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Older Persons Mental Health Services

80 is the New 65!

- More older people
- More people living longer
- Declining mortality
- Declining fertility and birth rate



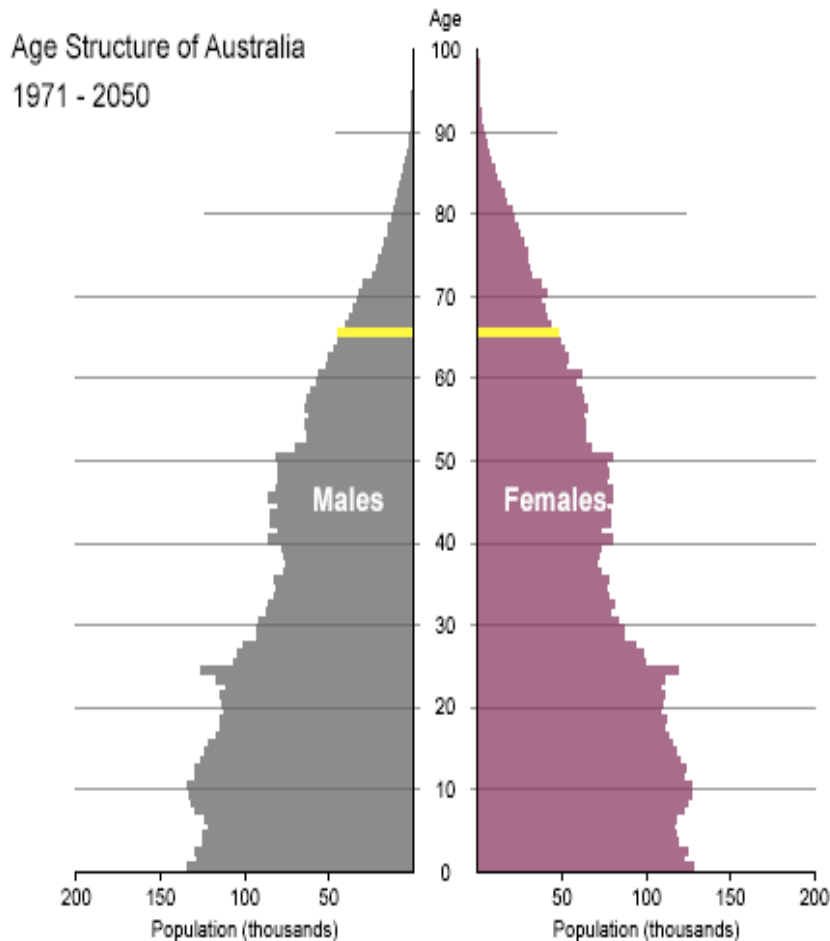
Projected population growth - Australia

(assuming highest population growth)

Year	65 yrs+	85 yrs +
2002 (19.7 million)	13% (2.6 million)	1.4% (0.3 million)
2051 (31.4 million)	30% (9.4 million)	9% (2.8 million)
2101 (37.7 million)	32% (12.1 million)	11% (4.1 million)

Population Growth SESIAHS

- **SESI AHS total population 115 402:**
 - **162 350 (14%) >65 yrs of age**
- **Projection for 2011 – 188 639**
- **Based on MH-CCP, approximately 20 918 (11%) of these people will have a diagnosable MH problem of some severity**
- **Rates of dementia to increase from 12 032 – 40 664 people in 2050**



1971
Total (mil.): 13.1

Aged 65
Born 1905-1906

Males: 44187
Females: 47704

Sex Ratio: 92.6
(males per 100 females)

Highlight surplus of males or females

Animate

play

pause

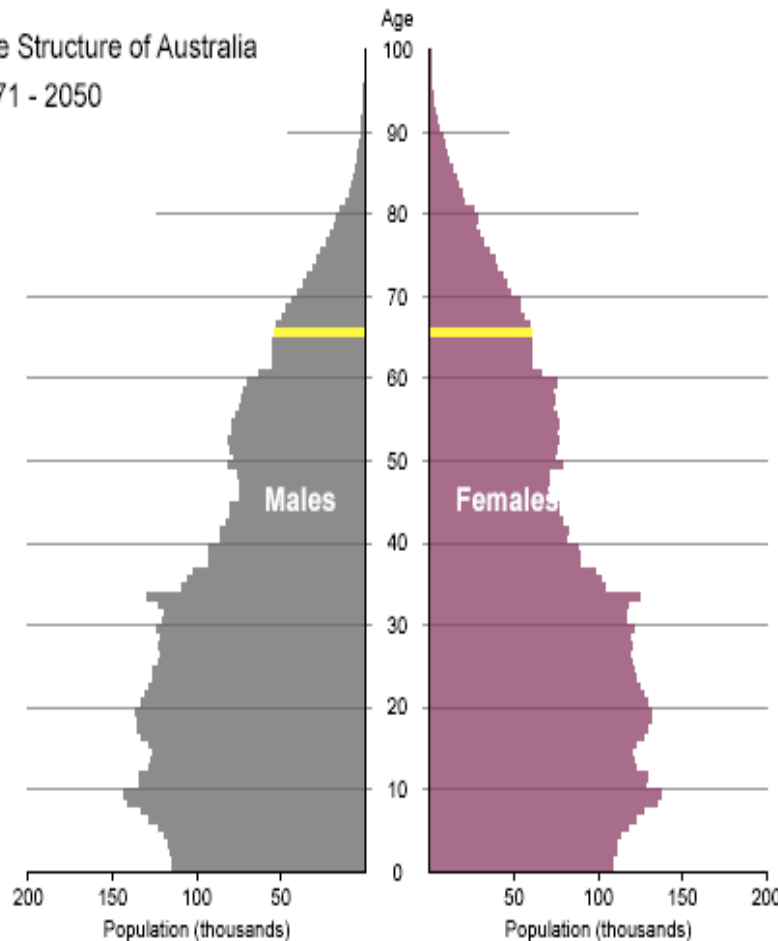
speed



Australian Bureau of Statistics

An agency of the Australian Government

Age Structure of Australia
1971 - 2050



1980
Total (mil.): 14.7

Aged 65
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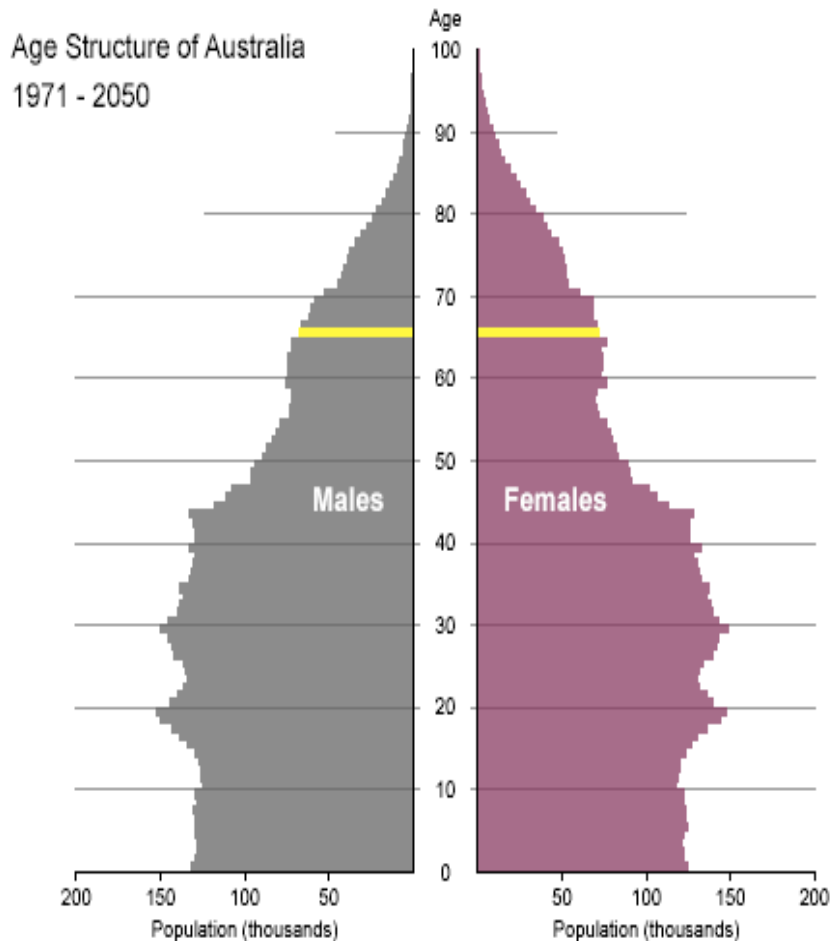
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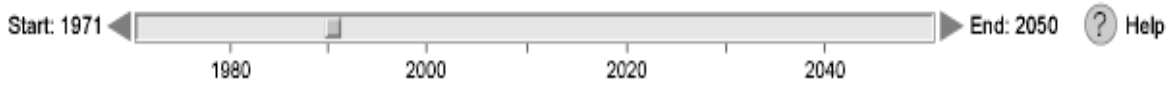
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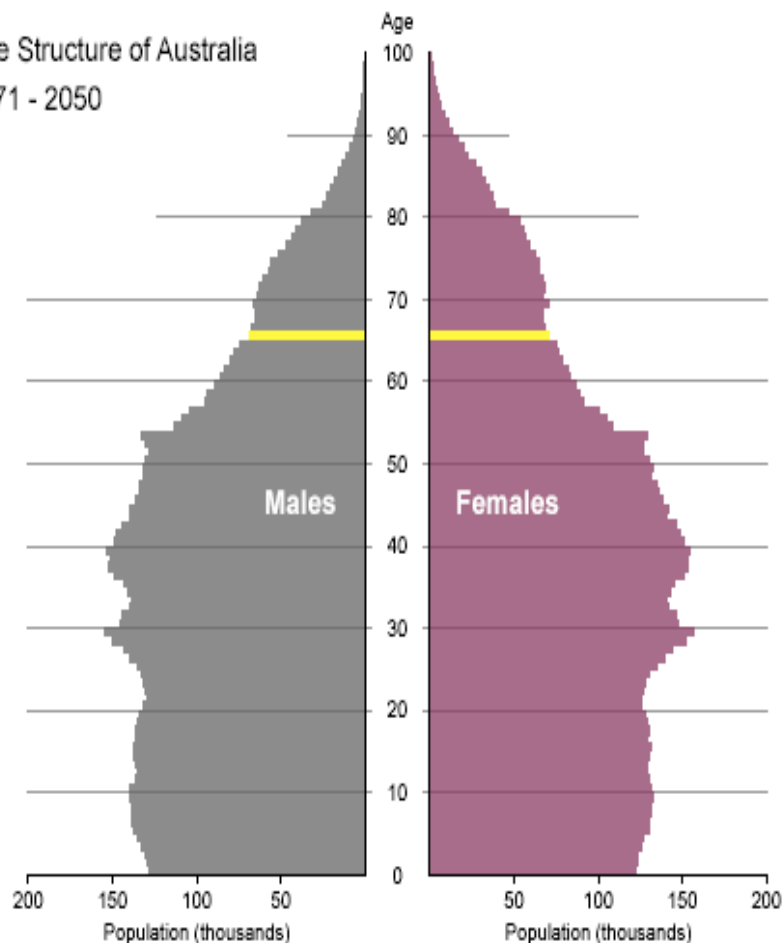




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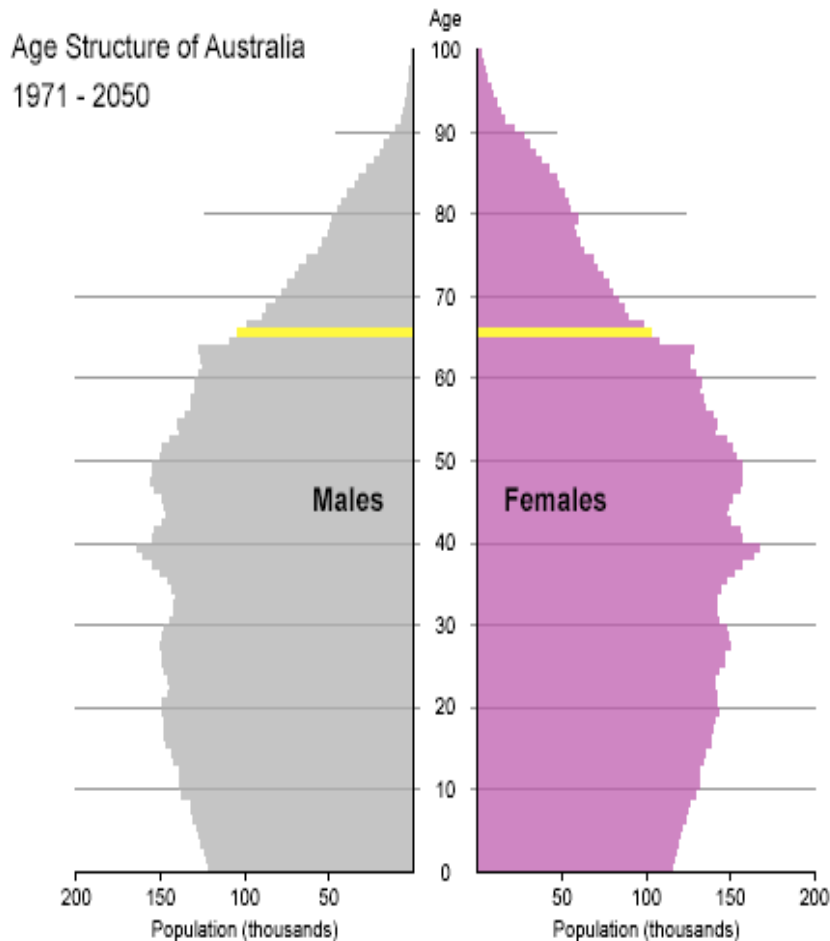
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2010
Total (mil.): 21.3

*** Projected Data**

Aged 65
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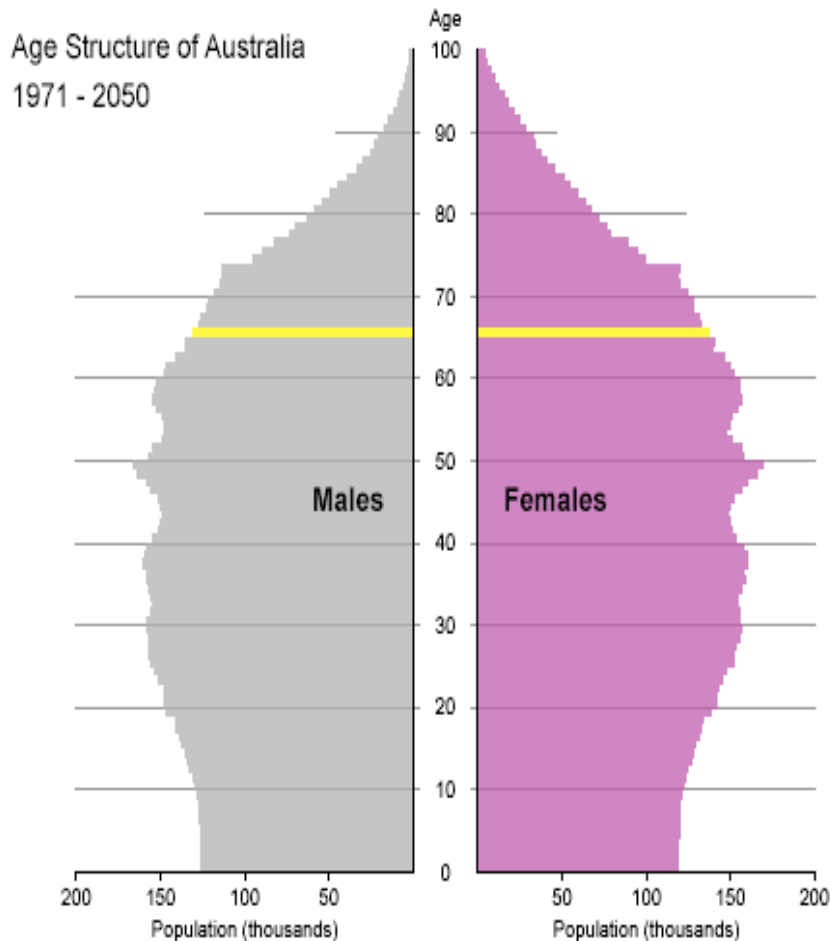
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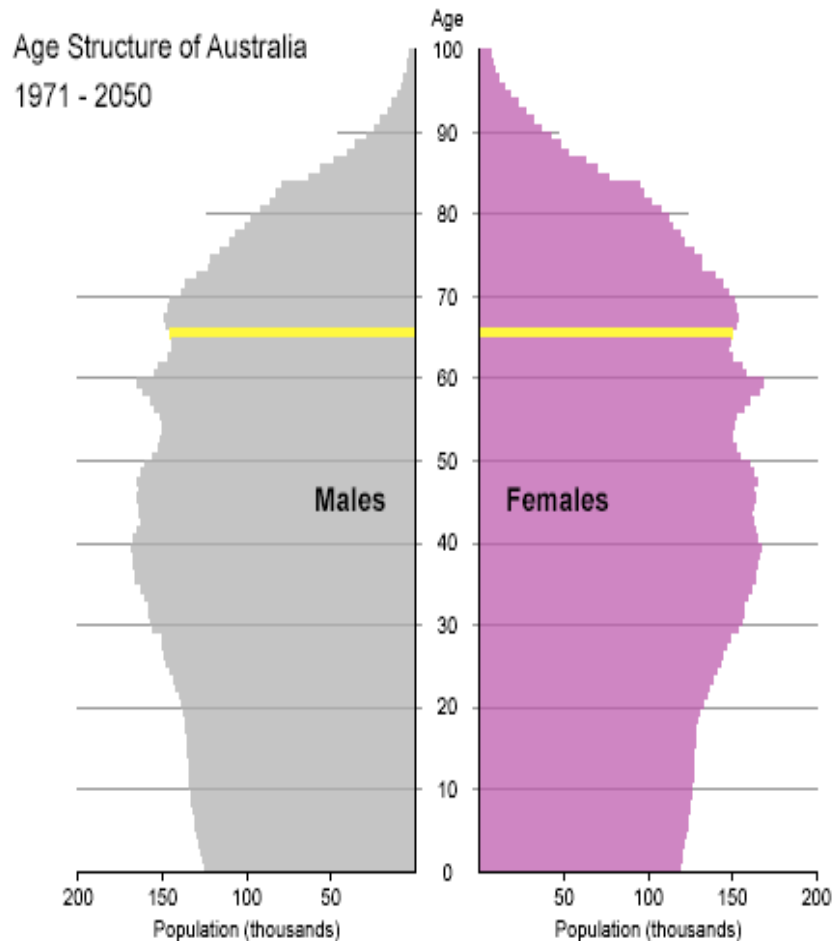
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2030

Total (mil.): 24.8

* Projected Data

Aged 65

Born 1964-1965

Males: 144827

Females: 149668

Sex Ratio: 96.8
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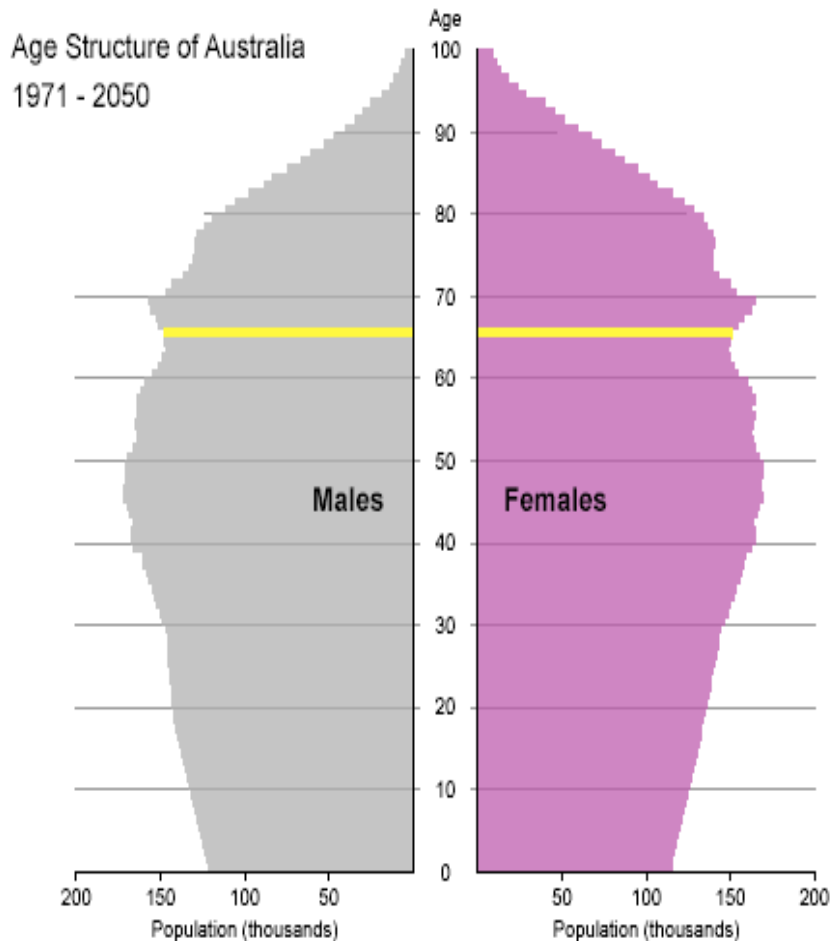
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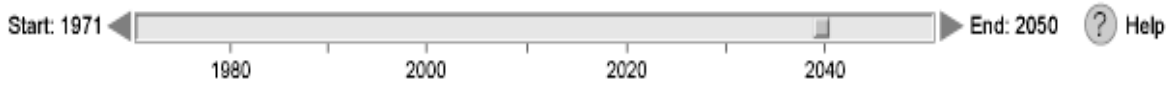
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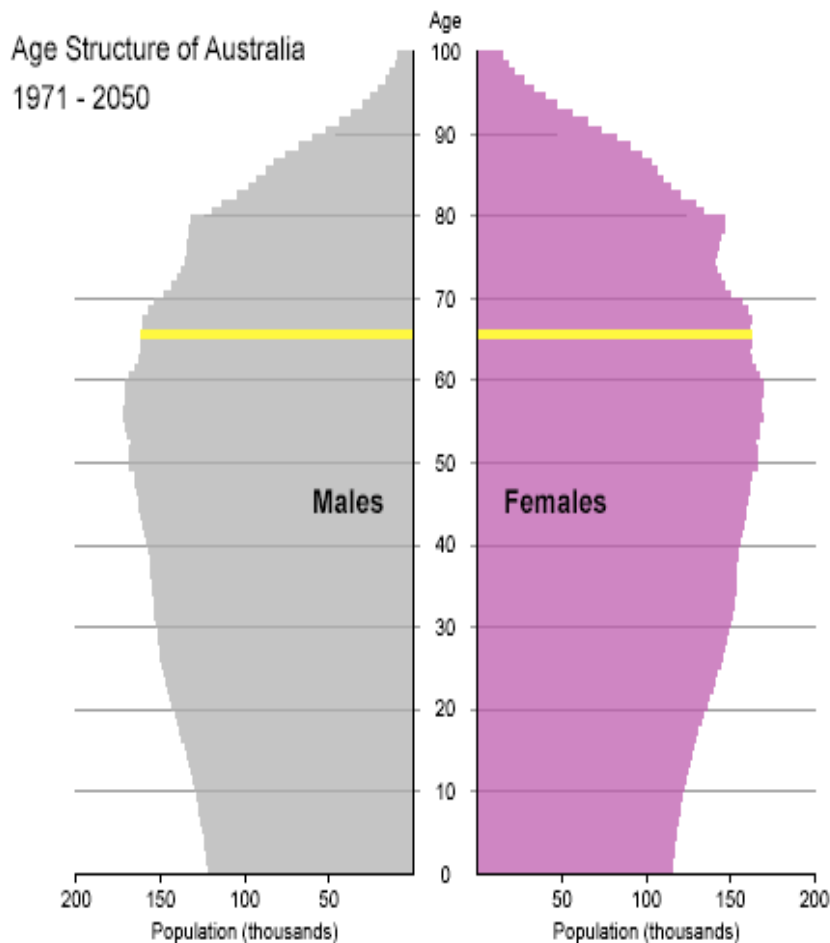




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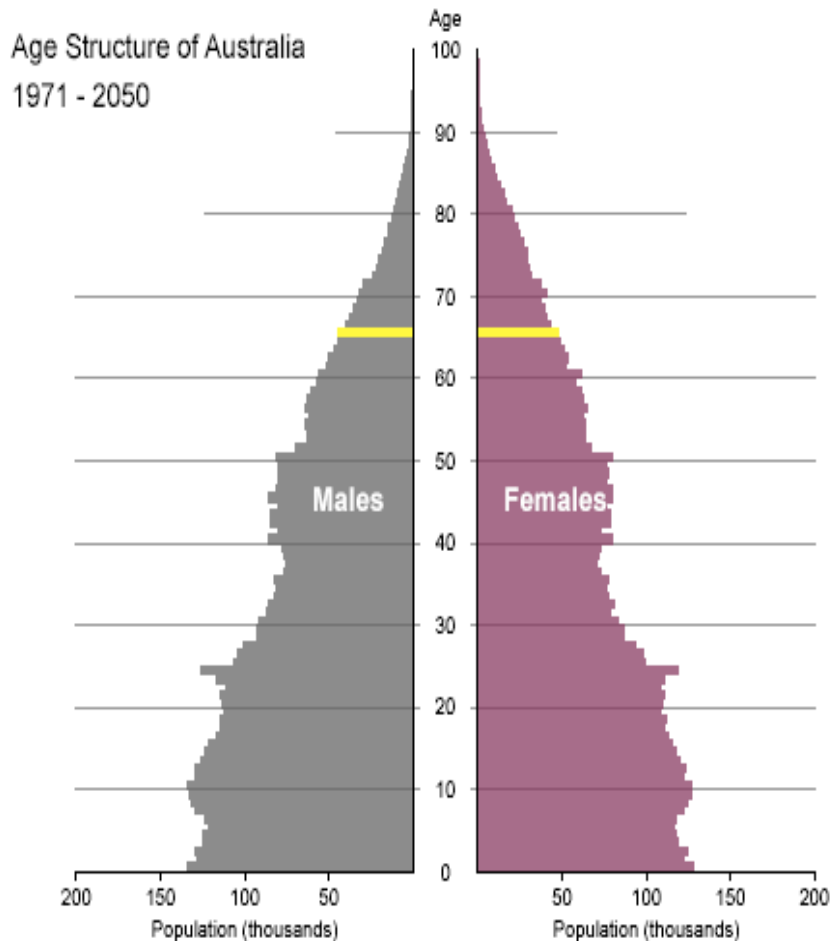
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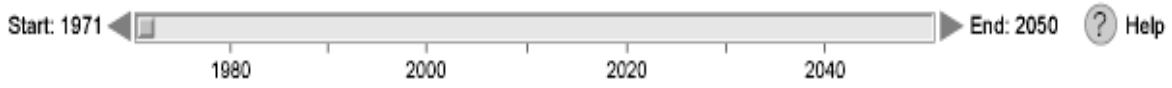
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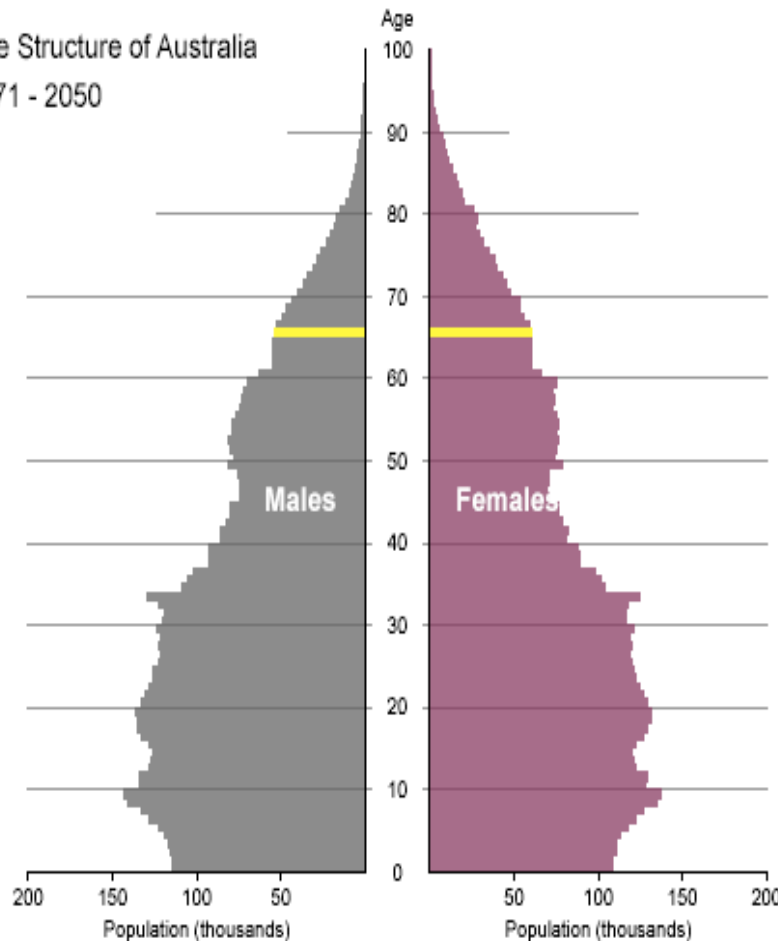




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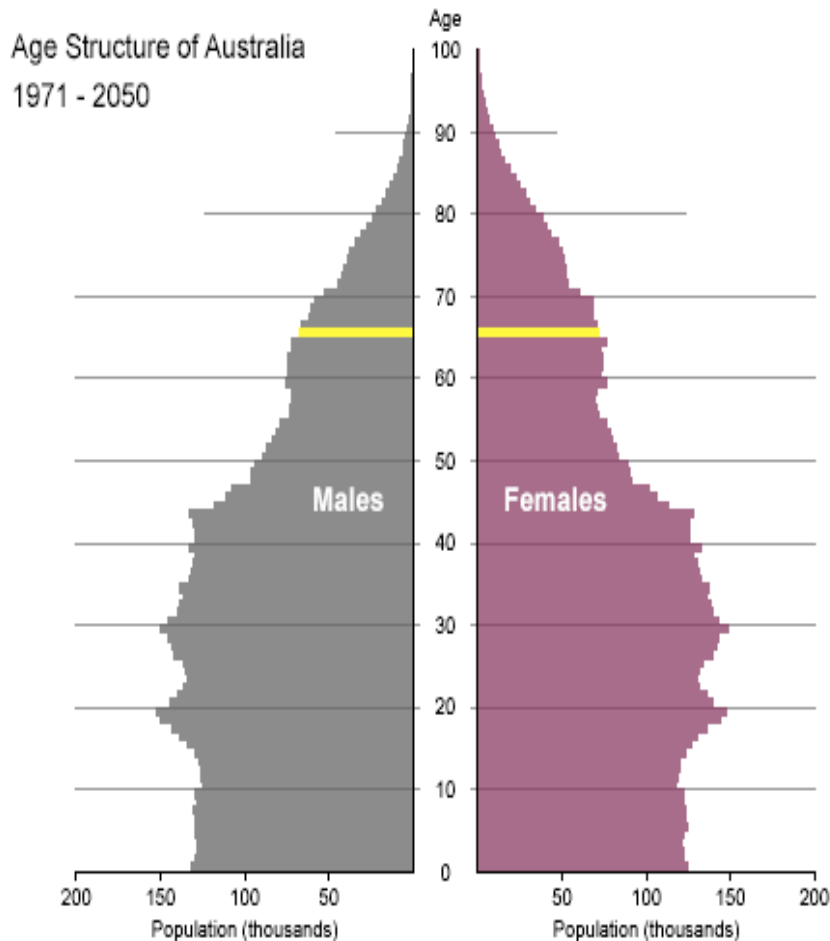
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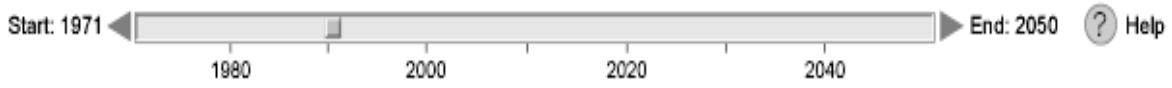
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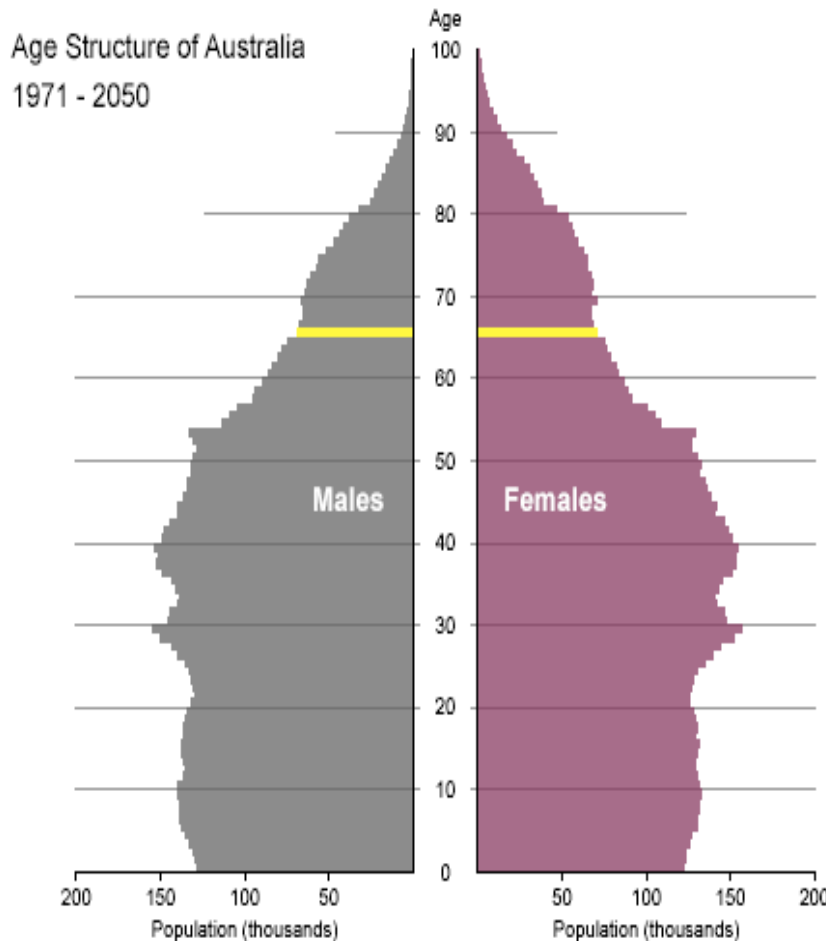
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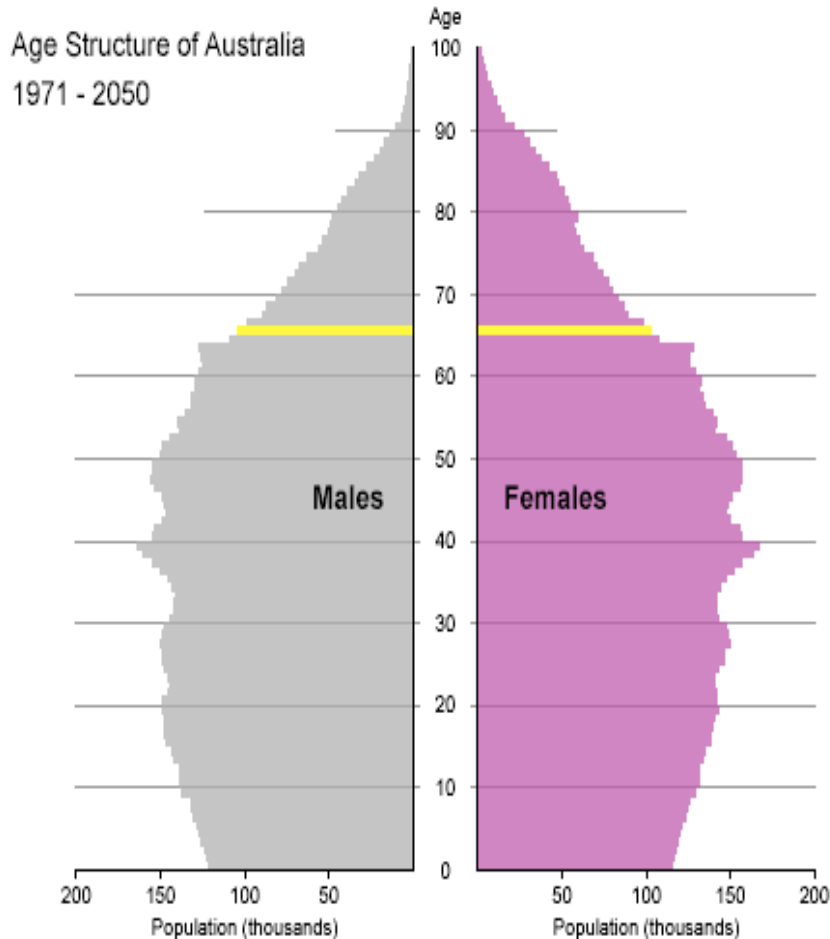
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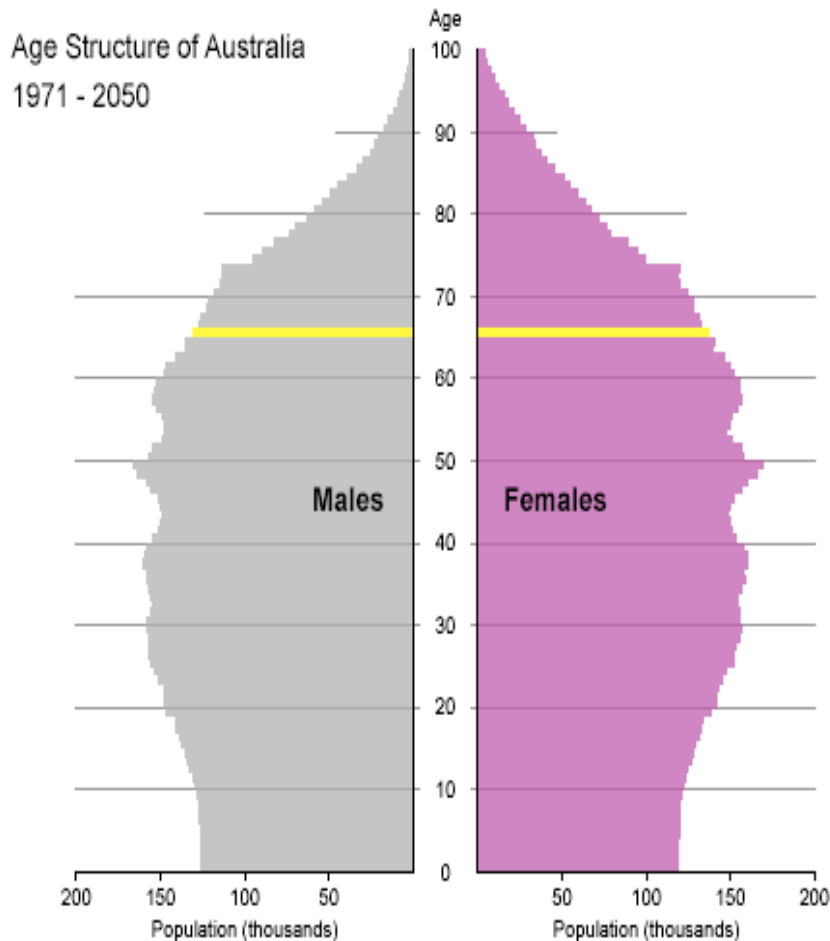
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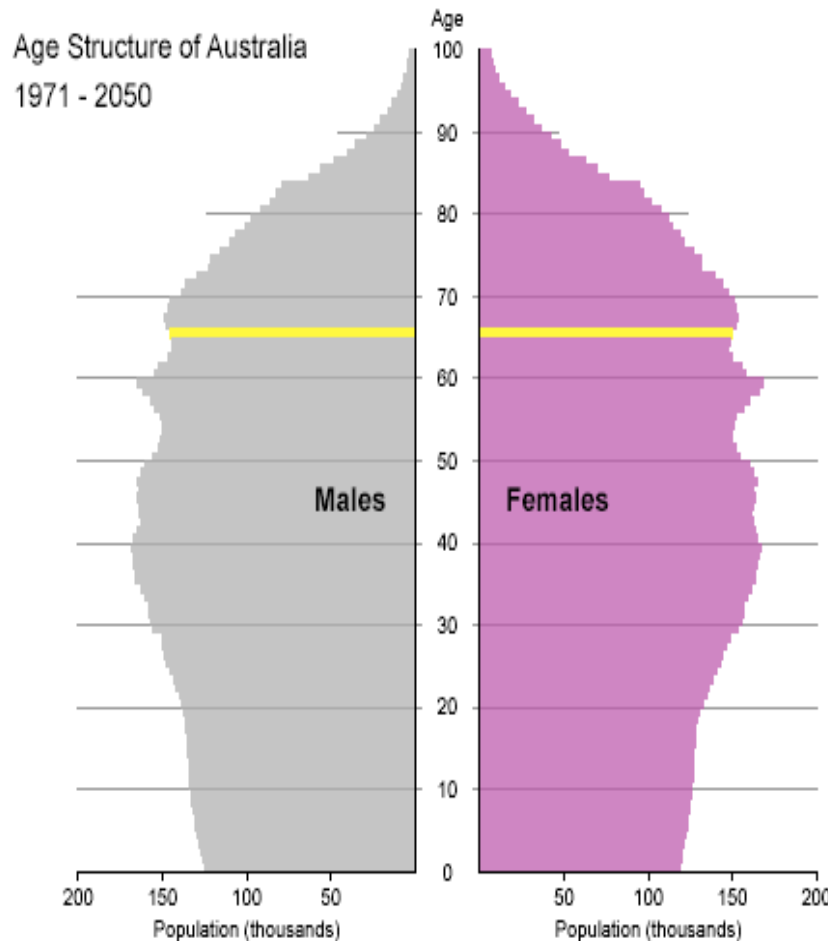
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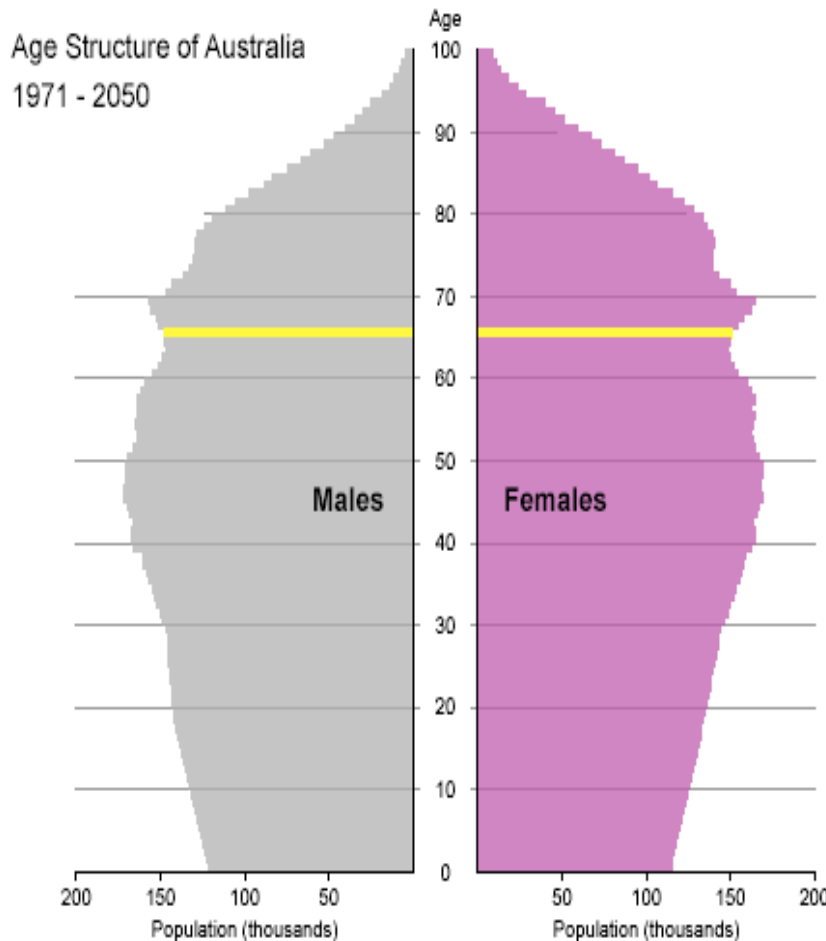
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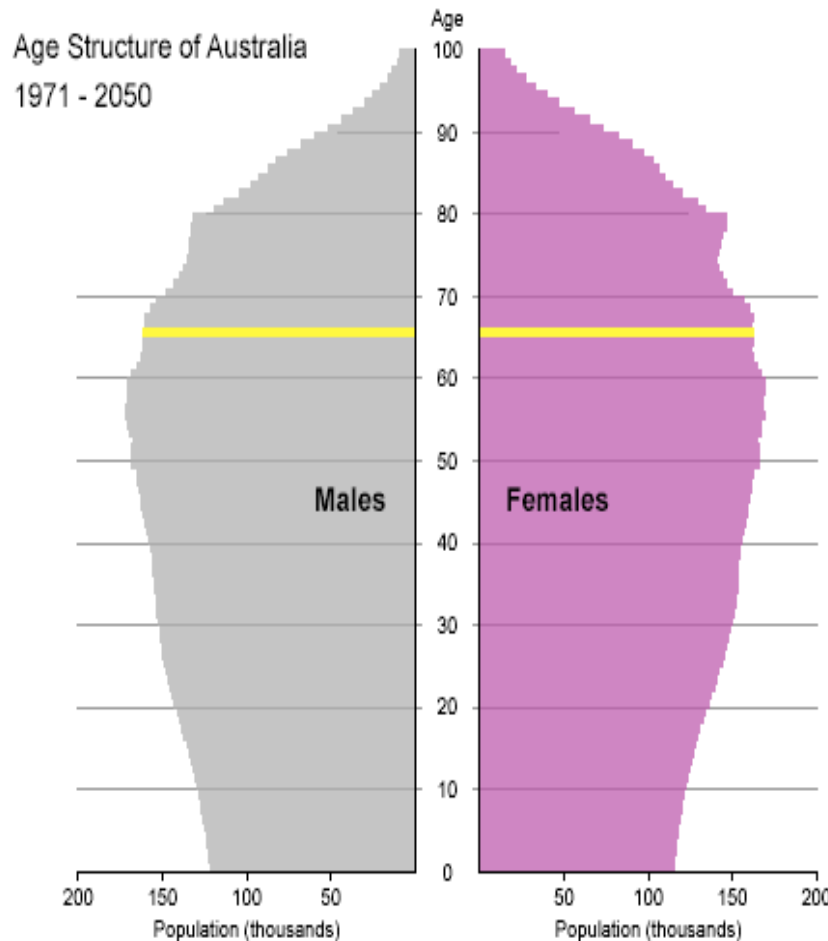
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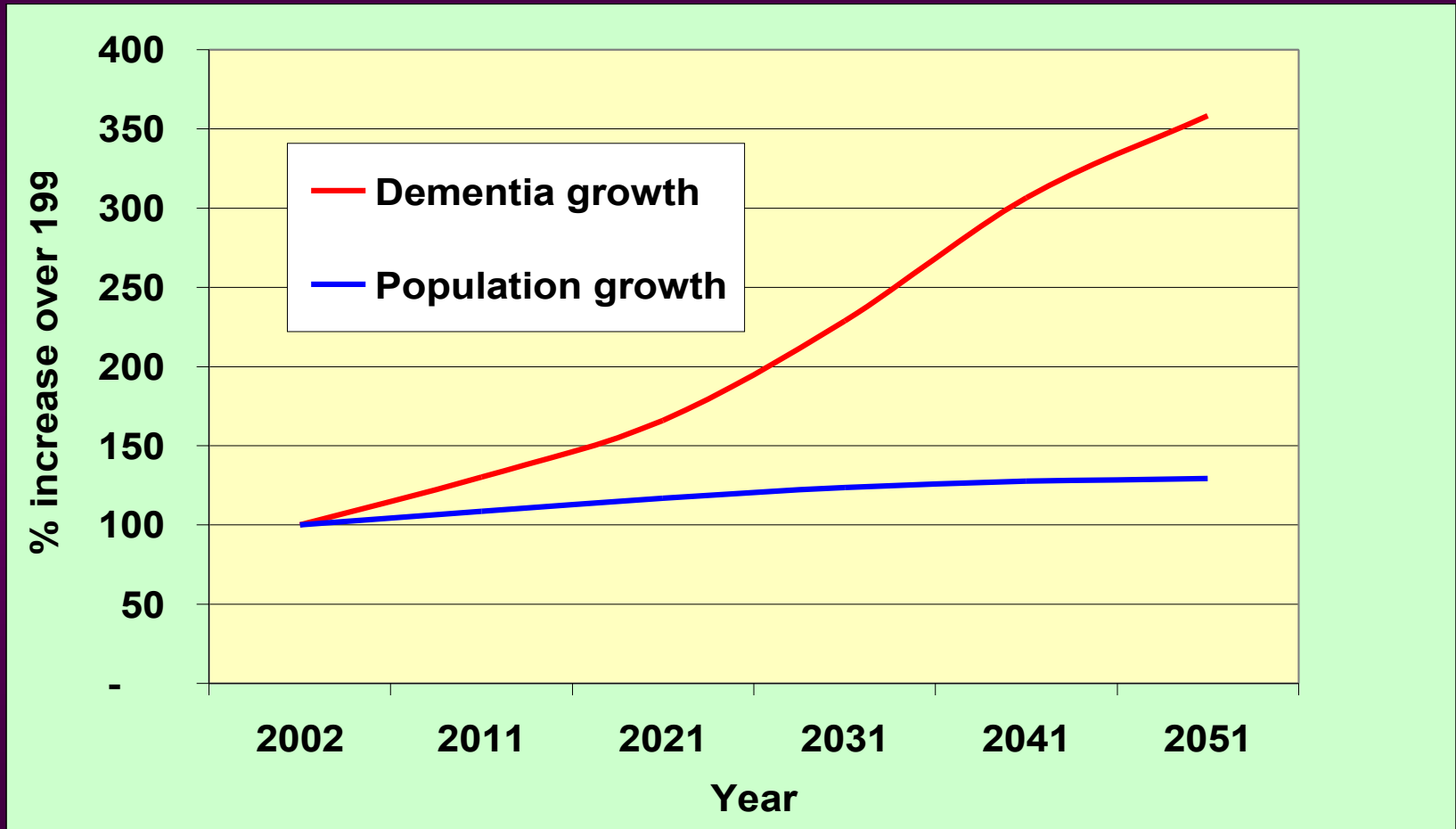


Prevalence of Psychiatric Disorders in Old Age

Dementia Prevalence

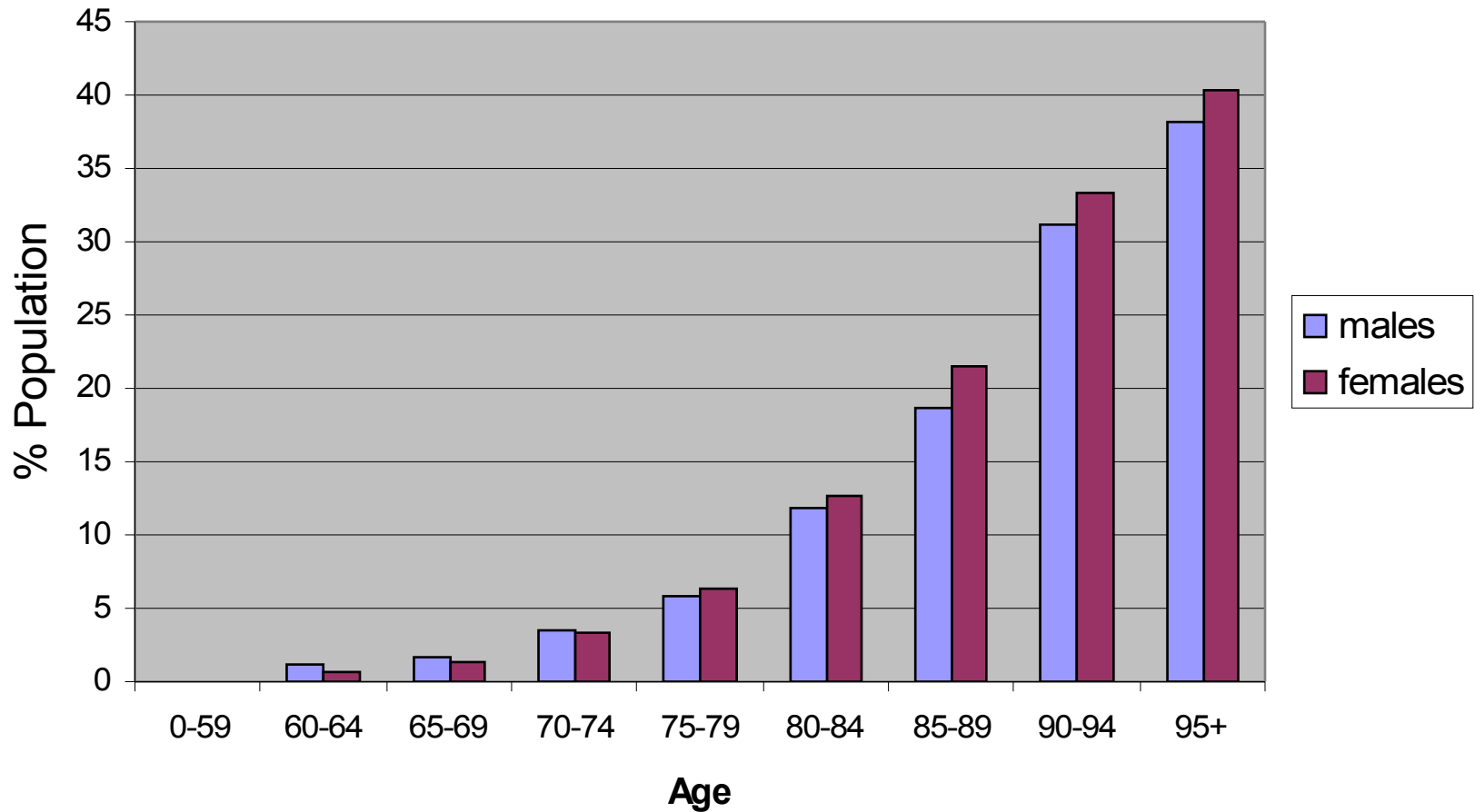
- **About 5% of population \geq 65 years old**
- **20% of persons \geq 80 years**
- **30% of \geq 90 years old**

Projections of dementia in Australia



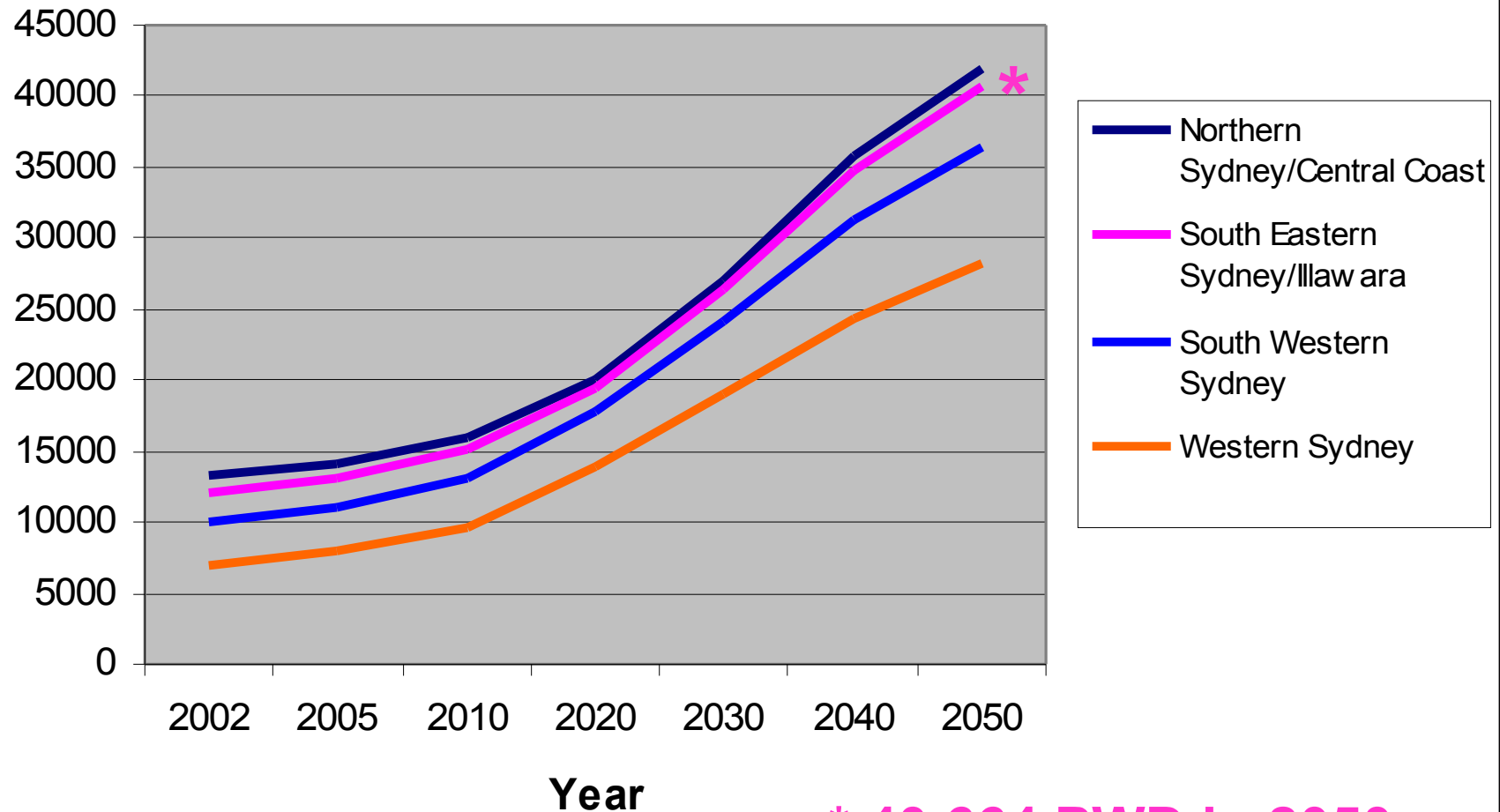
Access Economics (2003)

Dementia Prevalence Rates by Age and Gender



Access Economics (2005)

Dementia Projections Sydney



* 40 664 PWD in 2050

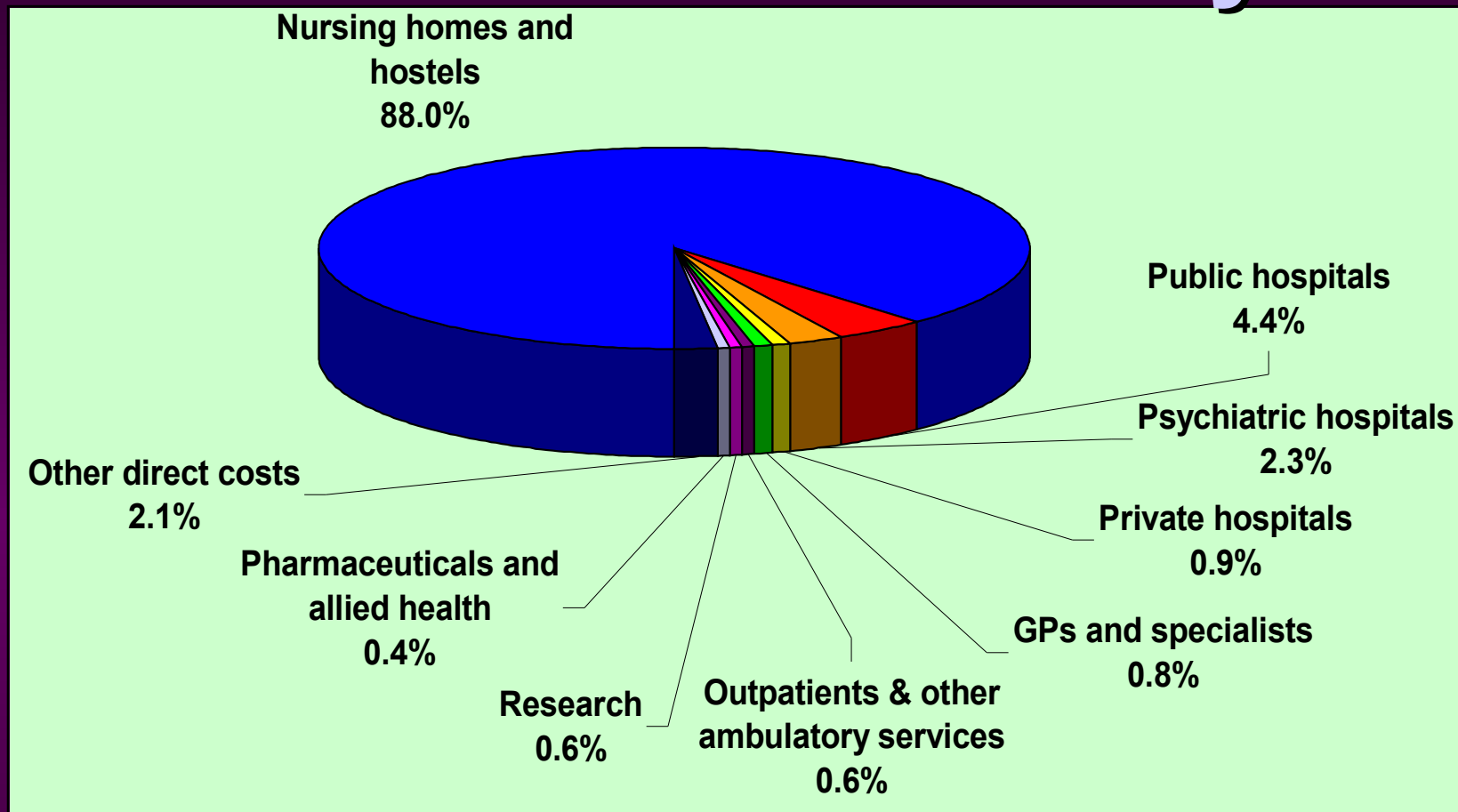
“Demographics is destiny”



Cost of dementia

- \$3.2bn in 2002; incl^u residential care \$2.9bn (88%)
- \$6 billion in direct costs in 2011
- + Indirect costs
- + Unpaid carer time

Costs – Direct Health System



- The most expensive mental health item
- \$3.2bn in 2002; residential care \$2.9bn (88%)
- Projected to increase to \$6 bn in 2011

Prevalence of Other Psychiatric Disorders in Old Age

Delirium	10 – 42%
Depressive Sx	10 – 15%
Dep Episode	3%
Bipolar Disorder	0.08 – 0.25%
Anxiety	0.1 – 4.8%*

***(variation by type of disorder)**

Jacoby, Oppenheimer (Eds), 2002, Psychiatry in the Elderly (3rd Ed);

Copeland, Abou-Saleh, Blazer (Eds), 2002, Geriatric Psychiatry (2nd Ed);

Depp & Jeste (2004), Bipolar Disorders, 6(5); 343-367

Range of Services

HACC

**Residential
Care**

Outpatients

Acute Hospital

**Private
Psychiatric
Hospital**

**Private
Psychiatry**

**Community
Health**

GPs

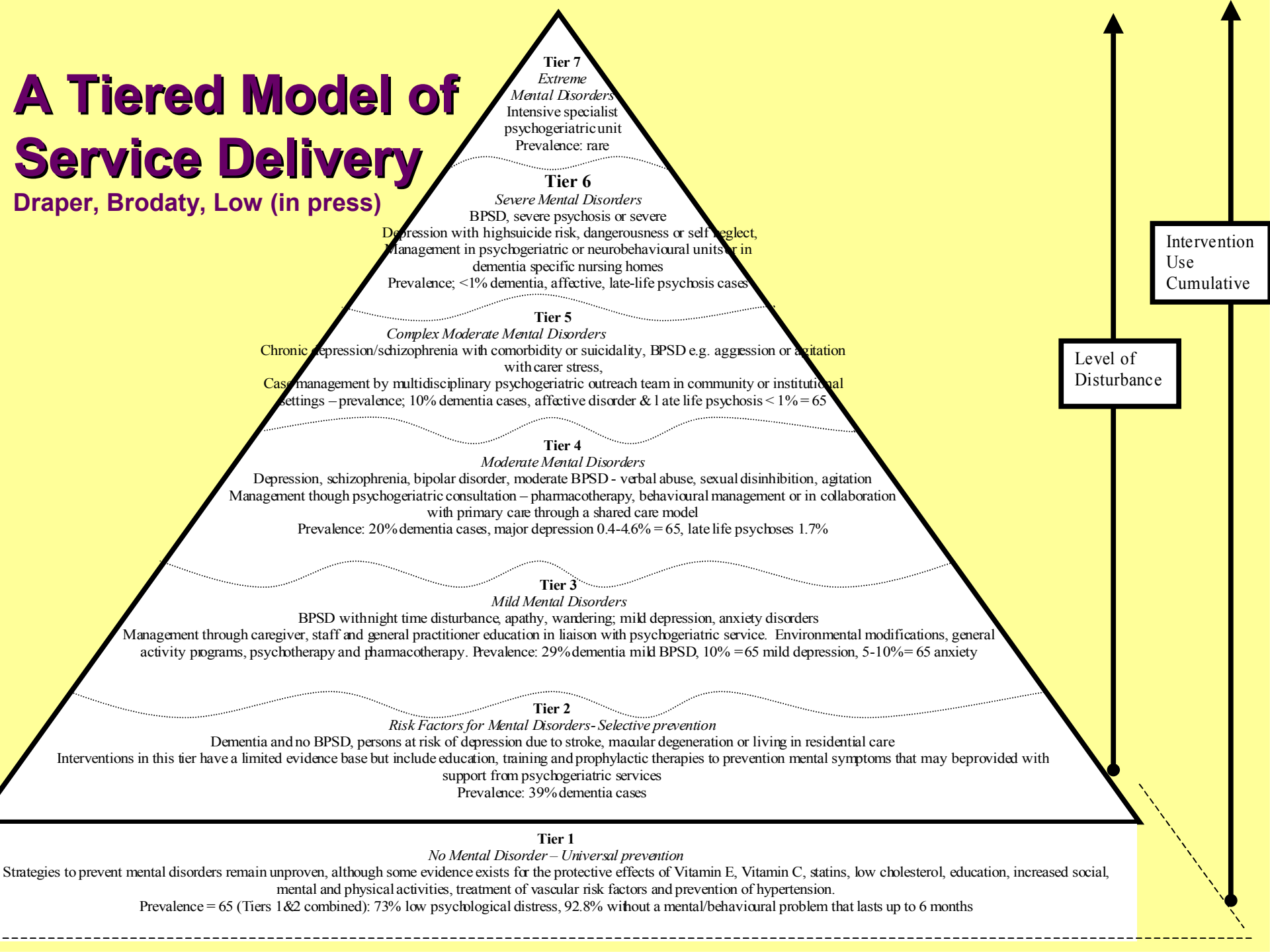
Respite Care

Evidence Base for Services



A Tiered Model of Service Delivery

Draper, Brodaty, Low (in press)



Tier 7

Extreme Mental Disorders
Intensive specialist psychogeriatric unit
Prevalence: rare

Tier 6

Severe Mental Disorders
BPSD, severe psychosis or severe Depression with high suicide risk, dangerousness or self neglect,
Management in psychogeriatric or neurobehavioural units or in dementia specific nursing homes
Prevalence; <1% dementia, affective, late-life psychosis cases

Tier 5

Complex Moderate Mental Disorders
Chronic depression/schizophrenia with comorbidity or suicidality, BPSD e.g. aggression or agitation with carer stress,
Case management by multidisciplinary psychogeriatric outreach team in community or institutional settings – prevalence; 10% dementia cases, affective disorder & 1 late life psychosis < 1% = 65

Tier 4

Moderate Mental Disorders
Depression, schizophrenia, bipolar disorder, moderate BPSD - verbal abuse, sexual disinhibition, agitation
Management through psychogeriatric consultation – pharmacotherapy, behavioural management or in collaboration with primary care through a shared care model
Prevalence: 20% dementia cases, major depression 0.4-4.6% = 65, late life psychoses 1.7%

Tier 3

Mild Mental Disorders
BPSD with night time disturbance, apathy, wandering; mild depression, anxiety disorders
Management through caregiver, staff and general practitioner education in liaison with psychogeriatric service. Environmental modifications, general activity programs, psychotherapy and pharmacotherapy. Prevalence: 29% dementia mild BPSD, 10% = 65 mild depression, 5-10% = 65 anxiety

Tier 2

Risk Factors for Mental Disorders - Selective prevention
Dementia and no BPSD, persons at risk of depression due to stroke, macular degeneration or living in residential care
Interventions in this tier have a limited evidence base but include education, training and prophylactic therapies to prevent mental symptoms that may be provided with support from psychogeriatric services
Prevalence: 39% dementia cases

Tier 1

No Mental Disorder – Universal prevention
Strategies to prevent mental disorders remain unproven, although some evidence exists for the protective effects of Vitamin E, Vitamin C, statins, low cholesterol, education, increased social, mental and physical activities, treatment of vascular risk factors and prevention of hypertension.
Prevalence = 65 (Tiers 1&2 combined): 73% low psychological distress, 92.8% without a mental/behavioural problem that lasts up to 6 months

Level of Disturbance

Intervention Use Cumulative

A Tiered Model of SMHSOP Service Delivery

- **Psychogeriatric service delivery ranges from primary prevention to the management of the most severely ill**
- **The model:**
 - **describes tiers of mental disorders in ascending order of severity and consequent interventions required**
 - **provides a basis for planning comprehensive service delivery**

Draper, Brodaty, Low (in press) A tiered model of psychogeriatric service delivery: An evidence-based approach

A Tiered Model of SMHSOP Service Delivery

- Interventions aim to *prevent* and *treat*
- **Prevention** = avert individuals from moving up tiers
- **Treatment** = move individuals down tiers

A Tiered Model of SMHSOP Service Delivery

TIER 1 - Universal Prevention of Mental Disorders

- General population without mental disorders or specific risk factors**
- Health promotion interventions aimed at keeping most of the population in this tier**

Tier 1 - examples of interventions

- Targeting of vascular risk factors
- Regular physical and mental exercise
- Increased social interaction
- Better nutrition (use of antioxidants)
- Interactive channels are most effective (e.g. “Train the Brain”, “Licking Late Life Loneliness”, “Facing Fears and Phobias”)
- little evidence for effectiveness

A Tiered Model of SMHSOP Service Delivery: Tier 2

TIER 2 - Individuals with risk factors (selective prevention)

- High risk of new or relapsing mental disorders (eg MCI impairment and dementia but no BPSD)**
- SMHSOP (educational input, liaison-style hospital services, collaborations with primary care)**

Draper, Brodaty, Low (in press) A tiered model of psychogeriatric service delivery: An evidence-based approach

Tier 2: examples of intervention

- **CG training programs**
- **Living with memory loss program (AA)**
- **Cholinesterase inhibitors**
- **Antidepressant medication and psychotherapy (depression relapse)**
- **Some limited evidence for benefit**

A Tiered Model of SMHSOP Service Delivery: Tier 3

TIER 3 - Mild Mental Disorders

- **Disorders that include dementia with mild BPSD, mild depressive Sx or mild-moderate anxiety disorders**
- **Primary care workers and carer/consumer organisations mainly provide interventions**

Tier 3 examples

- **Multidisciplinary consultation & collaboration, training of GPs & CG in detection/management of depression, & health education & activity programs**
- **Living with memory loss program (AA)**
- **Pharmacological management of BPSD**
- **Antidepressants**
- **some RCT evidence**

A Tiered Model of SMHSOP Service Delivery: Tier 4

TIER 4 - Moderate Mental Disorders

- Patients with moderate BPSD, major depression, severe anxiety disorders and mild-moderate late-life psychotic disorders
- Specially targeted interventions delivered in community settings
- *Specialist Consultation* usually necessary

Tier 4 examples

- **Some evidence**
- **Interventions include education, care management, antidepressant management or psychotherapy → 45% had a 50% reduction in depressive symptoms**
- **Dementia care program (AGE) = Activities, Guidelines for psychotropic medication and Educational rounds → reduced medication and restraints at 6 months**

A Tiered Model of SMHSOP Service Delivery: Tier 5

TIER 5 - Moderate-severe & complex mental disorders

- Pts determined by symptom severity AND by context and complexity of the case**
- Factors - lack of family support, physical disability & multiple physical illnesses**
- Individually tailored programs implemented by a specialist multidisciplinary team**

Tier 5 examples

- **Individualised packages of care for depressed frail elderly living at home from a multidisciplinary community SMHSOP team - 58% recovery at 6 months**
- **Older patients with chronic schizophrenia or paranoid psychoses require long periods of case management - no empirical data**

A Tiered Model of SMHSOP Service Delivery: Tier 6

TIER 6 - Severe Mental Disorders

4 main groups of patients:

- 1. Agitated/psychotic with delirium**
- 2. Severe psychosis or depression
(where home-based care not viable)**
- 3. Chronic schizophrenia**
- 4. Severe BPSD**

Tier 6 examples: Group 1 - Agitated/Psychotic with delirium

- **Best managed in a general medical ward with input from PG liaison service**
- **Combined PG & geriatric medical wards jointly run by PG-icians & geriatricians may be particularly useful**

Tier 6 examples: Group 2 - Severe Psychosis or Depression (where home-based care not viable)

- **Usually require admission to an acute PGU**
- **Medium term effectiveness is enhanced by integration with community care**

Tier 6 examples: Group 3 -Chronic Schizophrenia

Community residences superior to hospital wards in terms of family satisfaction, equipment and safety features (more “home like”)

Tier 6 examples: Group 4 - Severe BPSD

- **Require treatment in a facility specialising in the management of old age neurobehavioural disorders**
- **Some patients may require brief admission to an acute PGU to settle behaviour**

A Tiered Model of SMHSOP Service Delivery: Tier 7

TIER 7 - Extreme Mental Disorders

- Patients are generally men < 70 yrs who are very strong and violent**
- Often non-Alzheimer dementias, alcohol related brain damage or post-head injury**
- Sometimes they have intractable chronic paranoid psychoses or bipolar disorder**

Tier 5 examples

- **High security specialist care unit with a large ratio of male staff to patients**
- **More research required to determine the parameters of facilities in this tier**



Current Initiatives

LOCAL INITIATIVES

South Eastern Sydney & Illawarra Area Health Service

SMHSOP

Strategic Plan

2006 - 2011

PROCESS

- **Wide consultation across the Area**
 - **Aged Care**
 - **Mental Health**
 - **Residential Aged Care Facilities**
 - **Councils / Community services**
 - **Carers/consumers**
 - **CALD/ATSI**
 - **Divisions of General Practice**

Review of Existing Services

- **Mapping exercise**
 - **Identified models of care**
 - **Access to services / clinical pathways**
 - **Partnerships with SMHSOP and other service providers**
 - **Education / training and orientation available**
 - **Resources v MH-CCP**

Strategic Plan Content

- **Executive Summary**
- **Aims**
- **Introduction & context**
- **Area Planning**
- **Area Service Delivery**
- **SMHSOP Service model development**
- **Future challenges**
- **Goals and outcomes of the plan**
- **Implementation Plan**

Goals and Strategies Summary

<p>GOAL 1 Develop best practice, evidence based quality services that are responsive to the mental health needs of the older person</p>	<p>Clinical services/Community Inpatient/PPEI</p>	<p>Access / Equity EBP / Research / Clinical Pathways / Guidelines Models of care</p>
<p>GOAL 2 Develop and maintain effective partnerships with key service providers and community organisations</p>	<p>Identify / formalise partnerships/Consumer/ carer participation</p>	<p>Capacity building Models of care Integration</p>
<p>GOAL 3 Ensure services are developed to address and provide expert mental health interventions to special needs groups</p>	<p>ATSI / CALD / Older homeless people, rural areas, Justice Health</p>	<p>Identify Special Needs Group's Models of care Collaboration</p>
<p>GOAL 4 Development of a workforce that is valued, competent and actively involved in pursuing specialist training</p>	<p>Orientation pathways Core competencies Support</p>	<p>Fostering / collaboration /education & training partnerships</p>
<p>GOAL 5 Ensure services are developed within a quality improvement framework</p>	<p>Resource allocation Accountability Governance</p>	<p>Services are planned Population health models / MH-CCP</p>

Goal 1

- **Deliver best practice, quality services that are accountable and responsive to the mental health needs of older people across the community and inpatient settings**

Goal 1

Targets:

- Clinical, community and inpatient services
- Promotion, prevention and early detection

Outcomes:

- Development of community and inpatient services
- Development of evidence based practice
- Research to guide practice and carer
- Consumer involvement

Goal 2

- **Develop and maintain effective partnerships with key service providers and community organisations**

Goal 2

- **Strategies:**
 - **Partnerships with internal/external stakeholders**
 - **Consumer and carer participation**
- **Outcomes:**
 - **Integration and formal agreements with Aged Care and Mental Health Services, Private Psychiatrists and GPs**

Goal 3

- **Ensure services are developed to provide expert mental health interventions for special needs groups**

Goal 3

Target groups/ older people with MH problems who are from/have

- **ATSI backgrounds**
- **CALD backgrounds**
- **Homeless**
- **Live in rural areas**
- **The Justice Health System**

Goal 4

- **Development of a workforce that is valued, competent and interested in pursuing specialist training**

Goal 4

- **Strategy:**
 - **Development of core competencies and skill-base for all staff**
- **Outcomes:**
 - **Capacity building, training and education, research, orientation, clinical rotations with aged care and mental health services**
 - **Creative recruitment and retention**
 - **Development of a highly specialised and valued workforce**

Goal 5

- **Ensure services are developed within a quality improvement framework**

Goal 5

- **Strategies:**
 - Services are planned to meet the needs of an ageing population
 - Resource allocation
- **Outcomes:**
 - Resources to be distributed based on a population health framework
 - Services are accountable
 - Outcomes including indicators are collected consistently and are measurable

STATE INITIATIVES

**NSW Specialist Mental Health
Services for Older People Plan**

NATIONAL INITIATIVES

National Framework for Dementia

NATIONAL INITIATIVES

**Dementia: A National
Health Priority**

The Future



What Will the Future Bring?

- **Demographic imperative**
- **Changing family structure**
 - Fewer children to support ageing parents
 - from 3 generation families living together to nuclear families w all children working
 - Increased inter-generational gap
- **Increased awareness - demands for earlier and even predictive diagnosis**
- **Mild Cognitive Impairment now a diagnosis**

What Will the Future Bring?

- **Will there be a cohort effect?**
 - **Current carers more hardy or vulnerable, viz: Depression and War**
 - **Baby Boomers different expectations**
 - **BBs more affluent**
 - **BBs' children > dependent → 2^o role strain**
- **Effects of earlier Dx unknown and people with dementia (?) living longer**

What Will the Future Bring?

- **Genetics - greater predictability**
- **Technology - ?prosthetic memory, prosthetic environments, more accurate diagnosis**
- **Drug treatments**
 - **Cure, prevention**
 - **Cost, aged persons least likely to afford**
- **Prevention**

What Will the Future Bring?

New Treatments

- **Vaccine - to remove amyloid plaque**
- ▽ **β and δ secretase inhibitors - to prevent build up of plaque**
- **Clioquinol, Alzhemed - to prevent clumping together of β protein**
- **Leuprolide* - to reduce plaque formation**
- **Others - Statins, Serotonin antagonist* inhibitors, Rosiglitazone**

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What Will the Future Bring?

- **Better ways to help families and people with dementia**
- **Better long term care arrangements**
- **L/T care insurance**
- **More superannuation changes**
- **Better treatments of BPSD**



Dementia Risk Reduction Signposts

MIND your DIET

MIND your BODY

MIND your BRAIN

MIND your HEALTH CHECKS

MIND your SOCIAL LIFE

MIND your HEAD

MIND your HABITS



Other Policy Issues

- **Training for health and aged care workers**
- **Training for police, ambulance, emergency and hospital staff, general public**
- **Research**
 - **Basic science**
 - **Treatments**
 - **Diagnostic tools - may be culture specific**
 - **Best models of service delivery**