthy aging, but older adults having negative self-perceptions themselves on aging can impact their ability to age in a healthy manner due to delaying care.^{53,54}

The E4 Center offers a [webinar](#) that presents the evidence behind the impact of language as well as updates to outdated language. The [National Center to Reframe Aging](#) (NCRA) offers a guide with communication best practices, additionally including ways to use language that is inclusive.

Additional ways to partner with a patient include utilizing a collaborative relationship and allowing your patient to help guide treatment decisions. It is important to frame things as partnering together for your patient's health, and keeping things focused on the goals they'd like to achieve—whether that be continuing gardening, improving sleep, or increasing social interactions.

In caring for older adults, partnering not only with the patient but with their family, caregivers, guardians, etc., is an important aspect of care. Framing this as care for the family unit and partnering together as a team lets the patient and family members help dictate the

direction of care. Getting permission from patients prior to automatically including family members in a visit helps with allowing a patient to be in the driver's seat of their care.

One of the most difficult aspects of working with patients who have behavioral health concerns is that given the nature of the symptoms or condition, there is often a lack of insight or even an inability to recognize some of the more subtle symptoms, which is why utilizing family members as collateral informants can be crucial in appropriate diagnosis and treatment. Educating patients and their family members/caregivers about what is considered normal symptoms of aging versus things that you may be concerned about allows for trust and rapport to be built, knowing that you as the physician care about your patient and can discuss tough topics.

53. Levy B. Stereotype Embodiment: A Psychosocial Approach to Aging. *Curr Dir Psychol Sci*. 2009 Dec 1;18(6):332-336. doi: 10.1111/j.1467-8721.2009.01662.x. PMID: 20802838; PMCID: PMC2927354.

54. Sun JK, Smith J. Self-Perceptions of Aging and Perceived Barriers to Care: Reasons for Health Care Delay. *Gerontologist*. 2017 Aug 1;57(suppl_2):S216-S226. doi: 10.1093/geront/gnx014. PMID: 28854604; PMCID: PMC5881713.

Part 5

Measuring success and sustainability

Measuring success and adjusting as the evidence presents itself is crucial for the sustainability of integrated care models.

BHI has grown substantially in the past 10–20 years and continues to be a fluid field with a lot of potential for continued growth. With ongoing updates to billing codes and new evidence forthcoming utilizing different models, this field will continue to see evolution over the next several years. Evidence abounds for a renewed focus on caring for the behavioral health needs of older adults.





Different levels of behavioral health integration will have different ways of measuring success in their specific model. Evaluation measures can include but are not limited to:

- Decrease number of ED visits
- Decrease in number of hospitalizations
- Number of Falls
- Improvement in screening scores such as Geriatric Depression Scale or Geriatric Anxiety Scale
- Time to transition out of home (into a skilled nursing facility)
- Tapering patients off nonessential or potentially inappropriate medications
- Patient satisfaction scores

An additional measure of success is practice-focused specifically around decreasing ageism and improving an age-friendly practice environment. This can include organizational assessments of attitudes, knowledge and skills needed to effectively care for older adults. Improvement in these aspects will indirectly improve patient care and patient outcomes, even if that nuance is more difficult to track.

Depending on your level of BHI (co-located to fully integrated care), different BHI-related [CPT codes](#) can be utilized by a practice or system to capture additional screenings, behavioral assessments and treatments.

**TIP**

The following are codes that may be relevant during a primary care visit with an older adult with behavioral health needs:

****NOTE:** Codes listed below may be more applicable to certain models of care. Please download the [AMA's Behavioral Health Coding Resource](#) for more details. Codes marked with a (T) are telemedicine-related.

Behavior Change Interventions

- 99406, 99407 Smoking and tobacco use cessation counseling visit (T)
- 99408, 99409 Alcohol and/or substance (other than tobacco) abuse structured screening, brief intervention (SBI) services (T)

Developmental/Behavioral Screening

- 96127 Brief emotional/behavioral assessment (e.g., depression inventory, ADHD scale), with scoring and documentation, per standardized instrument
- 96110 Developmental screening (e.g., developmental milestones survey, speech and language delay screen), with scoring and documentation, per standard instrument
- 96161 Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

Adaptive Behavior Services

- 97151, 97152 (Assessment), 97153-97158 (Treatment)
- Address deficient adaptive behaviors, maladaptive behaviors, or other impaired functioning secondary to deficient adaptive or maladaptive behaviors (e.g., instruction following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care, daily living, personal safety)

Health Behavior Assessment and Intervention

- 96156-96171 (Individual, Group, Family)
- Focus on psychological, behavioral, emotional, cognitive, and interpersonal factors complicating medical conditions and treatments

Cognitive Assessment and Care Plan Services, 99483

- Provided when a comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition
- Thorough evaluation of a medical and psychosocial factors, potentially contributing to increased morbidity

****New in CY2023** HCPCS Code G0323: Care Management Services for Behavioral Health Conditions⁵⁵**

- Describes general BHI that a clinical psychologist (CP) or clinical social worker (CSW) performs to account for monthly care integration
- A CP or CSW, serving as the focal point of care integration furnishes the mental health services
- At least 20 minutes of CP or CSW time per calendar month
- Psychiatric diagnostic evaluation (CPT code 90791) serves as an eligible initiating visit for G0323

55. Behavioral Health Integration Services. cms.gov. January 2023. Accessed May 3, 2023. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>.

Appendix A

Key resources and tools

This resource is not meant to be all-inclusive in the care of behavioral health conditions for older adults. For further resources to support this population or to delve further into strategies for implementing behavioral health integration into your practice, please refer to the resources below.

Title	Description	Organization	Link
PART 1: Introduction			
Behavioral Health Integration (BHI) Compendium	The BHI Compendium serves as a tool to learn about integrating behavioral health care, which includes mental health and substance use disorders care, and how to make it effective for your practice and patients.	BHI Collaborative	https://www.ama-assn.org/delivering-care/public-health/compendium-behavioral-health-integration-resources-physician
Behavioral health integration in physician practices	Introduction to integration of behavioral and mental health care, the BHI Collaborative, and BHI Resources for physician practices.	American Medical Association	https://www.ama-assn.org/delivering-care/public-health/behavioral-health-integration-physician-practices
PART 2: Identification of the need			
Consumer/patient information	Information for older adults, family members, and caregivers on alcohol/drug abuse/misuse, Alzheimer's disease and other dementias, anxiety, caregiving, depression, disaster preparedness and response, healthy aging, and sleep.	American Association for Geriatric Psychiatry	https://www.aagponline.org/patient-article/consumer-patient-information/
Growing older: Providing integrated care for an aging population	This report for clinicians explains approaches to providing integrated care to older adults living with substance use disorder and mental illness. It highlights the importance of assessing patients for cognitive deficits and adapting behavioral interventions to help improve treatment outcomes.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/Growing-Older-Providing-Integrated-Care-for-An-Aging-Population/SMA16-4982?referer=from_search_result

Title	Description	Organization	Link
Get Connected: Linking Older Adults with Resources on Medication, Alcohol, and Mental Health, 2019 Edition	Designed for organizations that provide services to older adults, this toolkit offers information and materials to help understanding the issues associated with substance misuse and mental illness in older adults. The toolkit also contains materials to educate older adults.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/Get-Connected-Linking-Older-Adults-with-Resources-on-Medication-Alcohol-and-Mental-Health-2019-Edition/SMA03-3824
Words matter: Preferred language for talking about addiction	Defining stigma associated with substance use disorders and contains a chart to help chose person-first language.	National Institute on Drug Abuse/ National Institutes of Health	https://nida.nih.gov/research-topics/addiction-science/words-matter-preferred-language-talking-about-addiction#table
Improving care for LGBTQ+ communities	The Center of Excellence on LGBTQ+ Behavioral Health Equity provides behavioral health practitioners with vital information on supporting the population of people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, two-spirit, and other diverse sexual orientations, gender identities, and expressions.	Center of Excellence: LGBTQ+ Behavioral Health Equity	https://lgbtquequity.org/
What is dementia?	Explains about dementia, including symptoms, causes, diagnosis, treatments, and risk & prevention.	Alzheimer's Association	https://www.alz.org/alzheimers-dementia/what-is-dementia
Types of dementia	Shares details about, including symptoms, diagnosis, causes and risks, and treatment, of different kinds of dementia.	Alzheimer's Association	https://www.alz.org/alzheimers-dementia/what-is-dementia/types-of-dementia

Title	Description	Organization	Link
Alzheimer's disease facts and figures	An annual report released by the Alzheimer's Association which reveals the burden of Alzheimer's and dementia on individuals, caregivers, government and the nation's health care system.	Alzheimer's Association	https://www.alz.org/alzheimers-dementia/facts-figures
Education center	Online Alzheimer's and Dementia courses for scientists, clinicians, physicians and dementia professionals.	Alzheimer's Association	https://training.alz.org/ClinicalEducation
Understanding Parkinson's	Learn about its various symptoms, how it is diagnosed, treated, and most importantly, how to live a better life with Parkinson's.	Parkinson's Foundation	https://www.parkinson.org/understanding-parkinsons
Treatment Improvement Protocol (TIP) 59: Improving cultural competence	This TIP guide helps professional care providers and administrators understand the role of culture in the delivery of mental health and substance use services. It describes cultural competence and discusses racial, ethnic, and cultural considerations.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849?referer=from_search_result
Older adults living with serious mental illness: The state of the behavioral health workforce	The purpose of this brief is to provide a broad-based overview of workforce issues to consider when addressing the needs of older adults living with SMI and is not intended as a comprehensive literature review.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf

Title	Description	Organization	Link
Connect 2Tools to overcome social isolation	Provides support services and ways to overcome social isolation.	AARP	https://connect2affect.org/
Reducing loneliness and social isolation among older adults	Provides facts to understand loneliness, social isolation and their effects, identify and assess for loneliness and its risk factors, and connect lonely or socially isolated older adults to services or resources.	Suicide Prevention Resource Center	https://sprc.org/wp-content/uploads/2022/12/Reducing-Loneliness-and-Social-Isolation-Among-Older-Adults-Final.pdf
BHI workflow guide for your practice	Find actionable, evidence-based best practices and resources for creating an integrated behavioral health integration workflow for primary care practices.	American Medical Association	https://www.ama-assn.org/delivering-care/public-health/designing-workflow-behavioral-health-integration

PART 3: Treatment considerations

Psychopharmacology and behavioral health integration	Access actionable, evidence-based best practices on psychopharmacology enabling care providers to overcome key barriers to operationalizing integrated behavioral health care.	American Medical Association	https://www.ama-assn.org/delivering-care/public-health/psychopharmacology-guide-prescribing-psychotropic-medications
Behavioral interventions	Training and support for behavioral interventions including behavioral activation training.	AIMS Center	https://aims.uw.edu/training-support/behavioral-interventions
CBT and CT-R Training Catalog	Sign up for live or on-demand training and learn CBT and CT-R trainings from expert faculty.	Beck Institute	https://learn.beckinstitute.org/s/category/all-products/training/0ZG4M000000004E-WAQ?c__results_layout_state=%7B%7D

Title	Description	Organization	Link
Substance use disorder and behavioral health integration	Find actionable, evidence-based best practices on treating substance use disorder while operationalizing integrated behavioral health care.	American Medical Association	https://www.ama-assn.org/delivering-care/overdose-epidemic/substance-use-disorder-treatment-guide
TIP 34: Brief interventions and brief therapies for substance abuse	This TIP manual introduces counselors and therapists to brief intervention and therapy for mental illness, substance use disorders, or both. It presents practical methods and case scenarios for implementing shorter forms of treatment for a range of populations and issues.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/TIP-34-Brief-Interventions-and-Brief-Therapies-for-Substance-Abuse/SMA12-3952
TIP 26: Treating substance use disorder in older adults	This updated TIP is designed to help providers and others better understand how to identify, manage, and prevent substance misuse in older adults. The TIP describes the unique ways in which the signs and symptoms of substance use disorder (SUD) manifest in older adults; drug and alcohol use disorder screening tools, assessments, and treatments specifically tailored for older clients' needs; the interaction between SUDs and cognitive impairment; and strategies to help providers improve their older clients' social functioning and overall wellness.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/treatment-improvement-protocol-tip-26-treating-substance-use-disorder-in-older-adults/PEP20-02-01-011

Title	Description	Organization	Link
TIP 63: Medications for opioid use disorder (full document)	This TIP reviews the use of the three Food and Drug Administration (FDA)-approved medications used to treat OUD—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support recovery for people with OUD. This is a revision.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002?referer=from_search_result
Psychosocial interventions for older adults with serious mental illness	The guide provides considerations and strategies for interdisciplinary teams, peer specialists, clinicians, registered nurses, behavioral health organizations, and policy makers in understanding, selecting, and implementing evidence-based interventions that support older adults with serious mental illness.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/psychosocial-interventions-older-adults-serious-mental-illness/PEP21-06-05-001?referer=from_search_result
TIP 57: Trauma-informed care in behavioral health services	This manual helps behavioral health professionals understand the impact of trauma on those who experience it. The manual discusses patient assessment and treatment planning strategies. These strategies support recovery and the development of a trauma-informed care workforce.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816?referer=from_search_result
TIP 54: Managing chronic pain in adults with or in recovery from substance use disorders	This guide equips clinicians with information for treating chronic pain in adults living with a history of substance use. The guide discusses chronic pain management, including treatment with opioids. It also includes information about substance use assessments and referrals. Access the literature review.	Substance Abuse and Mental Health Services Administration	https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671?referer=from_search_result

Title	Description	Organization	Link
The physician's role in promoting firearm safety	In the United States, more than 38,000 persons die from firearm-related injuries each year. Screening and counseling to increase safety is performed by a minority of physicians despite the clinically accepted need. This module explores common barriers to communicating with patients about firearm safety.	American Medical Association	https://edhub.ama-assn.org/interactive/17579432
AMA Update: "How physicians can talk to patients about gun violence and firearm safety" with Sandra Fryhofer, MD	In this AMA Update, Sandra Fryhofer, MD, who serves as AMA's Board Chair and the inaugural chair of our Gun Violence Task Force, joins to discuss what physicians need to know about gun violence prevention. AMA Chief Experience Officer Todd Unger hosts.	American Medical Association	https://www.ama-assn.org/delivering-care/public-health/how-physicians-can-talk-patients-about-gun-violence-and-firearm
Firearm responsibility and planning: Creating a firearm life plan	Learn about an easy-to-use toolkit to facilitate conversations about firearms, aging, and planning for the future together.	Firearm Life Plan	https://firearmlifeplan.org/
How to counsel	Learn how to effectively assess risk, talk with patients about access to, firearms, and intervene appropriately.	BulletPoints Project	https://www.bulletpointsproject.org/how-to-counsel/
Lock to live	This tool can help you make decisions about temporarily reducing access to potentially dangerous things, like firearms, medicines, sharp objects, or other household items.	Lock2Live	https://lock2live.org/

Title	Description	Organization	Link
Older adults	Covers the unique needs of older adults when thinking about healthy eating.	MyPlate	https://www.myplate.gov/life-stages/older-adults
Walk. Run. Dance. Play. What's your move?	The Move Your Way® tools, videos, and fact sheets on this page have tips that make it easier to get a little more active.	US Department of Health & Human Services	https://health.gov/moveyourway
Physical activity guidelines for Americans, 2nd edition	The Physical Activity Guidelines for Americans is an essential resource for health professionals and policymakers as they design and implement physical activity programs, policies, and promotion initiatives. It provides information that helps Americans make healthy choices for themselves and their families, and discusses evidence-based, community-level interventions that can make being physically active the easy choice in all the places where people live, learn, work, and play.	US Department of Health & Human Services	https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf
Be prepared. Make a safety plan.	A safety plan is a prioritized list of coping strategies and sources of support. It can help you to identify what leads to your thoughts of suicide, and how to feel better when you are having these thoughts.	My Safety Plan	https://www.mysafetyplan.org/
Suicide prevention and behavioral health integration	Find actionable, evidence-based best practices and resources on suicide prevention for at-risk patients.	American Medical Association	https://www.ama-assn.org/delivering-care/public-health/suicide-prevention-guide-treat-risk-patients

Title	Description	Organization	Link
Our epidemic of loneliness and isolation: The U.S. surgeon general's advisory on the healing effects of social connection and community	Describes social connection, how it can impact a person's well-being / a community, and provides a national strategy to advance social connection.	US Department of Health and Human Services	https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

PART 4: Patient and caregiver engagement

Age-friendly health systems	Describes a movement helping hospitals, medical practices, retail pharmacy clinics, nursing homes, home-care providers and others deliver age-friendly care.	The John A Hartford Foundation	https://www.johnhartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative
E4 Center	The E4 Center measurably advances training and workforce capacity with a specific focus on the community-based implementation of evidence-based practices and programs for vulnerable older adults who experience the greatest behavioral and physical health disparities in the nation.	E4 Center	https://e4center.org/
Reframing Aging Initiative: Countering ageism by changing how we talk about aging	Includes a comprehensive guide uses the evidence-informed findings from the Reframing Aging Initiative and the best practices guidance from the APA, AMA, and AP style guides to show you how to apply age-inclusive, bias-free language in your communications.	National Center to Reframing Aging	https://www.reframingaging.org/
Society of Behavioral Sleep Medicine: Practice consultation webinars	Education on diagnosis and treatment of various sleep disorders.	Society of Behavioral Sleep Medicine	https://www.behavioralsleep.org/index.php/sbsm-educational-opportunities/webinars/sbsm-webinars

Title	Description	Organization	Link
PART 5: Measuring success and sustainability			
<p>Technical Assistance Publication (TAP) 33: Systems-level implementation of screening, brief intervention, and referral to treatment</p>	<p>This guide describes core elements of screening, brief intervention, and referral to treatment (SBIRT) programs for people living with or at risk for substance use disorders. It provides information on implementing SBIRT services and covering challenges, barriers, cost, and sustainability.</p>	<p>Substance Abuse and Mental Health Services Administration</p>	<p>https://store.samhsa.gov/product/TAP-33-Systems-Level-Implementation-of-Screening-Brief-Intervention-and-Referral-to-Treatment-SBIRT/SMA13-4741?referer=from_search_result</p>
<p>Behavioral Health Coding Guide</p>	<p>The American Medical Association Private Practice Group Membership Program provides access to resources that work to help you to improve reimbursement, advance care, and retain and acquire key team members.</p>	<p>American Medical Association</p>	<p>https://cloud.e.ama-assn.org/22-1580-Private-Practice#:~:text=The%20American%20Medical%20Association%20Private%20Practice%20Group%20Membership%20Program%20provides,and%20acquire%20key%20team%20members.&text=Copyright%201995%E2%80%932023%20American%20Medical,All%20rights%20reserved</p>
<p>Behavioral health integration services</p>	<p>Explains BHI, describes CoCM, gives CPT code descriptions, including new codes.</p>	<p>Centers for Medicare & Medicaid Services</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Behavioral-HealthIntegration.pdf</p>
<p>Integrating behavioral health care into primary care: Advancing primary care innovation in Medicaid managed care</p>	<p>The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.</p>	<p>Center for Health Care Strategies, Inc.</p>	<p>https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf</p>

Title	Description	Organization	Link
Deep dive: Practical billing strategies for the Collaborative Care Model	Building off the Behavioral Health Billing & Coding 101 webinar, coding experts take a deeper dive into effective billing and coding strategies specific to the Collaborative Care Model.	BHI Collaborative	https://www.youtube.com/watch?v=0LN8ipNuNgQ&list=PL7ZHB_CvG4qscB1BHkDNm_-7G8AHh5V2bz&index=13
Coverage for psychiatric collaborative care management codes	The American Psychiatric Association has compiled an interim list of payers who have either indicated they have approved coverage for psychiatric collaborative care management (CoCM) codes (CPT codes 99492–99494) or for whom we have confirmation that a paid claim(s) has occurred.	American Psychiatric Association	https://www.psychiatry.org/getmedia/c2b57396-00a3-4d46-90db-7bf3414014d3/Coverage-Psychiatric-CoCM-Codes-Payers.pdf

Appendix B Summary table: Common disorders in an aging population



	Major Depressive Disorder(MDD) ^{1,2,3}	Anxiety Disorders ^{4,5}	Substance Misuse and SUDs ^{6,7,8,9}	Suicidal Ideation and Death by Suicide ¹⁰	Dementia ^{11,12,13}
Risk Factors	<ul style="list-style-type: none"> • Prior history of depression • Female gender • Sleep disturbance • Disability and decreased mobility • Chronic physical illness • Social isolation • Loss of a spouse, partner, family member • Long-term caregiving • Retirement • Moving from the family home • Changes in vision/ hearing 	<ul style="list-style-type: none"> • Extreme stress or trauma • Bereavement and complicated or chronic grief • Alcohol, caffeine, drugs (prescription, over-the-counter, and illegal) • A family history of anxiety disorders • Other medical or mental illnesses or • Neurodegenerative disorders (e.g., Alzheimer’s, dementia). 	<ul style="list-style-type: none"> • Loss of a spouse, partner, family member • Retirement, especially when not voluntary • Physical health problems • Loss of mobility • Insomnia • Change in environment or relocation out of home • Chronic pain • History of trauma • Mental health diagnoses • Cognitive decline or dementia • Social isolation • Financial stressors • Prior history of SUD • Family history of SUD • Availability of substances • Health problems, loss of mobility, isolation / loss of social support 	<ul style="list-style-type: none"> • Prior attempts • White men over age 80 – 6x more likely to die by suicide than the general population • Depression and other mental health problems • Substance use problems (including prescription medications) • Physical illness, disability, and pain • Social isolation • History of violence • Dementia or cognitive impairment • Recent relationship or job loss • Firearm ownership • Suicide Ideation • Threats to hurt themselves • History of impulsivity 	<ul style="list-style-type: none"> • Depression • Age • Family History • Genetics • Head injury, Traumatic Brain Injury

	Major Depressive Disorder(MDD) ^{1,2,3}	Anxiety Disorders ^{4,5}	Substance Misuse and SUDs ^{6,7,8,9}	Suicidal Ideation and Death by Suicide ¹⁰	Dementia ^{11,12,13}
Key Symptoms	<ul style="list-style-type: none"> • Persistent sadness, low mood, alexithymia • Cognitive deficits or “pseudodementia” • Social isolation • Apathy • Episodes of tearfulness • Diurnal variations in mood • Somatic symptoms including GI symptoms, worsening pain, and increased preoccupation with bodily experiences • Feeling like a burden, feelings of worthlessness, feelings of guilt • Psychotic symptoms are common: nihilistic or somatic delusions are more common than hallucinations • Sleep disturbance • Changes in appetite • Low energy and motivation • Difficulty with decision making and concentration • Psychomotor slowing or agitation • Suicidal thoughts • Excessive worries • Inability to take care of ADLs 	<ul style="list-style-type: none"> • Excessive worry or fear • Refusing to do routine activities or being overly preoccupied with routine • Avoiding social situations • Overly concerned about safety • Racing heart, shallow breathing, trembling, nausea, sweating • Poor sleep • Muscle tension, feeling weak and shaky • Hoarding/collecting • Depression • Self-medication with alcohol or other central nervous system depressants 	<ul style="list-style-type: none"> • Altered mental status • Recurrent falls • Risk taking • Memory issues • Weight loss • Low mood or depression • Social withdrawal • Interference with relationships 	<ul style="list-style-type: none"> • Feel that life is no longer living • Feeling like a burden • Feeling like there is no other way out • Symptoms of impulsivity • Symptoms of depression • Thinking about plans • Actively looking up plans or working on a plan • Writing a suicide note, creation of a will • High anxiety 	<ul style="list-style-type: none"> • Memory loss that disrupts daily life • Challenges in planning or problem solving • Difficulty completing familiar tasks • Confusion with time or place • Trouble understanding visual images and spatial relationships • Rule out vision changes related to cataracts • New problems with words in speaking or writing • Sometimes having word finding difficulties • Misplacing things and losing the ability to retrace steps • Decreased or poor judgment • Withdrawal from work or social activities • Changes in mood and personality

	Major Depressive Disorder(MDD) ^{1,2,3}	Anxiety Disorders ^{4,5}	Substance Misuse and SUDs ^{6,7,8,9}	Suicidal Ideation and Death by Suicide ¹⁰	Dementia ^{11,12,13}
Differential Diagnoses	<ul style="list-style-type: none"> Medication side effects Vitamin deficiencies - B12, folate, D Anemia Infections Metabolic abnormalities Hypothyroidism Neurosyphilis Substance misuse or SUD 	<ul style="list-style-type: none"> Acute stress MDD ADHD Hyperthyroidism COPD or asthma Arrhythmias Substance withdrawal (alcohol, opiates, sedatives) Substance intoxication (cannabis, stimulants, caffeine) 	<ul style="list-style-type: none"> Dementia Depression Other medical illnesses 	-----	<ul style="list-style-type: none"> Delirium Depression OSA Medication side effects Vitamin deficiencies Thyroid problems Lyme disease Neurosyphilis Excessive alcohol or other substance consumption
Other Points & Considerations	Late life depression is underdiagnosed, especially in older African American and Hispanic men	Worsening of PTSD and anxiety disorders including OCD in older adults during and after COVID; Always consider co-morbid depression, substance use disorder	Changes in thinking attributable to alcohol misuse may appear similar to normal age-related changes in cognition; Screenings should be universal, not just presumed "high risk" groups; yearly screening and when major life changes occur	-----	"Older Latinos are about one-and-a-half times as likely as older whites to have Alzheimer's and other dementias, while older African-Americans are about twice as likely to have the disease as older whites"
Screening Tools	<ul style="list-style-type: none"> S-GDS; GDS MADRS CSDD HAM-D PHQ2, PHQ9 - PHQ2 has a higher likelihood of giving older adults a false positive 	<ul style="list-style-type: none"> GAS; GAS-10 PSWQ PTSD Checklist for DSM5 Primary Care PTSD Screen for DSM5 Y-BOCS 	<ul style="list-style-type: none"> Alcohol - SMAST-G, AUDIT-C or AUDIT, SAMI Cannabis - CUDIT-R Multiple substances ASSIST, CAGE-AID, NIDA Quick Screen V1.0, Brief Addiction Monitor No evidence-based, validated screening tools for assessing OTC or prescription medication misuse 	<ul style="list-style-type: none"> C-SSRS P4 	<ul style="list-style-type: none"> Mini-Cog MMSE MOCA
Additional Testing	<ul style="list-style-type: none"> CBC CMP TSH, free T4 Vitamin B12, folate T. pallidum antibody, HIV Urine drug screen Can consider sleep study 	<ul style="list-style-type: none"> EKG TSH, free T4 UDS 	<ul style="list-style-type: none"> Urinalysis Folic acid, Vitamin B12 T. pallidum antibody CT Head 	-----	<ul style="list-style-type: none"> Neuropsychiatric testing Brain MRI

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