

Geriatric Mental Health Outreach Program

...a new resource for Bob and Mary

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Who do we serve?

Older persons who have...

- Dementia with associated behavioural difficulties or mental illness associated with cognitive impairment
- Severe mental illness that developed late in life
- Chronic mental illness who develop complicating disorders arising from an age related decline in physical and mental health

Persons under 65 years who have an age-related severe mental illness

***Outreach* ...emphasis on those who cannot or will not seek traditional care**

How do we serve clients & families?

- Consultative in nature
- Assessment-focused
- Shared-care
- Short-term treatment in the context of the needs of older adults
 - Some programs offer longer term support
- Educational resource
- Outreach – home visits (community, LTCHs etc)

How we met Bob and Mary?

- Referral made by family physician
 - Diagnosis, treatment, management, support, risk issues, complexity & chronicity
 - Need for outreach service
- What has changed?
Why now?
- Expectations, goals and our role?



Referrals to the GMHOP

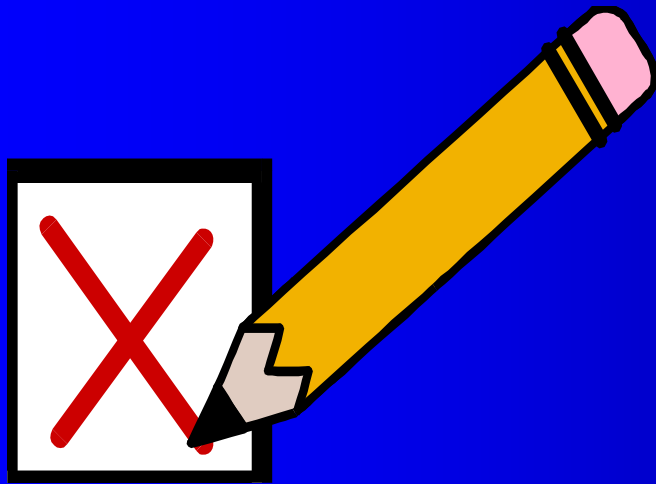
Bob

- A bit resistant to taking meds and FP wanting consult re: mood and pharmacological treatment, CBT?
- Won't come to an office
- Questions about memory loss
- Driving?
- Case manager to closely follow re: suicide, changes in mood, function and behaviour
- Joint visit with MH nurse
- Alcohol misuse?

Mary

- Query dementia superimposed on schizophrenia
- Psychiatry & case management support re: medication
- Caregiver support and education
- Assist with community linkages for Mary
- Work with CCAC & PSW agency to strategize to build rapport, trust to be able to assist
- Joint visit with nursing

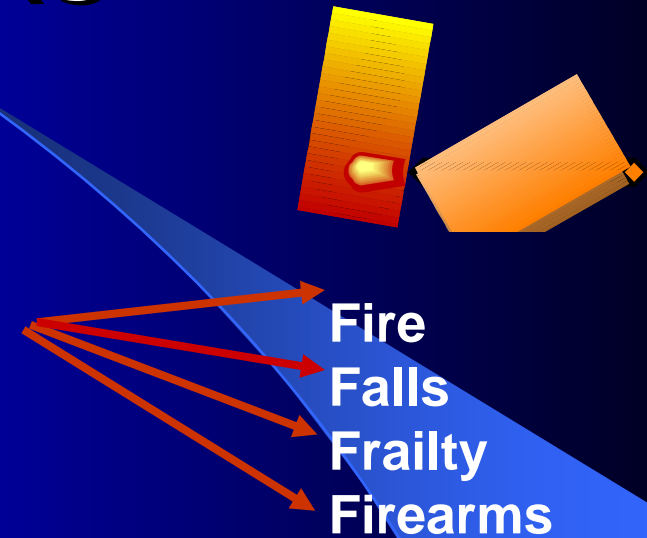
Telephone Clinical Screen



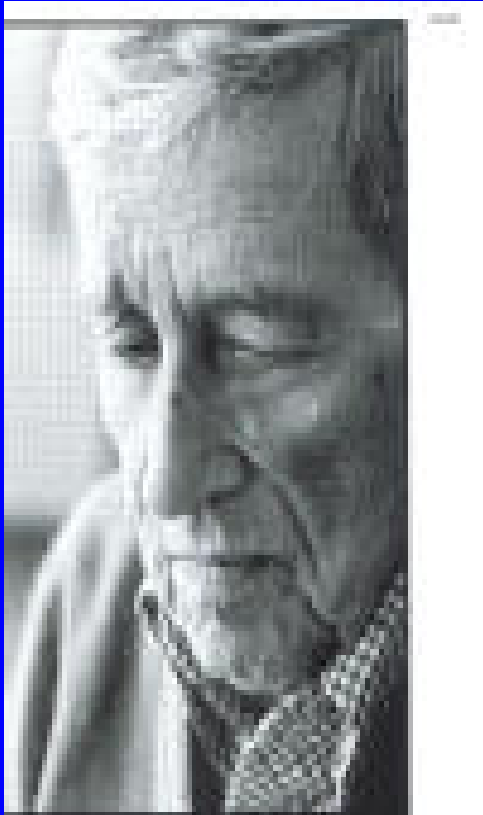
- Who to talk to? How many?
- Eligibility & Criteria
- Program orientation
- Basis of presenting problem
 - PIECES
- Risk Factors
 - Assign urgency
- Telephone intervention
 - education, support, plans & recommendations, links
- If a **change**, call us back!

Type of RISKS

- Roaming
- Imminent Physical Danger
- Suicidal
- Kinship
 - Risk to patient to others
 - Risk to patient from others
- Self neglect, safe driving, substance abuse



Suicide Risk Factors



Sex

Age

Depression

Previous attempt

Ethanol abuse

Rational thinking loss

Social supports lacking

Organized plan

No spouse

Sickness

- ✓ Have an index of suspicion.
- ✓ Practice good communication among all care providers.
- ✓ Ask good screening questions.
- ✓ **Be aware of your fear.**

Why Bother?

Scales and Assessment Tools

Based on what?

1. Identify areas of strength and need
2. Establish baseline measure and document change
3. Enhance communication (common language), consistency and continuity amongst care partners
4. Assist with care management and service planning
5. Monitor and evaluate impact of interventions

Reflect & Consider

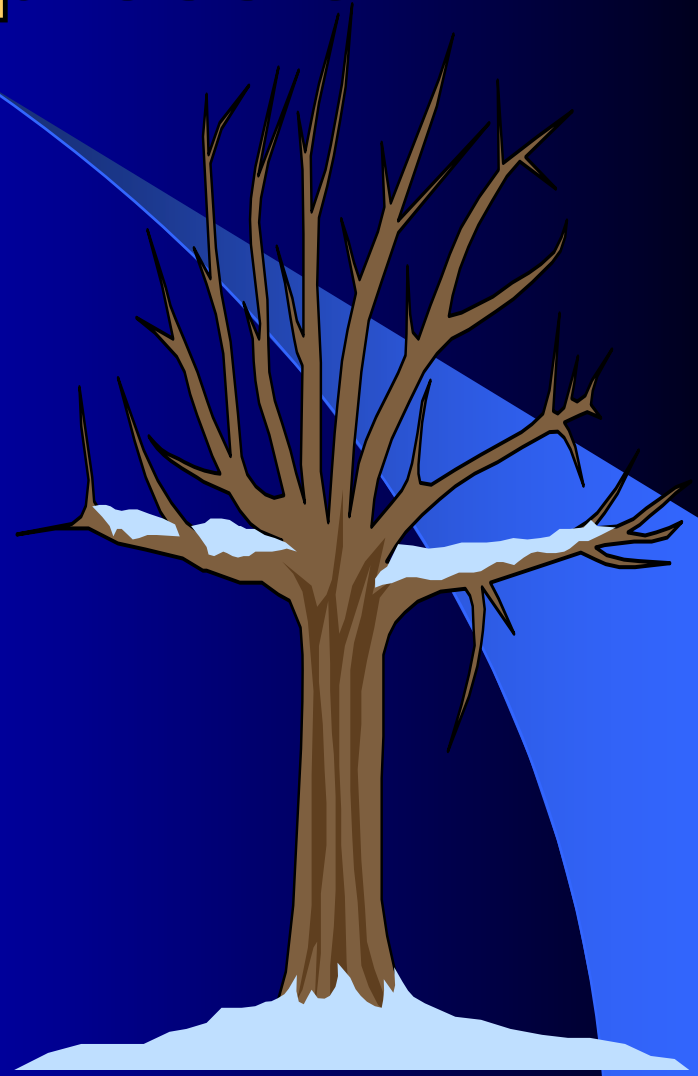
- > **Opportunities** for incorporating tools or scales into your practice or setting?
- > Help in **making decisions** about care and service planning?
- How could the information be helpful to clients, families or other care partners to
↑ **understanding** of the complex issues?





Facts About Depression

- The most common psychiatric illness for *people of all ages*
- **Under/mis- diagnosed** in older adults and **under treated**
- Mistaken for “problems of aging”
- The lifetime prevalence of major depressive disorder in adults is about 15%
 - 20% in ♀ and 10% in ♂
- ♀:♂ = 2 to 1.
- About 30 to 45% of the **medically ill** and those in LTC are depressed.
- Is **not part of normal aging**



Assessment and Diagnosis: Screening Tools

Geriatric Depression Scale (GDS).

- Originally a 30 item self-rating scale.
- Cut-off of 11.
- Sensitivity = 84% and Specificity = 95%.
- A 15 item version with similar sensitivity and specificity is available. Cut-off of 6-7 out of 15.
- The usefulness of the GDS ↓ with ↑ in cognitive impairment.

GERIATRIC DEPRESSION SCALE

Choose the best answer describing how you felt over the past week.		YES	NO
1.	Are you basically satisfied with your life?		
2.	Have you dropped many of your activities and interests?		
3.	Do you feel that your life is empty?		
4.	Do you often get bored?		
5.	Are you in good spirits most of the time?		
6.	Are you afraid that something bad is going to happen to you?		
7.	Do you feel happy most of the time?		
8.	Do you often feel helpless?		
9.	Do you prefer to stay at home, rather than go out and do new things?		
10.	Do you feel you have more problems with memory than most people?		
11.	Do you think it is wonderful to be alive?		
12.	Do you feel pretty worthless the way you are right now?		
13.	Do you feel full of energy?		
14.	Do you feel that your situation is hopeless?		
15.	Do you think that most people are better off than you are?		
Total			/15

- Score of 5 – 9 indicates mild depression
- Score of 10 – 15 indicates moderate to severe
- Reliable/ valid measure of depression

Reference: Vinkers et al., Int J. Geriatric Psychiatry 2004; 19: 80-84

Assessment and Diagnosis: Screening Tools

Cornell Depression Scale

- Designed specifically to assess signs and symptoms of depression in dementia.
- Semi-structured interview of a qualified informant and of the patient.
- There are 19 items, selected based on current literature regarding depressive signs and symptoms in patients with and without dementia.
- Rated on a 3 point score, “absent”, “mild or intermittent”, and “severe symptoms”. A note for unable to evaluate.
- Cut-off of 8. Higher scores are more supportive of depression.

CORNELL SCALE FOR DEPRESSION

Patient's Name: _____ Admin. Date: _____ Admin. By: _____

MOOD RELATED SIGNS

- 1. Anxiety _____
anxious expression, ruminations, worrying
- 2. Sadness _____
sad expression, sad voice, tearfulness
- 3. Lack of reactivity to pleasant events _____
- 4. Irritability _____
easily annoyed, short tempered

BEHAVIOURAL DISTURBANCE

- 5. Agitation _____
restlessness, handwringing, hairpulling
- 6. Retardation _____
slow movements, slow speech,
slow reactions
Multiple physical complaints
(score of 0 if GI symptoms only)
- 7. Loss of interest _____
less involved in usual activities
(score only if change occurred acutely,
i.e., in less than one month)

PHYSICAL SIGNS

- 8. Appetite loss _____
eating less than usual
- 9. Weight loss _____
(score 2 if greater than 5 lbs in 1 month)
- 10. Lack of energy _____
fatigues easily, unable to sustain activities
(score only if change occurred acutely,
i.e., in less than 1 month)

CYCLIC FUNCTIONS

- 11. Diurnal variation of mood _____
symptoms worse in the morning
- 12. Difficulty falling asleep _____
later than usual for this individual
- 13. Multiple awakenings during sleep _____
- 14. Early morning awakening _____
earlier than usual for this individual

IDEATIONAL DISTURBANCE

- 15. Suicide _____
feel life is not worth living, has suicidal
wishes, or makes suicide attempts
- 16. Poor self-esteem _____
self-blame, self-depreciation, feelings
failure
- 17. Pessimism _____
anticipation of the worst
- 18. Mood-congruent delusions _____
delusions of poverty, illness, or loss

SCORING SYSTEM

Ratings should be based on symptoms and signs occurring during the week prior to the interview. No score should be given if symptoms result from physical disability or illness.

0 = absent 1 = mild or intermittent
2 = severe n/a = unable to evaluate

AVERAGE CORNELL RATINGS

No psychiatric diagnosis	1.4	Non-depressive psychiatric disorders	4.8
Minor or probable major depressive disorder	12.3	Definite major depressive disorder	24.8

Reference: Burns et al., Assessment Scales in Old Age Psychiatry, Martin Dunitz Ltd 1999.

Depression – Signs and Symptoms

A memory aid to use to help recognize depressive signs

- S** sleep is disturbed
- I** interest is decreased, no longer enjoy pleasurable activities
- G** guilt
- E** energy is lower than usual
- C** concentration is poor, and memory problems appear
- A** appetite is disturbed; weight loss often
- P** psychomotor retardation (slowing), or agitation
- S** suicidal thoughts, or a passive a wish to die

Reference: Developed by: Dr. C raey Cross and reported in Jenke, M. (1989). Geriatric psychiatry and psychopharmacology: A Clinical approach. P. 36. Chicago: Yearbook Medical Publishers Inc.

DSM 4 Criteria for Major Depression

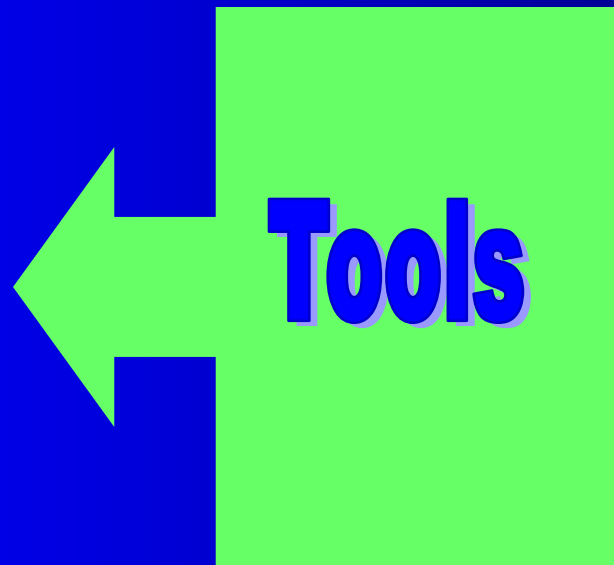
- At least 2 weeks.
- Five symptoms at least one has to be depressed mood or loss of interest.

- Decrease or increase in appetite or weight.
- Insomnia or hypersomnia.
- Psychomotor agitation or retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or inappropriate guilt.

- Decrease concentration.
- Thoughts of death or suicide.
- Functioning affected.
- Not due to substances.
- Not due to bereavement

Assessment

- Flag
- Assess
- Treat
- Stabilize
- Monitor
- Evaluate



Clock/Folstein/
MoCA

Cornell/GDS

Cohen-
Mansfield/ DOS

CAM

Other

← PARTNERS in CARE →

Montreal Cognitive Assessment (MoCA)

www.mocatest.org

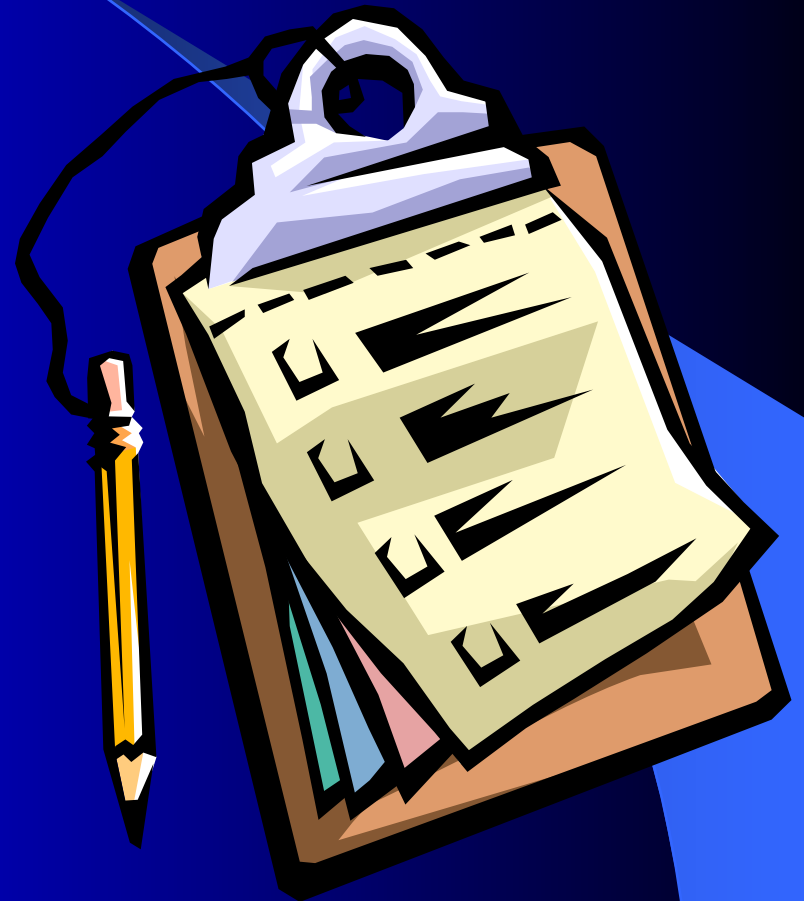
MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME : _____
 Education : _____
 Sex : _____ Date of birth : _____
 DATE : _____

VISUOSPATIAL / EXECUTIVE		Copy cube					Draw CLOCK (Ten past eleven) (3 points)			POINTS
							[] [] [] Contour Numbers Hands			
NAMING									___/3	
MEMORY	Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.	FACE	VELVET	CHURCH	DAISY	RED	No points			
	1st trial									
	2nd trial									
ATTENTION	Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [] 2 1 8 5 4 Subject has to repeat them in the backward order [] 7 4 2	___/2								
	Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors [] FBACMNAAJKLBAFAKDEAAAJAMOF AAB	___/1								
	Serial 7 subtraction starting at 100 [] 93 [] 86 [] 79 [] 72 [] 65 4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt	___/3								
LANGUAGE	Repeat : I only know that John is the one to help today. [] The cat always hid under the couch when dogs were in the room. []	___/2								
	Fluency / Name maximum number of words in one minute that begin with the letter F [] _____ (N ≥ 11 words)	___/1								
ABSTRACTION	Similarity between e.g. banana - orange = fruit [] train - bicycle [] watch - ruler	___/2								
DELAYED RECALL	Has to recall words WITH NO CUE	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUE recall only			
	Category cue	[]	[]	[]	[]	[]				
	Multiple choice cue									
ORIENTATION	[] Date [] Month [] Year [] Day [] Place [] City	___/6								
© Z.Nasreddine MD Version 7.0		www.mocatest.org		Normal ≥ 26 / 30		TOTAL			___/30	
Administered by: _____					Add 1 point if ≤ 12 yr edu					

Assessment Guides

- Folstein Mini-Mental State Exam (MMSE)
- Clock Test
- Montreal Cognitive Assessment (MoCA)
- Trails B
- Cornell Scale for Depression
- Geriatric Depression Scale
- SIG E CAPS
- Confusion Assessment Method (CAM)
- Michigan Alcohol Screening Test-G *
- Frontal Behavioural Inventory
- Dementia Observation System
- Cohen-Mansfield Agitation Inventory
- Caregiver Burden Screens **
- Other ...





Referrals to the GMHOP

Bob

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Schizophrenia

- Living with schizophrenia for decades can exact a heavy toll on education, career, relationships, health (high risk of physical illness)
- Women predominate those diagnosed with schizophrenia mid-late life
- Disease is characterized by unique pattern of symptom groupings:

Symptom grouping

- Psychosis (Positive)
- Negative symptoms
- Disorganization of thinking
- Deficits of cognition

Manifestation

- Hallucinations, delusions
- Apathy, lack of emotion, poor or non-existent social functioning
- Loose associations
- difficulty understanding, poor concentration, poor memory, difficulty expressing thoughts, difficulty integrating thoughts, feelings and behavior

DSM 4 Criteria for Schizophrenia

Two (2) or more of the following, each present for a significant portion of time during a 1 month period:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behaviour
- Negative Symptoms
- Social/occupational dysfunction
- Continuous signs of the disturbance persist for at least 6 months
- Exclude schizo-affective disorder, mood disorder, substance abuse, and general medical condition

Psychosis of AD vs Schizophrenia in Elderly Adults

Distinguishing between the two when evaluating older patients with psychotic symptoms (Jeste DV & Finkel, SI, 2000)

	Psychosis of Alzheimer Disease	Schizophrenia
Prevalence	Occurs in as many as 50% of AD persons	Occurs in less than 1% of the general population
Typical hallucinations	Visual	Auditory
Typical delusions	Not bizarre	Bizarre and complex
Misidentification of caregivers	Occurs frequently	Occurs rarely
Past history of psychosis	rare	Very common
Eventual recovery from psychosis	frequent	Uncommon
Length of maintenance on anti-psychotic medication	Brief	Long term
Recommended psychosocial treatment	Environmental modification, behaviour therapy and work with caregivers	Cognitive behavioural therapy, social skills training

Early-Onset Late-Onset and Very Late Onset Schizophrenia

A closer look at defining characteristics (Palmer, BW, Mc Clure, PS & Jeset DV, 2001)

	Early Onset Schizophrenia	Late-Onset Schizophrenia	Very late Onset Schizophrenia
Age of Onset	Younger than 40	Middle age (40-65)	Late life (older than 65)
Predominant Gender	Men	Women	Women
Paranoid subtype	Common	Very Common	Common
Negative Symptoms	Marked	Present	Absent
Thought Disorder	Present	Present	Absent
Progressive Cognitive Deterioration	Absent	Absent	Marked
Family History of Schizophrenia	Present	Present	Absent
Risk of Tardive Dyskensia (involuntary movements of mouth, face, limbs, trunk caused by long term anti-psychotic use)	Present	Present	Marked

Schizophrenia and the Elderly

The challenge for clinicians is to **distinguish between** cognitive impairments that are part of the life long course of schizophrenia from those in progressive illnesses such as Alzheimer Disease.

There is evidence that positive symptoms (delusions and hallucinations) become **less severe** with age and negative symptoms and cognitive deficits become more severe (Karim et al., 2005).

A review of studies found that the most powerful **predictors of poor outcome** were:

- Social isolation
- Long duration of episode
- Past history of psychiatric treatment
- Being unmarried
- Behavior disorders in childhood (Dale & Burns, 1997)

Cognitive impairment has been found to be the most important single **predictor of poor outcome** in chronic schizophrenia (Karim et al., 2005).

There is some evidence that coping skills in those with schizophrenia improve with age and as people become more involved in their own care and as their family members learn to “*speak the language of the illness*” (Karim et al., 2005).

Change, Challenges & Opportunities



- Is the change in Mary due to another cause
 - Infection, diabetes, other disease
- Diagnostic challenge to discriminate underlying factors of ↓CI
- Opportunity for >understanding, targeted treatment and proactive links/monitoring & intervention

Geriatric Mental Health Assessment A Framework

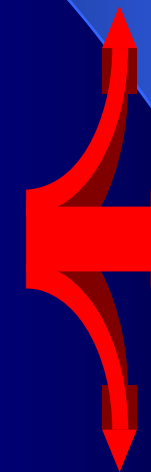
- Clinical Assessment
 - HPI, psychiatric history, medical history, investigations, medications, family and personal history, functional ability and safety, MSE
- Capability to understand & appreciate
- Assessment of values, wishes, strengths, usual decision-making
- Influences on Clinicians

Development
of Plan

Immediate

Short-term

Long-term



Service and Support Possibilities

Bob

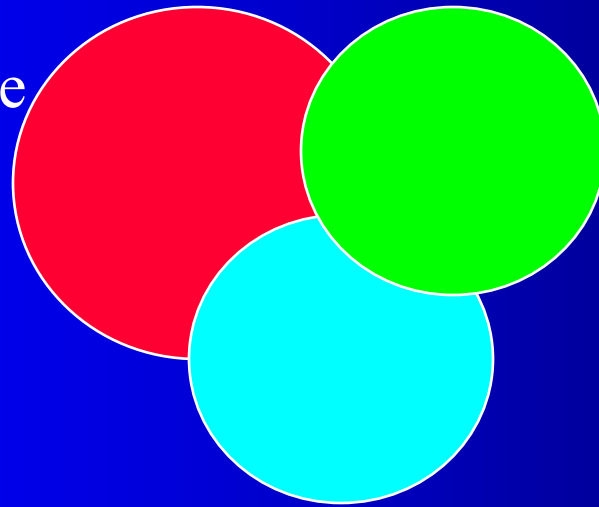
- Crisis plan
- Medication and counseling
- Monitor physical health e.g. pain management
- Structure & activation
- Monitor mood, cognition & IADLs, ADLs
- Temp stop driving
- Explore alcohol use

Mary

- Crisis plan
- Medication review and strategies for intake
 - Inpt or community?
- Physical assessment
- In-home community support for medication, ADLs, caregiver relief
- Caregiver education and support
- Structure and activation
- Long term planning

GMHOPs as a System Resource

Clinical
Shared Care



Learning and
Development-
Capacity Building

Partnerships, Linkages and
Community Development

Partnerships and Linkages



- Mental Health Programs
 - Crisis, inpatient, general adult
- Community Care Access Centre
- Telephone Reassurance
- Volunteer Visiting
- Meals on Wheels, Wheels to Meals
- Alzheimer Society
- Supportive Housing
- Retirement and Lodging Homes
- Addiction Programs
- Regional Police and EMS Services
- Justice Services
- Social and recreational programs
- **Adult Day Programs**
- **Long Term Care Homes**

“We must never let “*good enough*” be good enough.

We must be relentless in our pursuit of finding ways to improve our systems”



See you back at 1:00pm

