

Seniors Mental Health: A Guided Tour




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Objectives

- Communication / Education
- Learn about seniors in Nova Scotia
- Get to know what we do, why we do it and what we can do for you
- Meet our staff

Outline

- Seniors Mental Health - why are we different?
 - Criteria for service
 - Statistics
 - Services offered / clinical vignettes
 - Wrap up
- 

Seniors Mental Health

Criteria for Referrals

- Late-onset psychiatric problems
- Dementia with psychiatric complications
- Patients with complex medical problems:
 - E.g. Parkinson's, MS and other neurological disorders
- **Consults** on patients with chronic psychiatric problems if they have complex medical problems and multiple medications

Seniors Mental Health

Our patients

- Not exactly everyone over 65, not who you might expect
 - More late onset disorders:
 - Depression (vascular)
 - Anxiety (2° to medical problems)
 - Psychosis (from everything)
 - Epidemiology - how our population is different
 - New burgeoning population of elderly

Seniors Mental Health

What we do

- Keep people out of
 - Hospital
 - Nursing home
- Keep them as independent as possible

*Autonomy to some degree
in any setting*

Seniors Mental Health

Frailty

- Vulnerable state of health
- Determined by multiple factors including health, social and psychological
- “living on the edge”
 - Poor health
 - Poor function
- Needs supports at home

Frailty Cascade



Aging

- Life expectancy has increased
 - 1900 (USA) - 47 years
 - 2002 (Canada)
 - Men – 77
 - Women - 82

Aging

- Elderly only segment of the population expected to grow substantially¹
 - 2002: 13% over 65 in Nova Scotia
 - 2021: 18% over 65 (6.7 million people)
 - 2041: 22.6% over 65
 - Over 65 group growing faster than under 15 group
 - Significant increase in those over 85 years

Health Canada

Nova Scotia Seniors

➤ Provincial:

- Halifax County (Capital District Health Authority)
- Population Growth
 - 1990 318,000
 - 2000 342,000
 - 2003 380,000
 - 19% Increase
 - Senior Population Growth 65+
 - 24% increase
 - Age 65-74 years, increase by 12%
 - Age 75-84 years, increase by 34%
 - Age 85+ years, increase by 64%

- 85+ years consume the highest proportion of acute care and chronic care
 - 1/3 have dementia

Nursing Home Occupancy – Nova Scotia

- 5,400 beds
- Up to 80% of residents suffer from psychiatric disorders.
- 65% of residents in Long Term Care facilities are affected by Dementia
 - Rooner et al, 1990

Demographic Realities

➤ National:

- By 2021, 18% of Canadians will be 65 years of age or older for a total of 6.7 million people.
- The increasing demand for appropriate and effective long term care services will be inevitable.
- Canadian Invitational Symposium on Gaps in Mental Health Services for Seniors in Long Term Care Facilities, April 2001.


Aging population

- INCREASE IN ELDERLY POPULATION:
 - Will be unprecedented increase in mental illness
 - More demand on the systems current capacity to address seniors mental health needs

Aging

- Majority of seniors cope well with physical limitations, cognitive changes and losses
- Mental disorders are not part of “normal” aging
- Schizophrenia , major depression are not more common but dementia, psychosis, minor depression and delirium are more common
- **But...**often unrecognized and untreated
- Much can be done to prevent deterioration, restore health and enhance quality of life

Challenges of managing mental illness in seniors

- Symptoms differ from younger adults making diagnosis and treatment difficult
 - Ageism and stigma
 - Poor access to service
- 

Mental Disorders in Seniors



Mental Disorders in Seniors

- 12-20 % of those in community
- 40-50% of hospitalized for medical conditions
- 70-94% of those in nursing homes

➤ Mental illness leads to:

- Decreased quality of life for seniors and caregiver
- Premature institutionalization
- Caregiver distress

Dementia

- 364,000 Canadians over 65 have dementia (1994)⁵
 - 8% of over 65 group have dementia
 - 35% of over 85 group have dementia
- 750,000 will have dementia by 2031 ⁵

BPSD-

Frequency of symptoms

- Personality changes
 - up to 90%
- Affective
 - depression up to 80%
 - mania 3-15%
- Agitation
 - behavior up to 50%
 - aggression up to 20%
- Psychosis
 - delusions 20-73%
 - misidentifications 23-50%
 - hallucinations 15-49%

Depression in seniors

- 10-15% of seniors living in community have “depressive” symptoms²
- 2-4% have serious clinical depression²
- 15-25% in nursing homes have clinical depression; another 25% have depressive symptoms of lesser severity

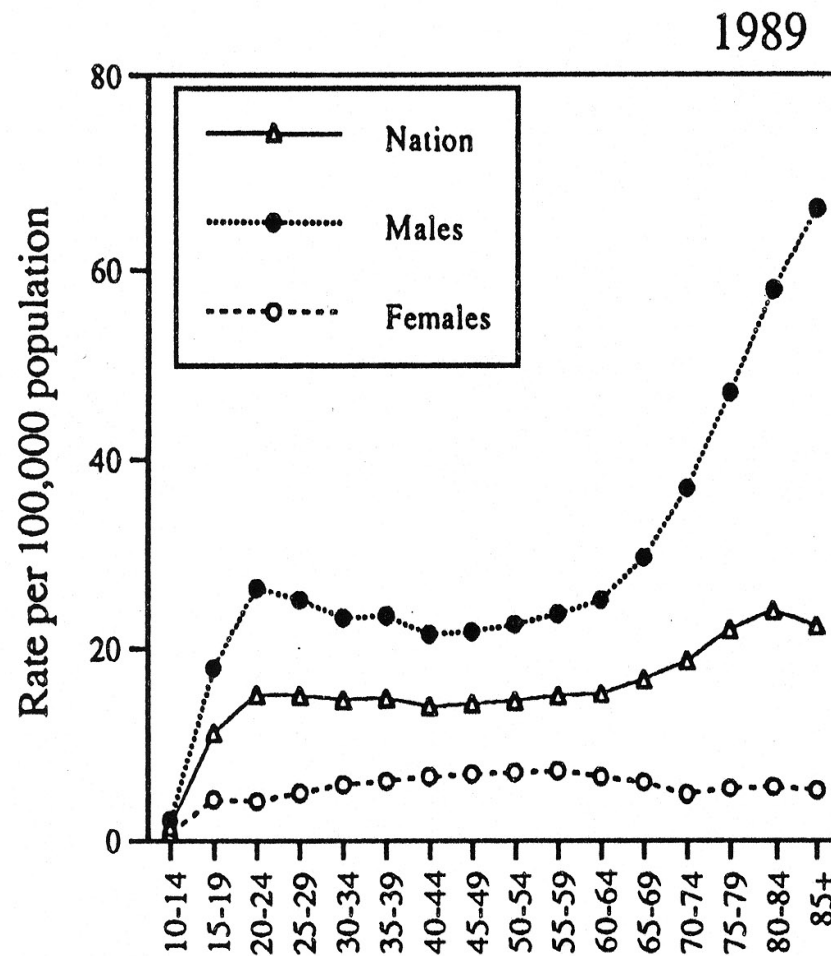


Figure 3. Suicide rates by 5-year age groups and sex: United States, 1989.

Psychosis is Common but it's not Schizophrenia

Elderly Psychiatric Outpatients

- Dementia (37%)
- Major depression (20%)
- Delirium (12%)
- Organic psychosis (10%)
- Alcohol (6%)
- Bipolar (6%)
- Late-onset Schizophrenia (2%)
- Chronic Schizophrenia (2%)
- Delusional d/o (2%)

Holroyd +Laurie: Int J Ger Psych 14, 1999. n=140; 27% psychotic

Epidemiology - Psychosis in the Elderly

- ⌘ 4% in community dwelling elderly (Christenson + Blazer, 1984)
- ⌘ 15% in geriatric medicine clinic (Greene and Asp, 1986)
- ⌘ 27% of geriatric psychiatry outpatients (Holroyd + Laurie, 1999)
- ⌘ 10-38% in nursing homes (Junginger 1993, Rovner 1986)

Caregivers



Caregiving

- Family or unpaid caregivers provide the majority of care
 - 70% are women (wives and daughters)¹³
 - 30% are employed¹³
 - 36% are over the age of 70¹²
 - Up to 46% are depressed themselves¹⁵
 - Save the public system over \$5 billion per year in Canada (270,000 full-time employees)¹²

The Service



Seniors Mental Health Goals

- Reduction of distress to the patient and family.
- Improvement and maintenance of function.

***Autonomy to some degree
in any setting.***

Seniors Mental Health

Target Population

- Individuals 65 years of age and older with a new presentation of a mental illness (complicated by the aging process).
- Individuals with dementia greater or less than 65 years of age.
- Individuals with a prior history of mental illness do not become specialty clients when they are 65. They are seen in consultation if there are significant medical issues complicating their clinical status.

Our patients - Location

27%

LTC

19%

Outpatient

17%

Home visit

6%

Inpatient

6%

Other hospital



Our patients

- Their medications at referral:
 - 30% on antidepressants
 - 28% on benzos (2.5:1, F:M)
 - 21% on atypicals
 - 17% on trazodone
 - 7% on cholinesterase inhibitors
 - 5% on typicals

Leadership

- Terry Chisholm, Clinical leader
- Beth Floyd, Administrative Director
- Joan Boniface, Nurse manager – Willow/ECT

Team Work

➤ Interdisciplinary Team

- Psychiatry
- General Practice
- Geriatric Medicine
- Nursing
- Social Work
- Occupational Therapy
- Psychology
- Recreation Therapist

Geriatric psychiatrists

- NS population > 65 years = 125,000
- Should have
- We have 4.6 FTE CDHA
- 5.6 FTE province wide


Seniors Mental Health

Physician staff

- Keri-Leigh Cassidy
- Terry Chisholm
- Mike Flynn 4.6 FTE
- Lara Hazelton 3.8 clinical FTE
- Cathy Hickey
- Cheryl Murphy

Outreach

Home Visits
Long Term Care
Outpatient



Outreach

- All physicians
- Outreach clinicians
 - Sarah Kreiger-Frost
 - Heather Rea
 - Sharon MacLeod
 - Mary Ritchie
 - Cindy Drake
 - Jeannette Flett

QEII site

NSH site

Outreach

➤ Occasional:

- Occupational therapy
 - John Dicks, Kathleen Drysdale
- Social Work
 - Alana, Patricia Cosgrove

Service Components OUTREACH

➤ Home visits

- From Windsor to Eastern Shore
- Useful to see patients in their homes

A Typical Home Visit - Mrs C

- 74 yo frail lady, lives with daughter
- Referral by HCNS for anxiety
- Issues:
 - Longstanding anxiety (house bound)
 - End stage COPD (O₂ dependent) & visual impairment
 - GP prescribing, doesn't do home visits
 - Prn lorazepam
 - Significant functional change, executive dysfunction
 - Caregiver stress

Outreach

Long term care – 17 facilities

- Typical cases
 - Dementia – unrecognized
 - BPSD – yelling, resistance to care, aggression
 - Depression, suicide

Seniors Mental Health

Outreach - Outpatient

- All physicians
- Type of patient: late onset depression, ECT, Parkinson's
- Patients from outside district or another province
- More mobile, less fragile

Seniors Mental Health Day Treatment Program

➤ Target population

- Individuals with affective disorders
- Grief
- Loss
- Isolation
- Anxiety
- Cognitive capacity



“At
Risk”

The diagram consists of two white lines that originate from the right side of the list items 'Grief' and 'Loss', and converge towards the text 'At Risk'.

** may take younger patients*

Seniors' Day Program

- Group-based program for non-demented seniors with anxiety and depression
- Referrals from psychiatrists and family physicians

Seniors' Day Program

- Group based
 - Cognitive Behavioural Therapy
 - Relaxation
 - Grief
 - Health Living
 - Leisure connections
 - Based on review of evidence/best practice

CBT Group

- 7 week group, meeting for 2 hours
- 2 co-therapists
- 6 – 12 participants
- Pre-group assessments and rating scales
- Post-group rating scales
- Runs approximately 4 times per year

Sample Goals

Decrease social isolation

Assertiveness skills

Boundary issues with adult children

Overcoming phobic avoidance

Enhance coping skills

Grief-related issues

Relaxation techniques



Case: Mr. L.M.

- 69 year old former teacher
- Referred to CBT group by family physician for anxiety symptoms
- Following CBT group, entered relaxation group
- Seen by OT on an individual basis for a while, including home visits

Mr. L.M. continued

- Psychiatrist saw L.M. at request of OT for possible Parkinson's disease
- Diagnosis confirmed by neurology
- Neuropsychological testing
- Driving assessment referral
- Ongoing involvement around cognitive and functional decline

Seniors Mental Health **In-Patient Service**

- Willow Hall; Drs' Flynn, Hickey
- 19 beds – for the province
- Active treatment, stabilization, resolution
- Target population – acute psychiatric disorders, dementia
- When community based service components cannot meet the need

Case Vignette 1

- 75 yo married male with severe vascular dementia and agitation
- Admitted after placing wife in headlock at nursing home, attempted to strangle her
- Required three security guards in Assessment
- Admitting diagnosis:
 - ?Delirium vs. ? Worsening of dementia in context of new stroke

Case Vignette 1

- Stabilized in milieu of Willow Hall
- Pharmacotherapy optimized and pt switched to another atypical antipsychotic
- Transferred back to NH within a month as bed held for him

Case Vignette 2

- 87 year old male with psychotic depression
- Nihilistic delusions
- Admitted in Winter/05 and had trial of ECT
- Failed to respond to same

Case Vignette 2

- Switched to Mirtazapine
- Tolerated well and discharged back to NH
- Some resolution of psychotic and depressive features

Seniors Mental Health

ECT

- Mike Flynn - coordinator
- Staffed by :
 - seniors nurses
 - Administration and organizing of the service
 - Pre-ECT preparation and Post ECT recovery
- 98% done at NSH site
- Sept 04 – Sept 05 : 1935 total treatments
 - 879 (45%) – senior patients
 - Of these, 80% – outpatients
 - 1056 (55%) – general adult patients
 - Of these, 56% - outpatients

Clinical vignettes

➤ Anne Hedonia

- Life-long intermittent periods of low mood usually in response to environmental stressors.
- Referred Sept/03 due to emotional flatness and insomnia. Also decreased appetite and weight loss.
- Prior to assessment was using trazodone 150 mg, chloral hydrate 1 g, flurazepam 30 mg, and had been on mirtazepine 30 mg/day for three months without change.

A.H. cont.

- Mood worse over the past 8 years since feeling “pushed out of the workplace”
- 2002 had several mini strokes, but gives no history of dysarthria or lateralizing signs.
- Mirtazepine tapered and d/c'd. Venlafaxine XR started at 37.5 mg x 1 week, then 75 mg/day x 1 month. Nil change.
- Dose increased over 2 weeks to 150 mg/day.
- One month later mood sx significantly better, but still c/o poor sleep.

A.H. cont.

- Two weeks later, phone message – “as low as ever”. Dose increased to 225 mg/day over two weeks.
- After three weeks, marginally better, but c/o feeling very jittery, and of having headaches.
- Venlafaxine decreased to 150 mg/day, and bupropion SR 100 mg added.
- Six weeks later, slightly better according to husband, but still c/o insomnia and feeling flat.

A.H. cont.

- Quetiapine 50 mg added at HS. Eight weeks later sleep better, more energetic in the morning. Advised to increase quetiapine by 25 mg/day weekly up to 150 mg.
- June '04 – feeling great. Sleep improved, deriving significant enjoyment from leisure pursuits. Underwent major abdominal surgery in July without incident.
- Continued well through August and referred back to GP.

A.H. cont.

- Re-referred in mid October, as husband had noticed a 3-4 week change – more social withdrawal and more emotional blunting.
- ECT began in November following a head CT scan. At 4 bilateral treatments note made of increased motivation and initiative, improved sleep, but post-ictal confusion.
- Switched to unilateral stimulus delivery, and frequency of treatments spaced. After 8 treatments, very much better, sleeping 8-9 hrs per night.
- Over Xmas tripped and broke her hip and underwent the surgery with no problem.
- Currently maintenance ECT q 3 weeks, continues well, recently returning from a 2wk holiday in Florida.
- Bupropion has been tapered, next will be to slowly taper the venlafaxine.

Seniors Mental Health

Consults

- Geriatric Medicine (9 Lane)
- Psychiatry inpatients at Lane and NSH

Seniors Mental Health

Education

- Undergrad, Postgrad students
 - Clinicians from around province
 - Multidisciplinary
 - Telehealth
 - GP's and fellows in Geriatric Medicine
 - Community- Public lectures
 - Caregivers
- 

Seniors Mental Health

Provincial Role

- Dept of Health
 - Challenging Behavior Working Group
 - Development of standards
 - Network*
- Telemedicine
- PIECES
- Consultation of setting up new services

Seniors Mental Health

New Projects

- Collaborative Care
- Telemedicine
- Caregiver group

Summary

- Learn about seniors in NS
- Clinical examples
 - Missed the psychosocial aspects of support, collaboration with community partners
 - Work done to stop them from “falling through the cracks”
- Collaboration with other teams

?Questions

