

Triage in Aged Persons Mental Health



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OLDER PEOPLE – CORE BUSINESS

- People >70yo (13% of Victorian population) use >46% of bed days
- The population is ageing
- Hospital use increases with age
- Appropriate use of hospital services

World Alzheimer Report 2009

- Global Estimates
- 35.6 million in 2010
- 65.7 million in 2030
- 115.4 million in 2050





Australia

- 245,400 in 2009
- 1.13 million by 2050.

Access economics



Victoria

- It is estimated that by 2011... 790,018 Victorians will be aged 65 or over, and by 2021 there will be 1,106,646

Life expectancy (years) at selected ages, 1901-10 to 2004-06^(a)

Year	At Birth		At age 15		At age 65	
	Male	Female	Male	Female	Male	Female
1901-10	55.2	58.8	49.0	51.9	11.3	12.9
1920-22	59.2	63.3	51.4	54.6	12.0	13.6
1946-48	66.1	70.6	54.3	58.3	12.3	14.4
1960-62	67.9	74.2	55.1	61.0	12.5	15.7
1980-82	71.2	78.3	57.4	64.3	13.8	18.0
1990	73.9	80.1	59.8	65.8	15.2	19.0
1991	74.4	80.4	60.2	66.0	15.4	19.1
1992	74.5	80.4	60.3	66.1	15.4	19.2
1993	75.0	80.9	60.8	66.5	15.7	19.5
1994-96	75.2	81.1	60.9	66.7	15.8	19.6
1995-97	75.6	81.3	61.3	66.9	16.1	19.8
1996-98	75.9	81.5	61.5	67.1	16.3	20.0
1998-2000	76.6	82.0	62.2	67.6	16.8	20.4
2000-02	77.4	82.6	63.0	68.1	17.4	20.8
2003-05	78.5	83.3	64.1	68.9	18.1	21.4
2004-06	78.7	83.5	64.3	69.0	18.3	21.5

Policy directions?

Greater flexibility regarding age criteria in the transition between adult and older persons specialist mental health services will enable older people to continue to attend adult services, and people who prematurely experience age-related conditions to access aged services, where appropriate.

Policy directions?

- The entry point to specialist aged persons mental health services will be changed from 65 years to 70 years in acknowledgement that mental health problems in the ageing population are increasingly occurring later in life and to align with the age criteria generally used by Aged Care Assessment Teams. Access to adult and aged specialist mental health services will, however, be flexible regarding age criteria, so that people receive the right care in the right part of the service system (see Reform Area 8).

Groups at risk

- Graduate population –those that have had enduring or severe mental illness throughout adulthood
- Those who develop age associated mental health issues through frailty or dementia
- Those with late onset or very late onset schizophrenia
- Those with late onset mood disorders
- Those with significant physical comorbidities (cardiovascular, cerebrovascular, obesity, alcohol abuse etc)

PGAT, APAT, MAPS?

- Rather confusing as different services have different names.
- Clients didn't like the term "psychogeriatric" and who can blame them
- Confusing for us but also the community – consumers/carers/other agencies/GP's etc

Criteria for service

- Defined catchment area
- Serious mental illness
- Over the age of 65 (can be flexible, depends on the problem and/or the service)
- Functional psychiatric illness
 - Schizophrenia, BPAD, Major Depression etc
- Dementia with severe “Behavioural and Psychological Symptoms of Dementia” (BPSD)

Common sources of referral

- Client/consumer
- Carer – paid/unpaid
- ED
- Other psychiatric services (turning 65, moving area etc)
- GP
- ACAS
- RDNS
- Police
- etc

- The importance of establishing and maintaining good relationships with the community and referring agencies cannot be over- emphasised
- Intake/triage clinicians should be respectful and helpful
- Helping to negotiate the intricacies of the service/s is part of the role – also serves an educational component for other agencies/GP's
- Moving from a 'gatekeeping' role to a 'gateway' role

- The importance of secondary/tertiary consultation...
- Sometimes other services/GP's/Private Psychiatrists will ring to “run something by you...”
- This can be an important part of an Intake/Triage service
- Clients may be seen for the purpose of providing an opinion or suggested management

What happens ?

- Most services run an intake/triage service during business hours
- Arrangements outside these hours will vary
 - Telephone triage through area health network
 - ED
 - CATT
 - Inpatient Units

In the best of all possible worlds...

- Patients can be managed by Triage/CATT/ED/CL etc overnight/over weekend until APMHT service can take over

- Wherever possible patients are managed in the community setting
- Home
- Residential – low/high level care
- SRS
- Boarding House

Presentations

- Delirium - elderly and those with cognitive deficits at particular risk, especially in the setting of acute medical illness and polypharmacy
- Dementia
- Depression – may present with classic symptoms but also could be less likely to admit feeling depressed, may focus on physical issues. May be more difficult to assess in the context of physical illness

Presentations

- Anxiety – some studies have found this to be the most common disorder amongst older people
- Schizophrenia/Delusional Disorders – either longstanding or late/very late onset

What is an APMHT ?

- Variations on Multidisciplinary Team approach
- Consultant Psychiatrist
- Registrar
- Psychiatric Nurses
- Psychology
- Occupational therapy
- Social Work

Possible reasons for referral

- Diagnosis
- Medication review/advice
- Self harm – deliberate/inadvertent
- Harm to others
- Damage to environment e.g. breaking windows or furniture
- Wandering – aimless, intrusive (inadvertent or deliberate)
- Wandering – active and purposeful eg attempts to abscond

Possible reasons for referral

- Depression
- Hallucinations (e.g. visual hallucinations in DLB)
- Delusions – e.g paranoid
- Sleep/wake cycle disruption, sundowning syndrome
- Refusal of services
- Vulnerability – self neglect, neglect by carer, refusal of services
- Squalor or hoarding behaviours that have become a risk due to hygiene concerns or risk of fire

Possible reasons for referral

- Sexual disinhibition
- Carer burnout/exhaustion
- Apathy
- Anxiety
- Alcohol/substance abuse
- Suspected abuse – physical, financial, sexual, emotional
- Review for authorisation of cholinesterase inhibitors (not usually done by APMHT)
- Competency/capacity assessment e.g. to support application for Guardian or Administrator (may be done in some circumstances for existing clients)

What happens on Intake/Triage?

- Collection of basic demographic data
- Presenting problem – onset, duration
- Past psychiatric history
- Medical history
- Comorbidities are particularly important in this population e.g.
 - Thyroid disorder
 - Alterations to medication

What happens on Intake/Triage?

- Current medication
 - * polypharmacy (including OTC's)
- Recent investigations eg FBE, U &E's, TFT, B12 & Folate, LFT, CT Brain etc
- Exclusion of Delirium is important!
- Social circumstances
 - Living arrangements
 - Carer availability/burnout
 - Financial circumstances

What happens on Intake/Triage?

- Collateral History
 - Clients may be unreliable historians
 - Info should be gathered from as many sources as possible
 - GP
 - Family/friend
 - Other support agencies
 - Previous file/episodes

- Triage workers need a well developed knowledge of available community resources and service to enable appropriate referral on when clients do not meet criteria for our service.
- Again 'gateway vs gatekeeping'

- In Aged Psychiatry there may be an increased level of communication and liaison with family or carers.
- Additionally clients may have a number of services involved
 - GP
 - Specialists
 - HACC
 - RDNS
 - Primary health services
 - Carer respite
 - DBMAS

Case Scenario

'The mysterious case of Mr Young (30's) and Mr Old (elderly)'

