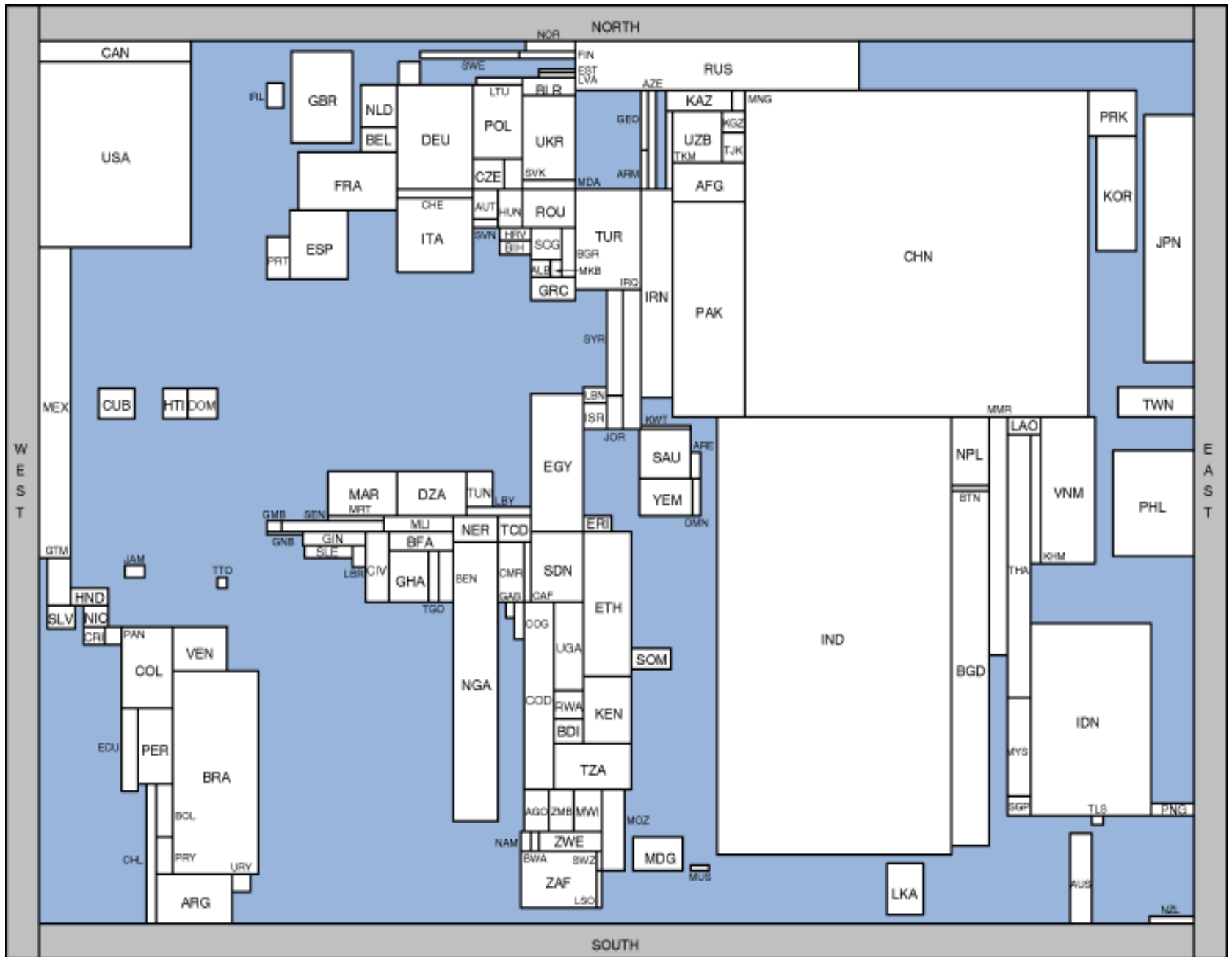


A Geriatrician's View of Mental Health and Addiction of Older People and Dementia





My experience

- Auckland DHB
- Waitemata DHB
- Small hospital –Waitakere
- Small town Warkworth
- Rural
- Personal
- Colleagues

What do we do?

Inpatients

- Inpatient care ATR -10/15 currently have dementia (2 had serious depression as well)
- Inpatient liaison work –high proportion have dementia or delirium
- Orthopaedics-high no with underlying dementia and yes they do get better with rehab
- Acute general medicine
- ED

What do we do?

Outpatient clinics

- My clinic (general geriatric medicine) -last 5 months
- 95 patients
- 40/95 dementia and for most it was a major part of the referral reason

Waitemata DHB outpatient audit 2006

Main Reason	Appts	%
Continance	1	0%
Falls	14	4%
GEM	195	51%
Memory	71	19%
Osteoporosis	9	2%
Parkinson's	28	7%
Stroke	62	16%
Total	380	100%

Clinic patients with common age related problems

Condition	No of clinic pts with active condition	% of total clinic pts
Stroke	93	24%
Continenence	26	7%
Osteoporosis	31	8%
Falls	62	16%
Memory	142	37%
Parkinson's	39	10%
CORD	7	2%

Memory clinic

- 28 new patients seen
- All were diagnosed as having dementia
- Cf 71 patients seen in other OPH clinics with the main issue being problems with memory
- And 142 patients overall had memory issues

Home visiting

- Selected group
- Majority have dementia as one of their problems
- January 2009 20 patients 17 had dementia

What sort of issues do they have?

- Work covers the whole spectrum –early diagnosis to palliative care
- Most have other comorbidities
- Many have behavioural issues
- Many have acute/sub acute illness which has triggered a decline in function often reversible with timely support and intervention

Close relations with Mental Health Services

- Our view of what they help with
 1. Major behavioural issues
 2. Gateway to Stage 3 Dementia care
 3. 10-20% of ATR inpatients have an opinion from them
 4. Diagnosis of depression in dementia
 5. Management of severe depression
 6. Help with staff training to cope with personality disorders
 7. Capacity assessment in borderline /difficult situations
 8. Access to clinical psychologists /early diagnosis / atypical presentations

Alcohol/Addiction

- High rate of medical complications
- Can be hard to tell between intoxication and dementia –but eventually the brain cells suffer
- Geriatricians see a lot
- The “accidental alcoholic”
- Reality is that alcohol and addiction services are rarely helpful “need to want to stop”
- Often need to await a crisis or enough cognitive impairment to intervene

Ageing and Chronic mental illness

- All services need to understand ageing
- Ageing in place is still a goal
- “Please see they are now 65 syndrome”
- Special issues –adult children with very old caregivers

Intellectual disability

- Ageing –ageing in place still a goal
- Reasons for age related residential care the same as everyone else –not just “now we are 65”
- Universal design principles should avoid inappropriate housing being a reason for moving
- Have the same right to other health services as everyone else –should have a lower age of entry to older peoples services
- should be able to flexibly wrap services around them – should be able to cater to cohorts or “family groups” and ageing

Gaps/Issues

- Dementia friendly acute inpatient services
- All health professionals need training (except obstetricians ,?paediatricians)
- Single point of referral=shared patient management system ,access to notes, overlapping service margins
- Dementia service pathway
- Under recognition of how much dementia care is provided in stage 2 rest homes
- Residential care funding fails to recognise the stages of care for dementia
 - Funding of AChEI
- Crisis care at home
- Moving to Retirement Villages with established dementia

Gaps /issues-society level

- Tolerance
- Risk / “unsafe”
- Workforce issues/vocation
- “Compulsory volunteer service”
- Impact of this economic crisis on retirement savings

Person first, dementia second, behaviour third

- Each individual is different
- Behaviour has a weak correlation with pathology e.g.
 - catastrophic decline in different settings
 - improvement in quality care settings
- Know the person from their perspective to understand their world and behaviour

Residential care profiles of people with dementia

1. social care needs-a) fit , b) comorbidity
2. Behaviour that can challenge
3. Severe behavioural disorders often still quite robust (stage 3)
4. High dependency nursing care –most of their care needs driven by frailty , comorbidity and sensory issues –not dementia
5. High dependency/end of life issues –when dementia may have little impact on the care needed

Dementia

