

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

- The number of people diagnosed with dementia is projected to increase, with the number of cases increasing from 245,400 in 2009 to 1.13 million cases by 2050.

Access economics



- The Victorian population is ageing, with both the number and proportion of older Victorians increasing significantly. It is estimated that by 2011 790,018 Victorians will be aged 65 or over, and by 2021 there will be 1,106,646
- (Because mental health matters)

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

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.

(Because Mental Health Matters)

- 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).
- (Because Mental Health matters)

PGAT, APAT, MAPS, APMHS?

- 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)

Who can refer?

- Basically anyone can refer, for example:-
- Client/consumer
- Carer – paid/unpaid
- ED
- Other psychiatric services (turning 65, moving area etc)
- GP
- ACAS
- RDNS
- Police
- etc

Who can refer?

- The importance of establishing and maintaining good relationships with the community and referring agencies cannot be over- emphasised
- “that’s not psychiatric” should be avoided
- 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

Who can refer?

- 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

Common Presentations

- Delirium
- Dementia
- Depression
- Anxiety
- Schizophrenia/Delusional Disorders – either longstanding or late onset
- Or combinations of above...

What is an APMHT ?

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

Some likely reasons for referral

- Diagnosis
- Medication review/advice
- Self harm/suicidality – 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
- Sexual disinhibition
- Carer burnout/exhaustion
- Apathy
- Anxiety

Some likely 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
- Alcohol/substance abuse
- Suspected abuse – physical, financial, sexual, emotional
- Review for authorisation of cholinesterase inhibitors
- Competency/capacity assessment e.g. to support application for Guardian or Administrator

What happens on Intake/Triage?

- Collection of basic demographic data
- Presenting problem – onset, duration
- Past psychiatric history
- Medical history
- Current medication
 - * polypharmacy
- Recent investigations eg FBE, U &E's, TFT, B12 & Folate, LFT, CT Brain etc
- Exclusion of Delirium is important!

What happens on Intake/Triage?

- Social circumstances
 - Living arrangements
 - Carer availability/burnout
 - Financial circumstances
- Collateral History
 - Client's 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 services to enable appropriate referral on when clients do not meet criteria for our service.

- In Aged Psychiatry there may be an increased level of communication and liaison with family or carers.

Case Scenario

'The mysterious case of Mr S (30's) and Mr G (elderly)'

