WELCOME to the

Geriatric Mental Health in Primary Care ECHO

January-June 2025

Funding Statement

The Health Resources and Services Administration made this program possible through U1QHP53034.Views expressed by speakers, moderators, and in writing may not reflect the policies of the Department of Health and Human Services. Mentions of trade names, commercial practices, or organizations do not imply endorsement by the U.S. Government.

Series Learning Objectives

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

Series Sessions

Date	Session Title
1/23/2025	Social Isolation/Loneliness
2/27/2025	Substance Use Disorder
3/27/2025	Depression
4/24/2025	Anxiety
5/22/2025	Cannabis/CBD and Older Adults
6/26/2025	Serious Mental Illness

Core Panel

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

Social Connectedness and Aging

Renée Pepin, PhD

Connecting

- Who are you
- Where are you from

BACKGROUND: Key Definitions

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

BACKGROUND: Context of Aging

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

BACKGROUND: Social Connectedness and Mental Health

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

Social Connectedness Screening: UCLA 3-Item Loneliness Scale

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

Anne, 69 yo Female (UCLA = 6)

Married, strong relationship with 4 children, 8 grandchildren

Retired teacher

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

Greg, 81 yo Male (UCLA = 8)

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

Retired IT manager

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

Rebecca, 73 yo Female (UCLA = 6)

Single, lives alone with cat in senior housing

Retired

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

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Loneliness is Identified

Something Happens

Enhancing Social Connectedness: Intervening

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

Enhancing Social Connectedness: Intervening

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

Enhancing Social Connectedness: Intervening

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

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

Video Presentation

WELCOME to the

Geriatric Mental Health in Primary Care ECHO

Session 2, Substance Use Disorder
February 27, 2025

Substance Use and Older Adults

Stuart Lewis, MD FACP

Associate Professor of Medicine

Geisel School of Medicine at Dartmouth

CONFLICTS:

None to Report

Not Today's Topic, But….

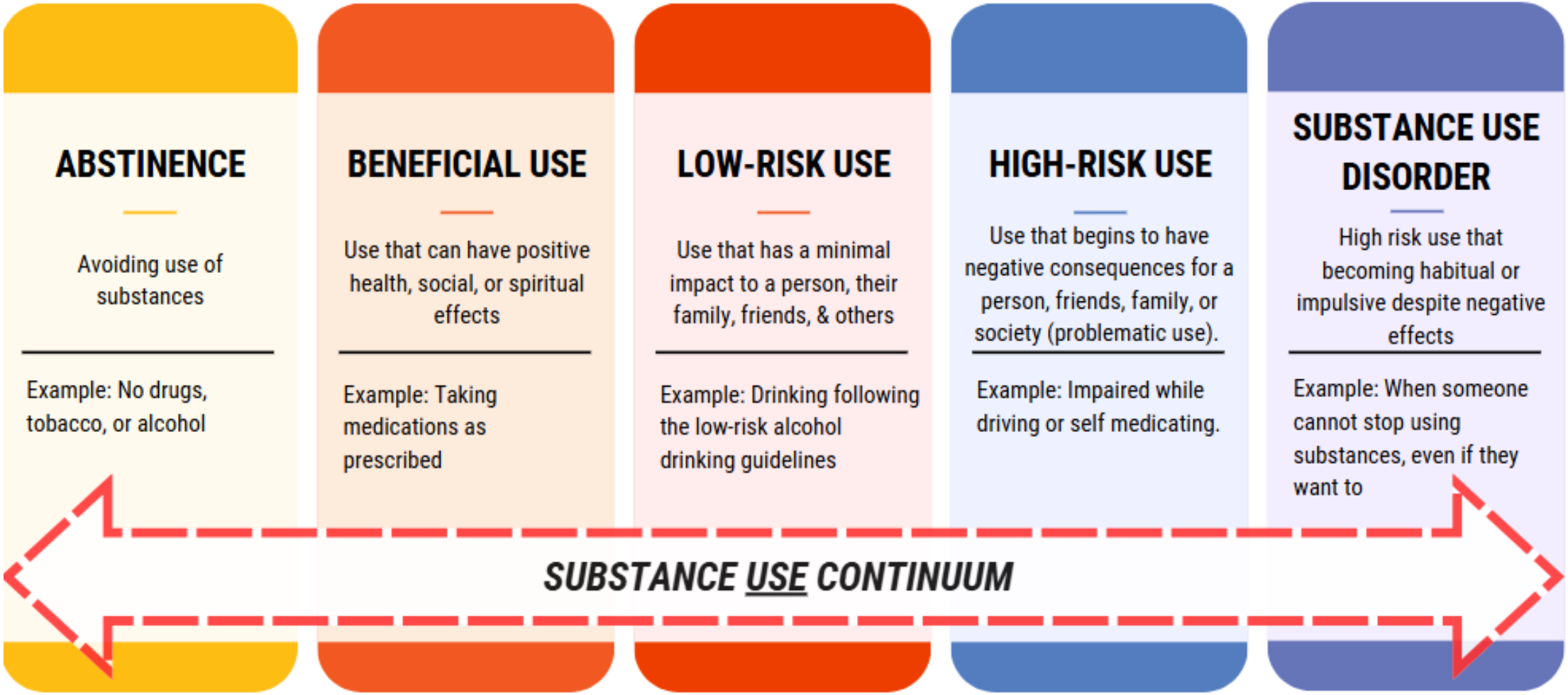
CDC estimates that **38%** of all alcohol-related deaths in 2020 and 2021 were in people ages 65 or Older

Learning Objectives

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

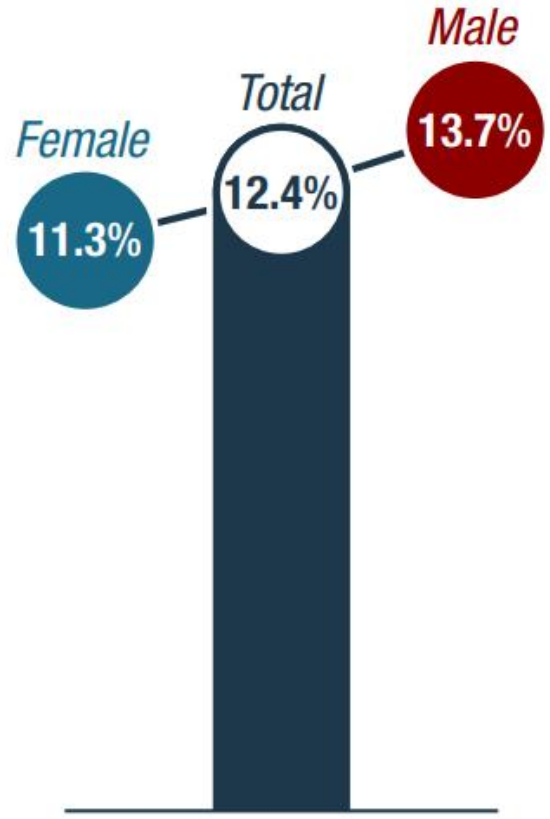
What's A Substance?

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


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

CIGARETTE SMOKING

Percentage using in past month

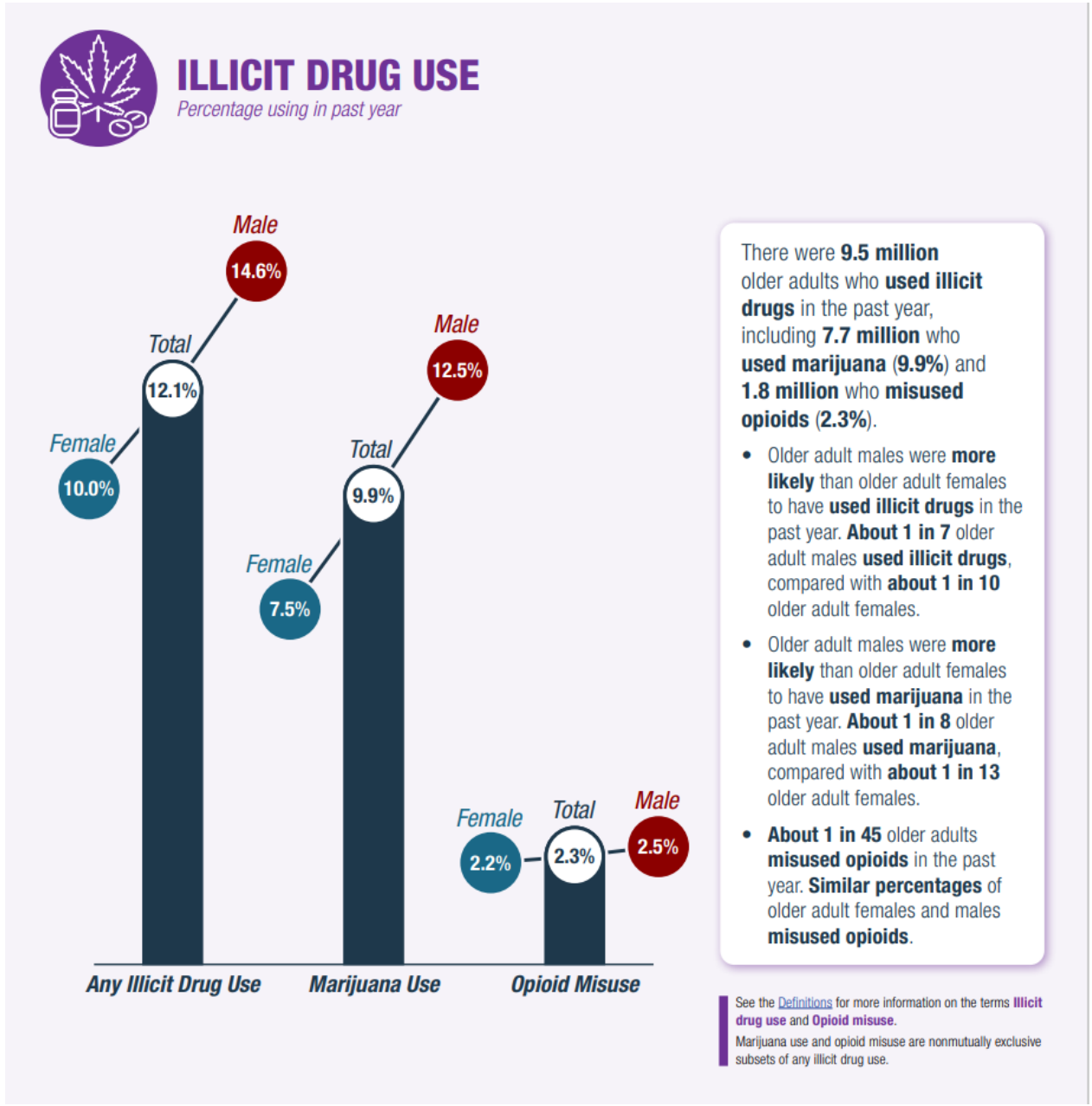


About 9.7 million older adults, or **nearly 1 in 8**, **smoked cigarettes** in the past month.

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

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

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



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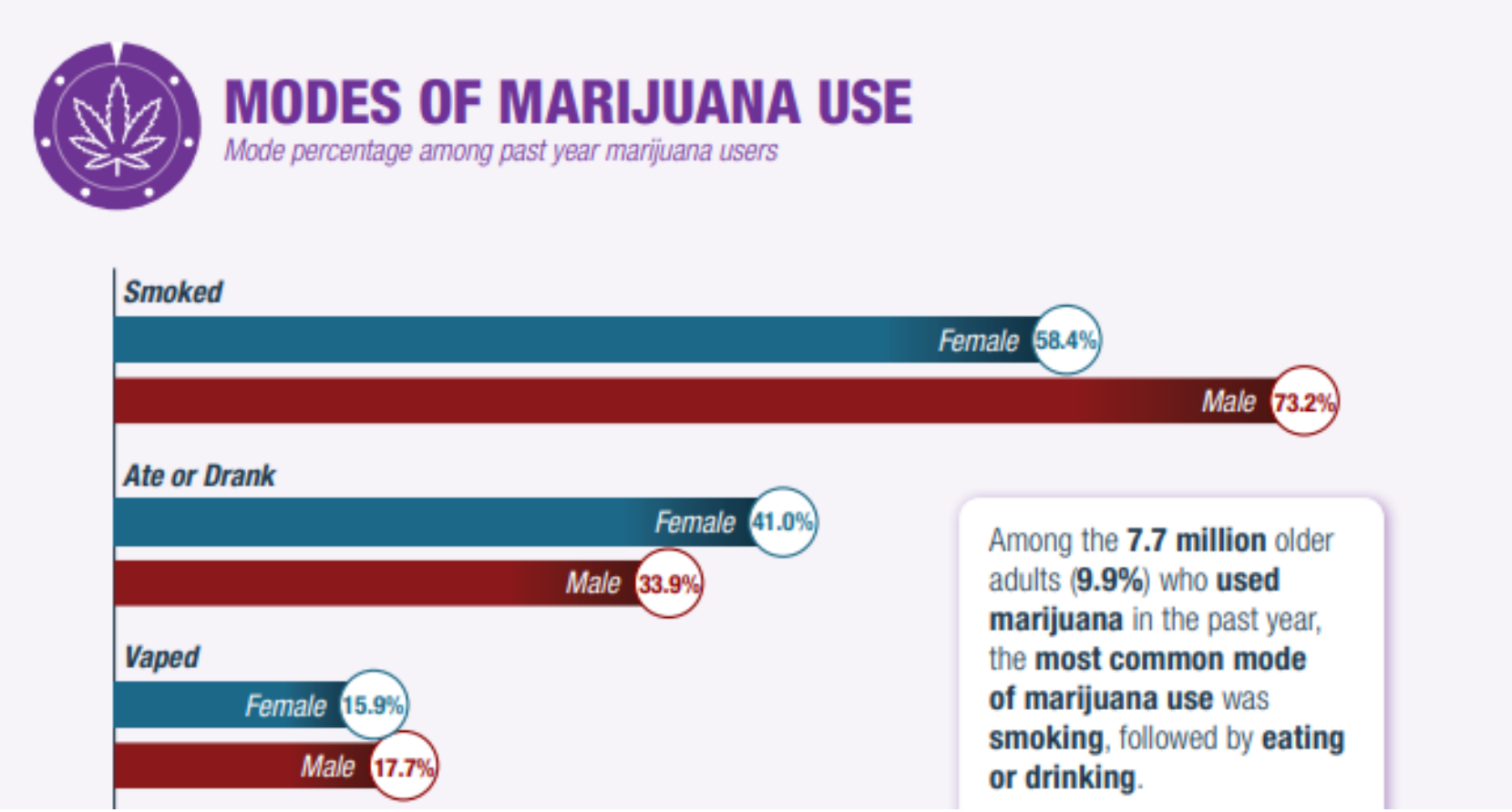

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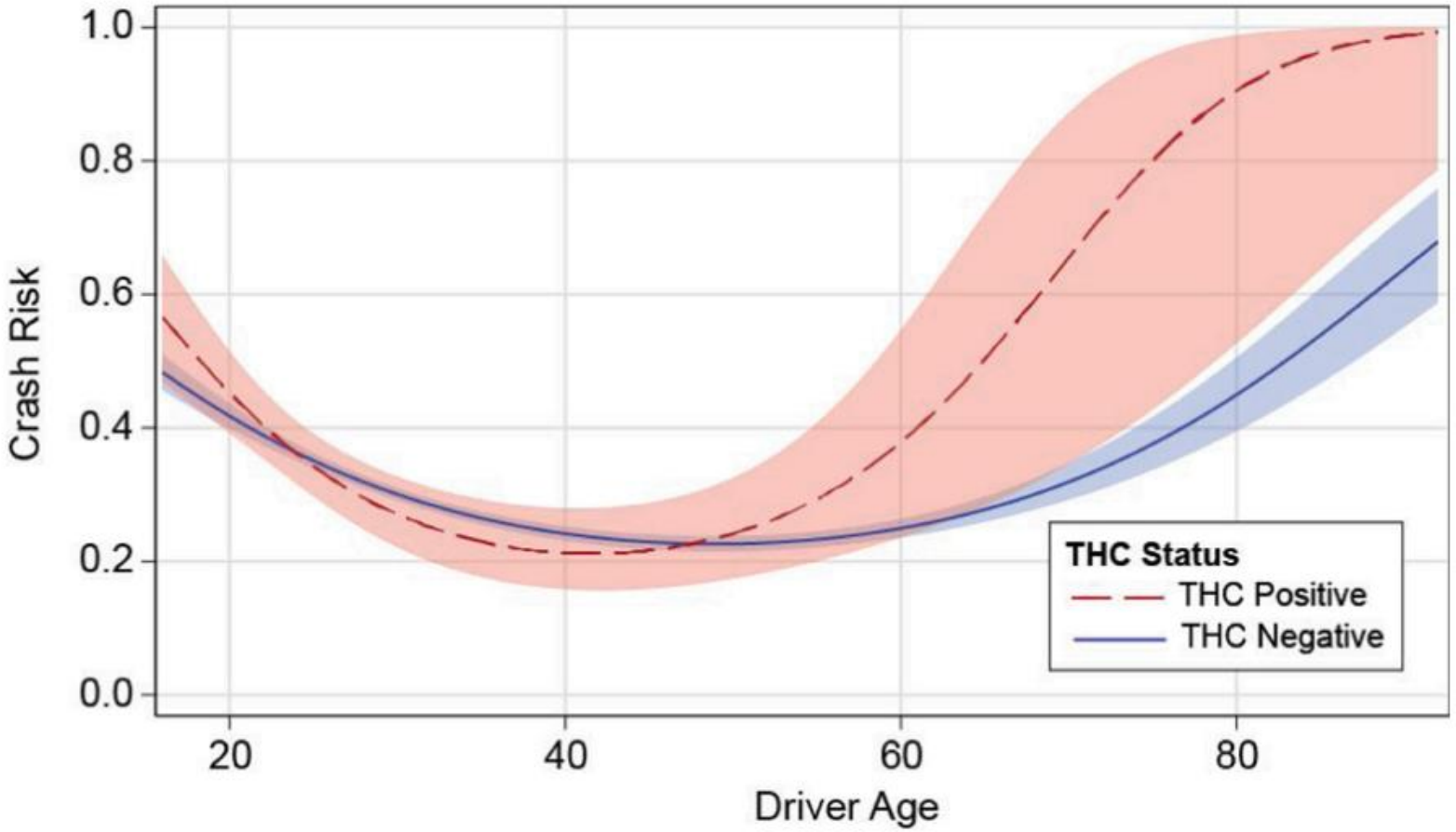


Fig. 1. Crash risk as a function of driver age and THC category.

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

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

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

Opioid Use Disorder 2013-2018 in Adults over 65

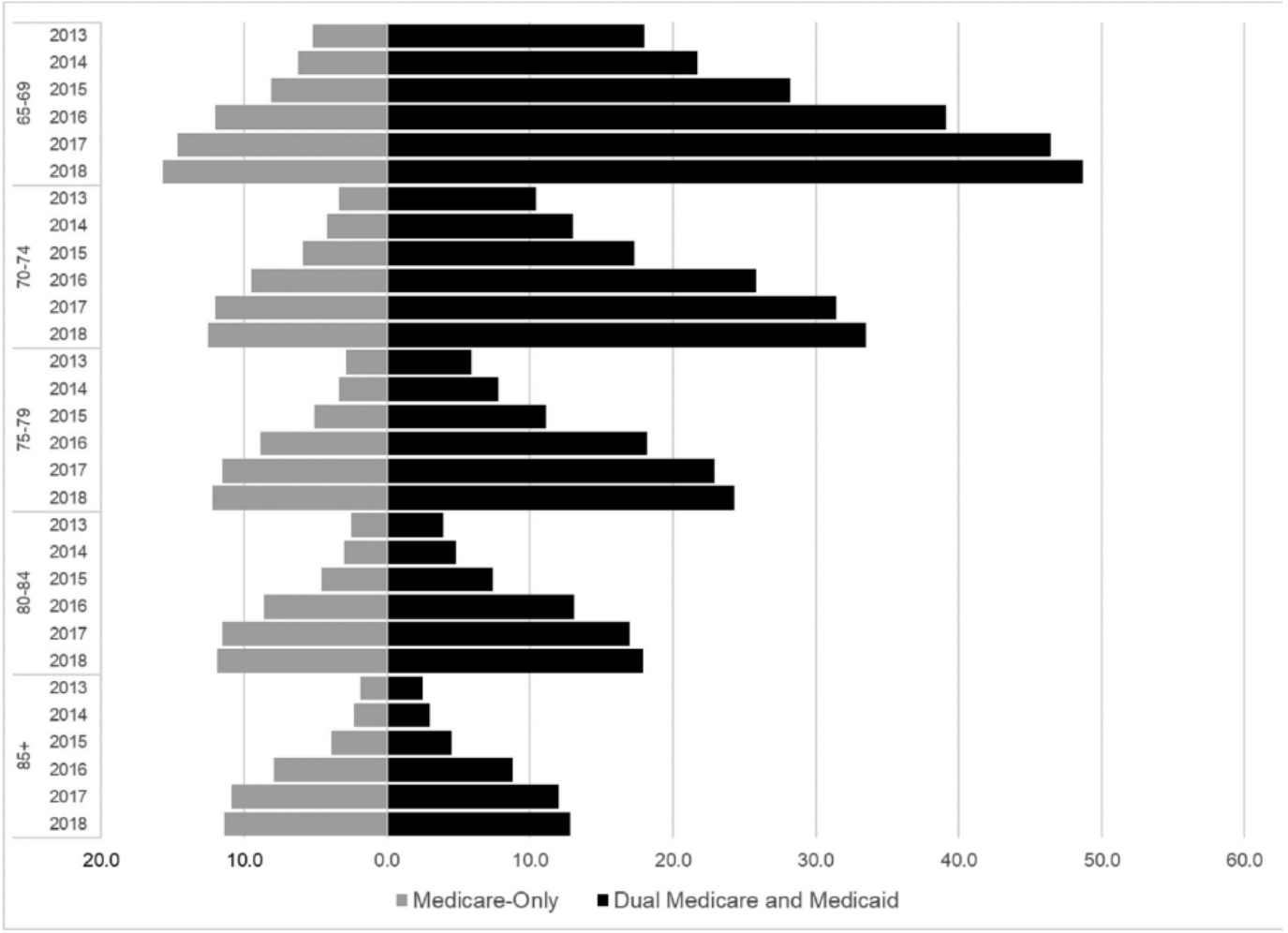
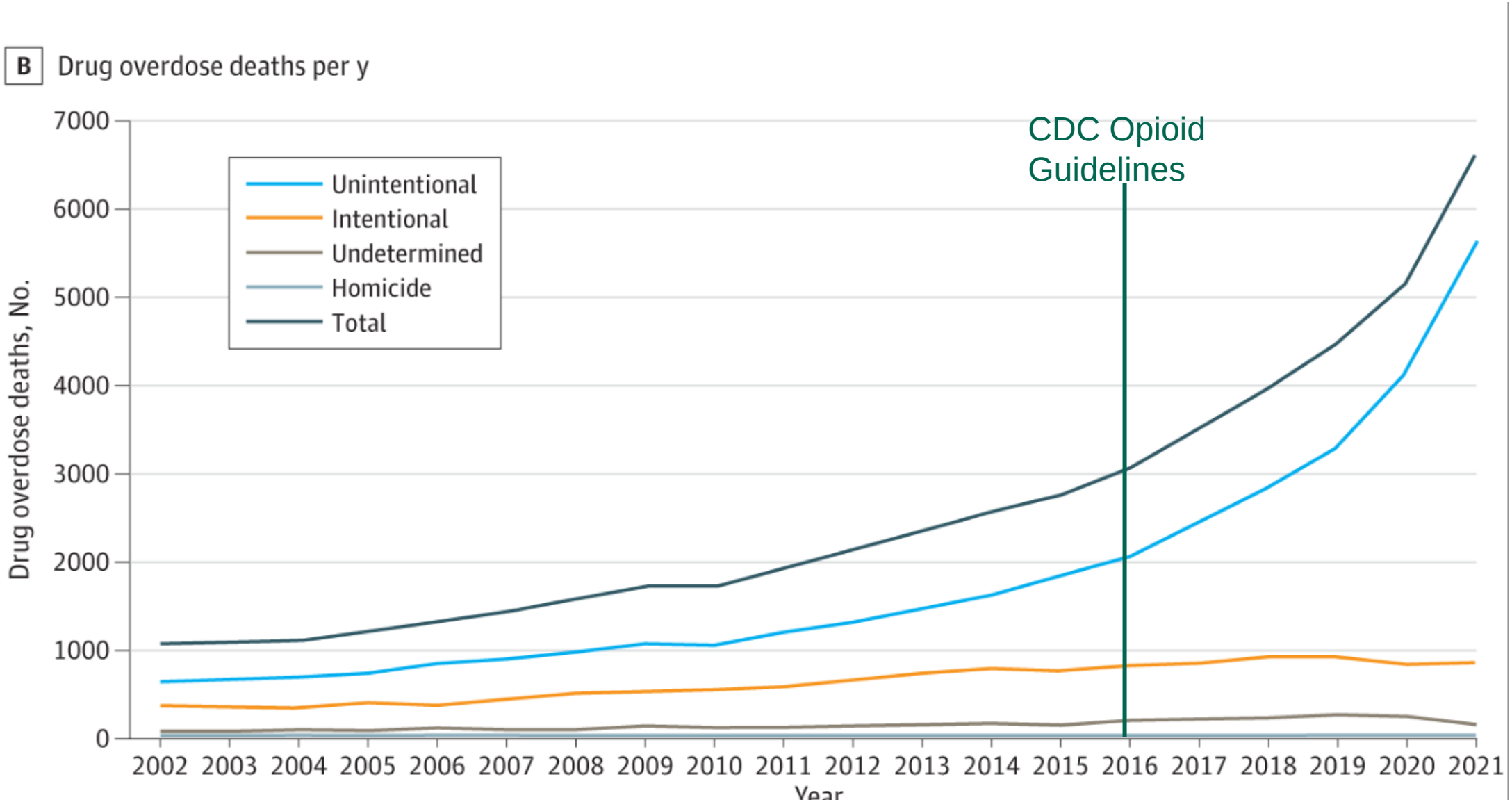


Figure 1. Estimated opioid use disorder prevalence per 1,000 Medicare beneficiaries by age and dual eligibility status, 2013–2018.

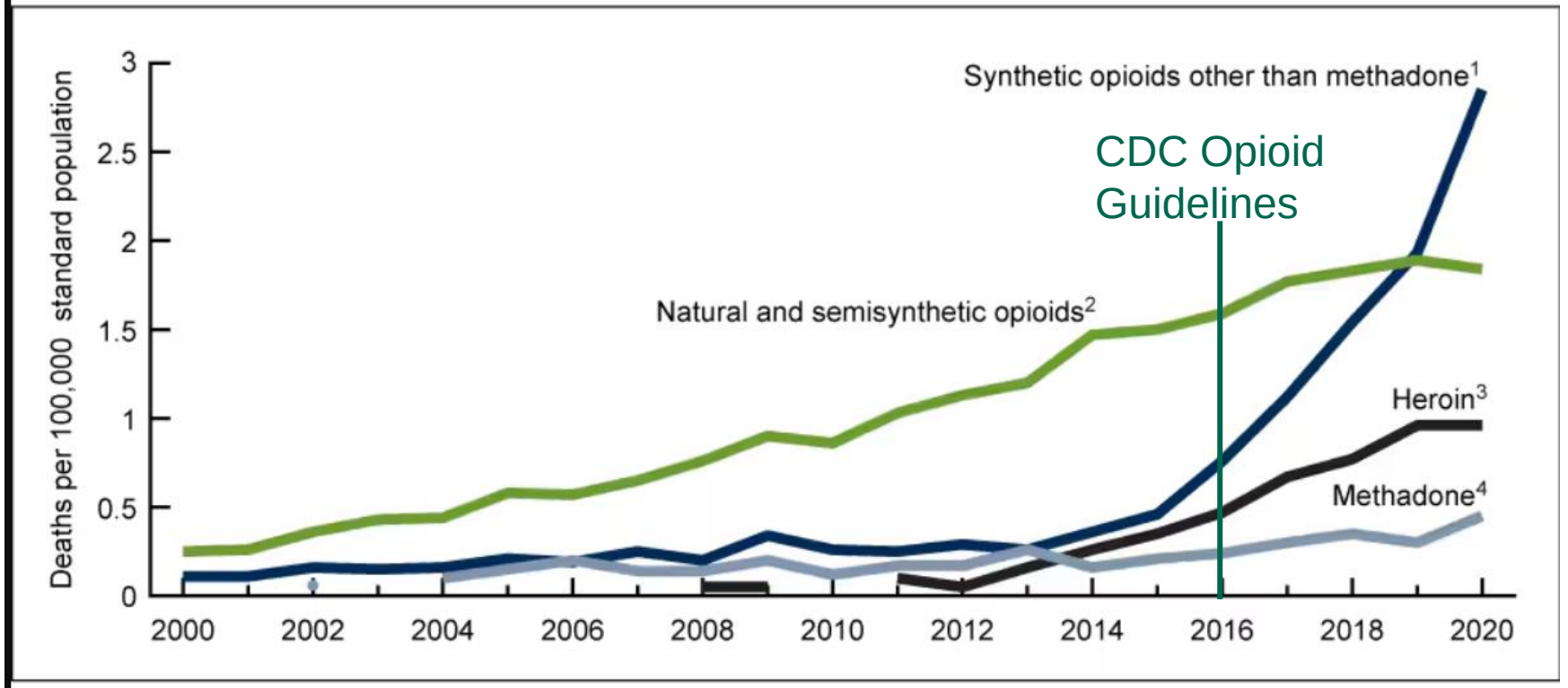
Note: All differences are statistically significant ($p \leq 0.001$).

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



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

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



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

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

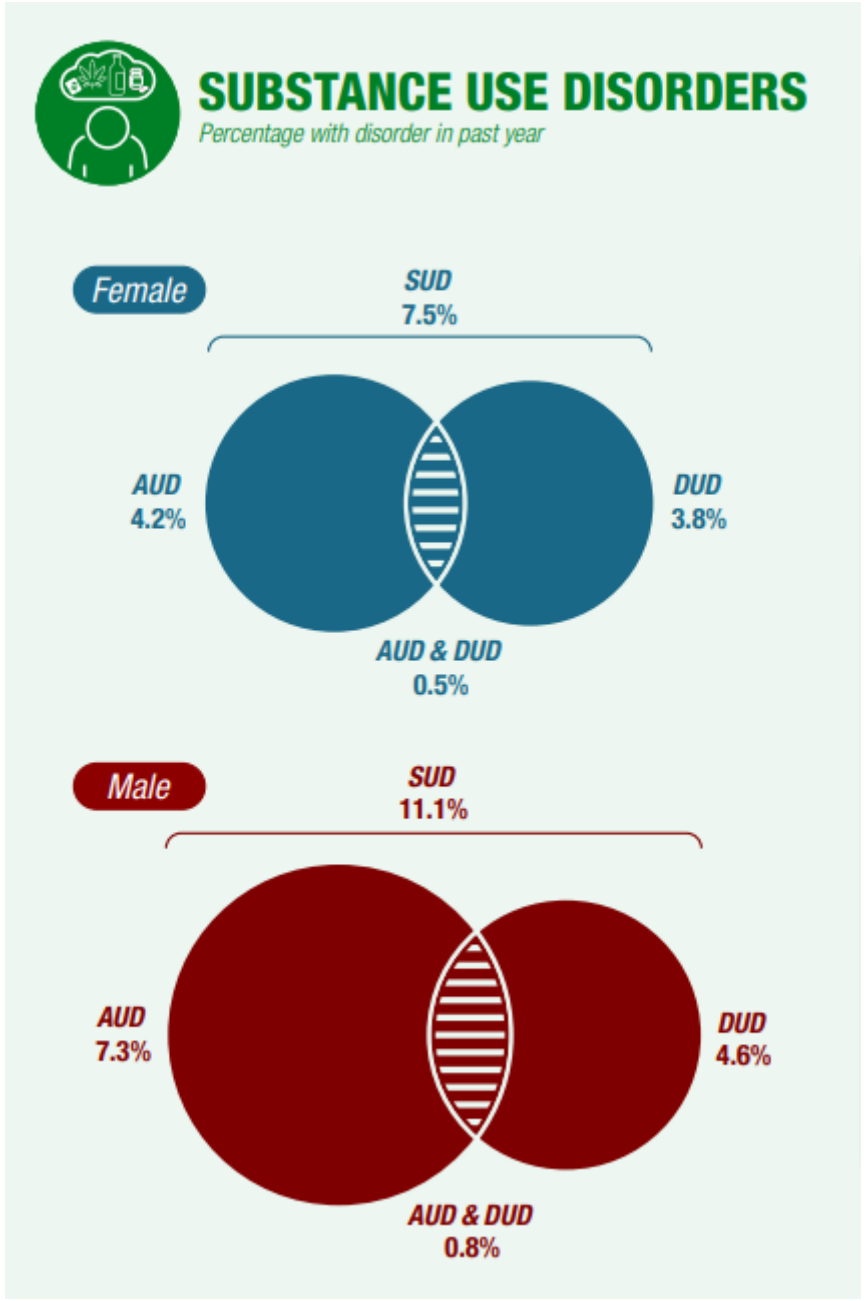


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Table 1. Use of DSM-5 Criteria for the Diagnosis of Substance-Use Disorder in Older Adults.*

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

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

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

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

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

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

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

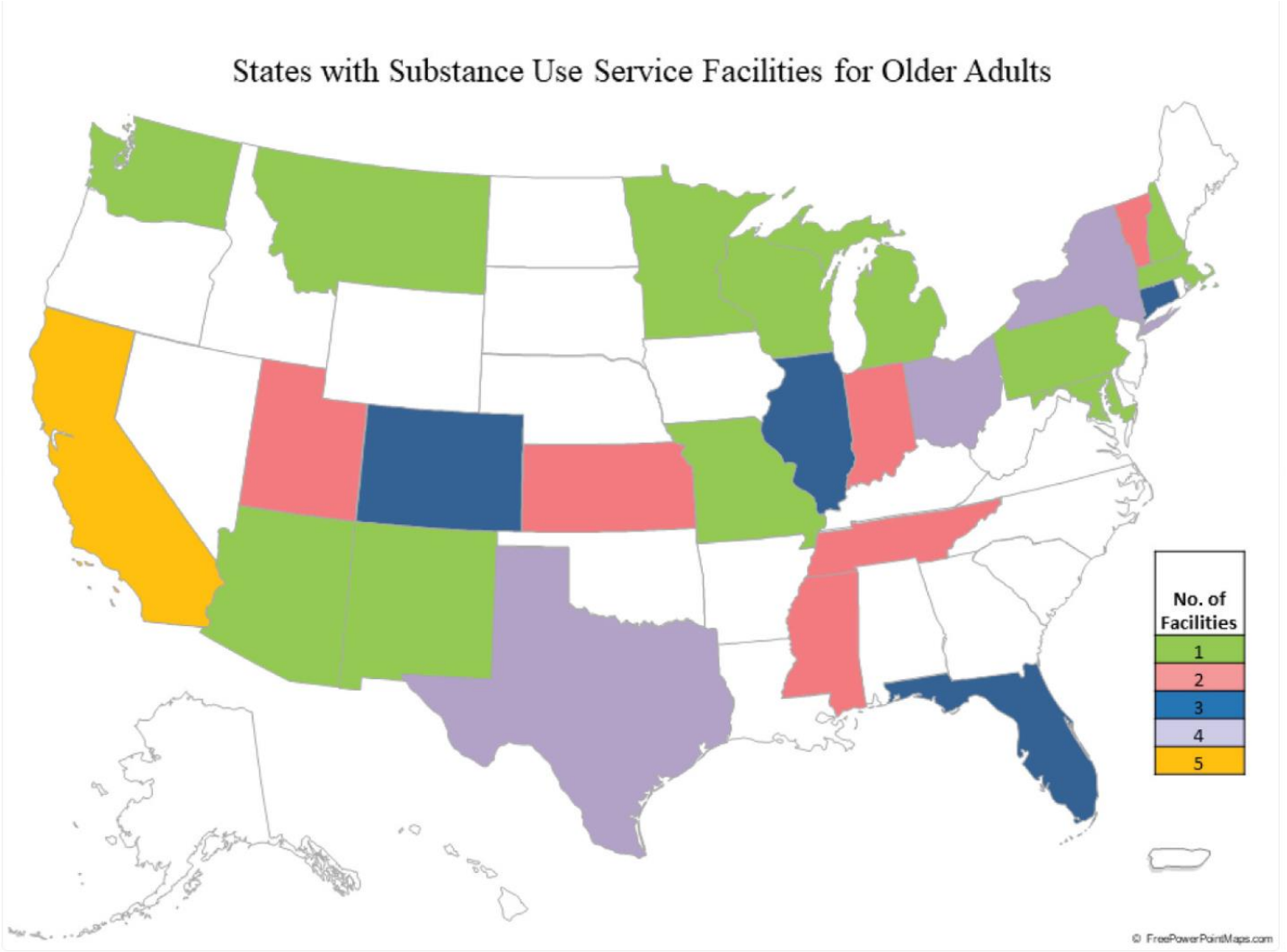
Substance Use is Often Not Recognized by Health Care Providers

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

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

Stigma Gets in the Way….

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



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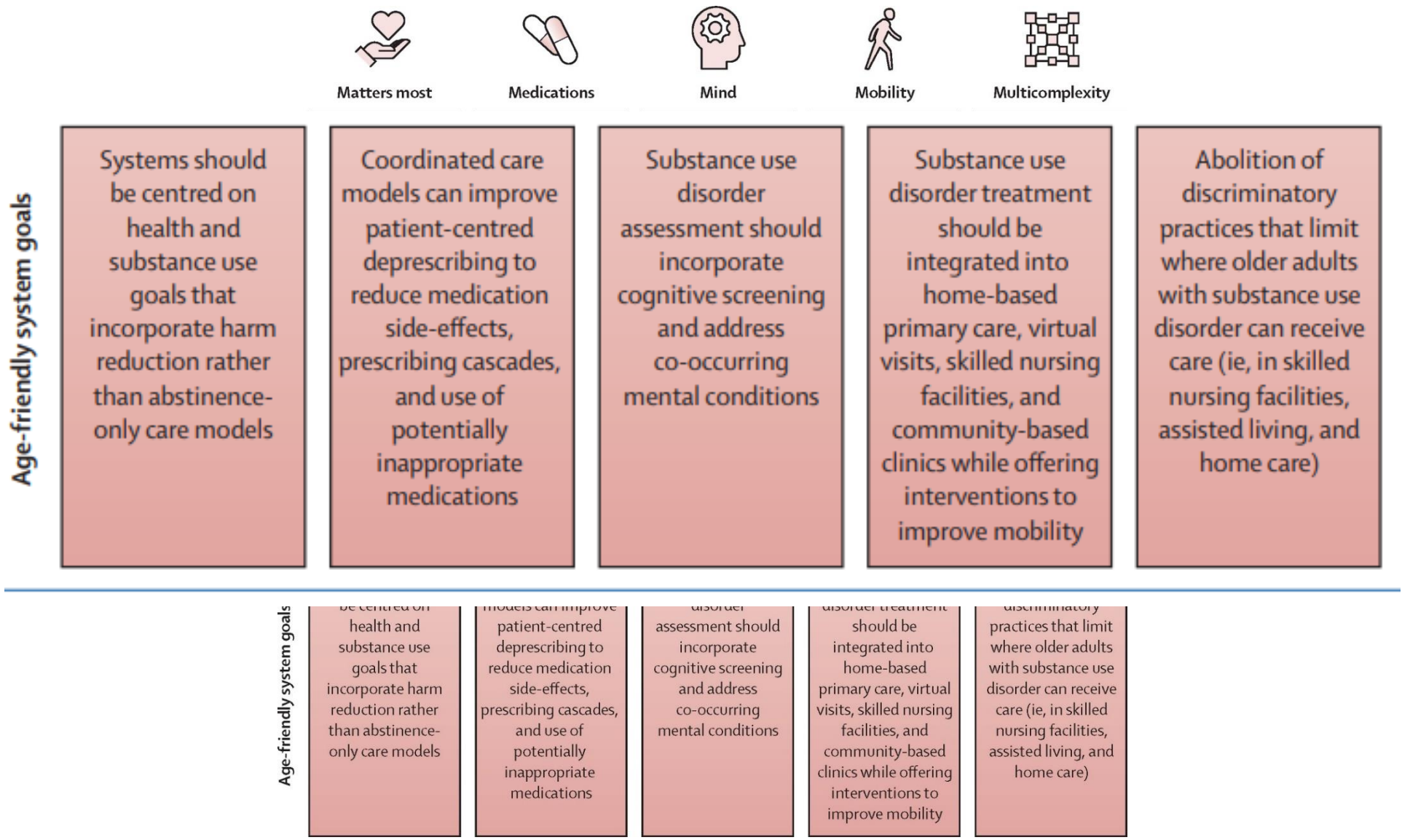
The “M”s of Substance Use



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