Portland State UNIVERSITY
Institute on Aging

TALKING POINTS: Making the case for Primary Care and Older Adult Behavioral Health Integration

1. Behavioral Health Integration with Primary Care is preferred by older adults

- Because of their coexisting physical health conditions, older adults with behavioral health and substance use disorders are frequently seen in medical care settings, such as primary care offices, hospitals, and emergency departments (Wang, 2011; Institute of Medicine, 2012).
- Given the stigma often connected with seeking behavioral health treatment and the relative shortage of behavioral health providers to refer to, older adults are more likely to seek care from a PCP (Rybarcyzk et al., 2013).
- No more than half of older adults referred to a mental health specialist followed through with the referral (Callahan et al, 1994).
- Many older adults prefer to receive their depression treatment in primary care, where providers can address not only behavioral health problems, but also acute and chronic medical conditions that are often comorbid with depression (Park & Unutzer, 2011).
- Older adults are receptive to screenings of anxiety and depression by their PCPs. In a recent study, 95% of older adults reported not being uncomfortable at all in being asked questions about depression and anxiety by PCPs; 99% reported not being embarrassed at all by being asked questions about depression and anxiety by PCPs (Samuels et al., 2014).

2. Collaborative partnerships are essential and when done well, result in positive outcomes

- Behavioral health providers benefit from PCPs' knowledge of older adults' co-existing physical health conditions, which often contribute and interact with their behavioral health conditions (Institute of Medicine, 2012) making a collaborative relationship most effective for optimizing care.
- The opposite is true, too. When PCPs and their staff understand the complex interactions among coexisting conditions and the person's behavioral health or substance use disorder and know how to adapt usual treatments and services to accommodate the coexisting conditions, older adult patients are more likely to experience positive outcomes (Institute of Medicine, 2012).

3. Barriers (real and perceived) are being successfully addressed with the adoption of evidence-based integrated and/or collaborative models

- More than 70 randomized controlled trials have shown collaborative care for common mental disorders such as depression to be more effective and cost-effective than usual care (Unutzer, Harbin, Schoenbaum, & Druss, 2013).
- Models usually include (1) care coordination and care management; (2) regular/proactive monitoring and treatment to target using validated clinical rating scales; and (3) regular, systematic psychiatric caseload reviews and consultation (Unutzer, Harbin, Schoenbaum, & Druss, 2013).
- Integrated model examples:
    - **General behavioral health:** Cherokee model (Hunter & Goodie, 2010), Collaborative Care Model (Unutzer, Harbin, Schoenbaum, & Druss, 2013), PASSE-PC (Abrams et al, 2015)
    - **Depression care/suicide prevention:** IMPACT (Unutzer et al, 2008 and see AIMS.UW.edu), PEARLS, TEAMcare, PROSPECT (Unutzer et al, 2006)
    - **Substance use:** Prism-e (Oslin et al, 2006), BRITE, SBIRT