The world is changing
Global ageing trends

Percentage of population over 60 years

2012

2050

World Health Organisation: http://www.who.int/world_health_day/2012
Outline

• Our ageing world
• Ageing, mental health and health services
• A broader view of Health
• A broader view of Integrated Care
• Evidence for Integrated Care
• Safety
• Conclusions
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Global ageing trends

Population over 60 years (millions)

Global ageing trends

Population ≥ 80 years (millions)

Percentage of population ≥60 by region

% of population ≥ 60

Distribution of population ≥60 by region

% of total ≥60 population

Percentage of population ≥80 by region

% of population ≥ 80

United Nations, Department of Economic and Social Affairs, Population Division
Distribution of population ≥80 by region

% of total ≥80 population

Global ageing

• Population ageing is global and occurring fastest in low and middle income countries
• By 2050 80% of older people (60+) will live in low-middle income countries
• Speed of this change is increasing
  – France - 100 yrs for percentage of 65+ to increase from 7% to 14%
  – Brazil, China, Thailand will experience a similar shift in just over 20 yrs

Japan: No longer Asia's fastest-aging nation?

Nyskha Chandran | by nyshka
Thursday, 22 Jan 2015 | 5:48 PM ET

Taiwan is set to surpass Japan as Asia's fastest aging nation this decade, experts warn, as a dwindling labor force poses a structural challenge to economic growth.

"An imminent issue Taiwan will face is population aging, it seems the aging trend is unfolding faster than forecasted," Societe Generale economist Claire Huang said in a recent note.
Outline

• An ageing world

• **Ageing, mental health and health services**

• A broader view of Health

• A broader view of Integrated Care

• Evidence for Integrated Care

• Safety

• Conclusions
Estimated prevalence (millions) of mod/severe disability for people 60+

- Depression prevalence (millions)
  - High income: 6.2
  - Low/middle income: 7.0
- Dementia prevalence (millions)
  - High income: 0.5
  - Low/middle income: 4.8

World Health Organisation: http://www.who.int/world_health_day/2012
## Mental health in elderly

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mental illness, non-dementia</td>
<td>20%</td>
</tr>
<tr>
<td>Depression</td>
<td>5-10%</td>
</tr>
<tr>
<td>Major depression</td>
<td>1-5%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>6-12%</td>
</tr>
<tr>
<td>Psychotic syndromes</td>
<td>1.7-4.2%</td>
</tr>
</tbody>
</table>

Skoog I Can J Psychiatry. 2011;56(7):387–397
Numbers of people with dementia by world region (2015-2050)

- **Europe Western:** 14.8
- **Europe Central and Eastern:** 14.3
- **North America:** 4.7
- **Latin America & Caribbean:** 18.1
- **Africa and the Middle East:** 15.8
- **Asia (high income):** 4.0
- **Asia (low and middle income):** 58.3
- **World:** 131.5

Slide courtesy of Martin Prince
Psychiatric services
Psychiatric services globally

- Policy & infrastructure
  - 1 in 3 countries has no mental health policy
  - In African region this rises to nearly 1 in 2
  - Most countries have some disability benefits
    - 22% of all countries & 45% of low income countries exclude mentally ill people
- Mental health services
  - Community based in 52% Low income vs. 97% high income countries

High vs low income countries

- Global spending on MH is < US$2 pp/ year
  - In LMIC, <25c pp/ year
- MH legislation 92% Hi, 36% Low income
- Consumer organisations n ≤ 2x in hi income
- Outpatient services 58x more prevalent

WHO Mental Health Atlas, 2011
Number of psychiatrists by income

- Large differences in psychiatrists and other MH workers by income group
- Almost half world have <1 psychiatrist/100,000
- Median rate of psychiatrists per 100,000
  - Low: 0.05
  - Low-Middle: 0.54
  - Upper-Middle: 2.03
  - High: 8.59

Total mental health workers per 100,000

Income Group
(World Bank definition of economies)

## Median expenditure on medicines (US$) per 100,000

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Mood Stabilisers</th>
<th>Antipsychotics</th>
<th>Anxiolytics</th>
<th>Antidepressants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>320</td>
<td>400</td>
<td>320</td>
<td>200</td>
</tr>
<tr>
<td>Lower-Middle</td>
<td>2,720</td>
<td>11,480</td>
<td>4,500</td>
<td>10,140</td>
</tr>
<tr>
<td>Upper-Middle</td>
<td>3,480</td>
<td>16,350</td>
<td>5,740</td>
<td>15,120</td>
</tr>
<tr>
<td>High</td>
<td>71,420</td>
<td>1,099,800</td>
<td>315,560</td>
<td>796,880</td>
</tr>
<tr>
<td>World</td>
<td>41,870</td>
<td>247,920</td>
<td>94,880</td>
<td>310,110</td>
</tr>
</tbody>
</table>

## Health spending in LMIC

<table>
<thead>
<tr>
<th>Country</th>
<th>% GDP spent on health</th>
<th>% Health budget spent on mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>5.9</td>
<td>?</td>
</tr>
<tr>
<td>India</td>
<td>4.2</td>
<td>0.06</td>
</tr>
<tr>
<td>Nepal</td>
<td>5.3</td>
<td>0.17</td>
</tr>
<tr>
<td>Nigeria</td>
<td>5.0</td>
<td>0.40</td>
</tr>
<tr>
<td>South Africa</td>
<td>8.4</td>
<td>4.50</td>
</tr>
<tr>
<td>Uganda</td>
<td>7.3</td>
<td>0.44</td>
</tr>
</tbody>
</table>
Outline

• An ageing world
• Ageing, mental health and health services
• **A broader view of Health**
  • A broader view of Integrated Care
  • Evidence for Integrated Care
• Safety
• Conclusions
• WHO definition (1948): Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity
What determines health?

Socio-environmental

Interpersonal

Biological

Psychological

Translating dementia research into practice
What determines mental health?

Socio-Environmental
- Role
- Accommodation
- Finances
- Supports

Biological
- Genes
- CV disease
- Neoplasia
- Drug effects
- Infection

Interpersonal
- Relationships
- Family dynamics

Psychological
- Internal schema
- Development
- Negative cognitions
- Grief
Biological
- Genes
- CV disease
- Neoplasia
- Drug effects
- Infection

Psychological
- Internal schema
- Development
- Negative cognitions
- Grief

Interpersonal
- Relationships
- Family dynamics
Social-Environmental

- Role, occupation, leisure
- Meaning in life and meaningful activities
- Age friendly environments
- Access to health care: geographic, financial
- Employment opportunities
- Housing
- Transport
- Spiritual
Interpersonal: Loneliness

- U.S. nationally representative sample of 2101 adults aged 50+ 2002 to 2008
- Feelings of loneliness associated with increased mortality over 6-year period
- Loneliness ↔ depression
- Loneliness (independent of depression) is a risk factor for morbidity and mortality

Y Luo 2012 Social Science & Medicine; 2012: 74; 907–914
Social relations and depression

• Review of 51 studies
• Significant protective effects of perceived emotional support, perceived instrumental support, and large, diverse social networks.
• Little evidence if social connectedness or negative interactions are related to depression

Santini ZI J Aff Dis 2014
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Integrated care

WHO definition

- Integrated care ... brings together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion

- Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency

Integrate with whom?

- Medical
- Nursing
- Social work
- OT
- Psychology

- Physiotherapy
- Aged care
- Community services
- Community groups
  - e.g. TADA
- Housing
- Transport
- Legal & financial
The missing piece?

- The person must be at the centre of the service
Settings for integrated care

- Population
  - eg prevention
- Primary care
- Community health
- Nursing homes
- Acute hospital
- Hospice
Vertical & Horizontal integration

- Vertical integration

- Horizontal integration

Vertical integration
- linking different levels of care
- primary, secondary and tertiary care
Vertical Integration

• Hospital/ hospice
  – Admission procedures
  – During admission eg GP with specialist team
  – Discharge handover
    • To GP
    • To nursing home
• Office practice
- **Population**
- **Community**
- **Hospital**
- **Hospice**
- **Long-term**

- **Prevention**
- **Life-course**

- **Person**
- **Family**
- **Primary health**
- **Secondary health**
- **Tertiary health**
- **Context**
Horizontal integration
- linking similar levels of care
- multi-professional or multi-disciplinary teams

How does integration occur?
- Is it organic?
- Does it need a coordinator?
Integrated care in dementia

- Person with dementia
- Family
- Primary care
- Outpatient services
- Memory clinic
- Specialist services
- Community nurses
- Aged care workers
- Day care centre
- Respite care
- Alzheimer’s Associations e.g. TADA
- Legal, financial
- Home help
- Professional brokers
Who is conductor of the orchestra?

- Patient
- Consumer Directed Care
- Family carer
- Professional coordinator
- Key worker
- GP
- Community nurse
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Health care of the elderly

• Combined geriatric and psychogeriatric ward
  – eg delirium vs mania
  – BPSD vs acute medical illness
  – Comorbidity is common

• Arie T, *Health Care of the Elderly*, 1981
Acute hospital and consultation-liaison psychogeriatrics

- Review of benefits of acute hospital service delivery in old age psychiatry → 46 studies
- Only RCTs were C/L and delirium prevention
- Evidence for interventions to prevent delirium, reduce costs and length of stay (LOS) in medical wards (level II outcomes)
- Decreased length of stay with PG C/L service

1 Draper B, Low LF, Int Psychogoger, 2005
2 Desan PH et al, Psychosomatics 2011; 52:513–520
Collaborative Care Management for Depression in Primary Care

- **IMPACT Intervention**
  - Education for patient and pt preferences
  - Depression manager (nurse/psychologist)
  - Team psychiatrist and liaison PCP

- Treatment plan → pt’s PCP (a’depressants and/or Problem-Solving Therapy for 1st Care)

- Pleasurable events

- Additional health & social services as needed

Unutzer J, JAMA; 2002;288:2836-2845
Collaborative Care Management for Depression in Primary Care

- At 12 m, Intervention compared to UC groups
  - >50% ↓ depressive Sx: 45% v 19% in UC
  - ↑ depression Rx, ↓ depression severity
  - ↑ satisfaction with care
  - less functional impairment
  - better QOL

- Cost effective?

Unutzer J, JAMA; 2002;288:2836-2845
Integrated Model of Psychosocial Rehab & Health Care Mx for Older Adults w SMI

• ≈ 2% of older adults in US have serious mental illness (SMI eg Sz, BAD, Refractory Depression, Psychosis) & persistent functional impairment requiring ongoing supportive services
  – ↓ social function, impaired living skills
  – more physical health problems, poorer health practices, poorer access to services

• Helping Older People Experience Success HOPES
  – Psychosocial rehabilitation +
  – Health care Mx & health promotion by nurse

Pratt SI et al, Am J Psychiat Rehab 2008;11:1, 41-60
Helping Older People Experience Success

- HOPES program (n = 183), RCT
- ITT significant improvements for older adults in HOPES vs usual care in:
  - social skill
  - psychosocial and community functioning
  - negative symptoms
  - self-efficacy
- Effect sizes moderate (.37–.63)

Meuser KT, Pratt SI et al J Consulting and Clinical Psychology, 2010;78:561-573
Integrated IMR for Psychiatric and General Medical Illness for Adults Aged 50 or Older With Serious Mental Illness

- 8 month program combining training in self-Mx for psychiatric and general medical illness, including embedded nurse care management
- improving self-management of psychiatric illness and diabetes
- → fewer psychiatric or general medical hospitalisations

Barthels SJ et al *Psychiatric Services* 2014;65:330–337
Integrated care in depression


Integrated care in depression

• Robust evidence of collaborative care in
  – improving depression Sx (SMD =0.34)
  – adherence to treatment (OR=2.22)
  – response to treatment (OR=1.78)
  – remission of symptoms (OR=1.74)
  – recovery from symptoms (OR=1.75)
  – quality of life/functional status (SMD=0.12)
  – satisfaction with care (SMD=0.39)

Integrated Care for Older Adults

- Care Team = elderly care physician, community nurse, and social worker. (Netherlands)
- Training for team and GPs eg multimorbidity, polypharmacy (3 days)
- Social workers and district nurses received specific training (8 days)
- Teams received monthly on-the-job coaching
- The Elderly Care Team provided comprehensive, patient-centred, proactive, and preventive care and support

Uittenbroek RJ et al. J GEN INTERN 2016, pp1-8
Integrated Care for Older Adults

- Team met monthly at participating GP practices
- Intensity and focus of care & support at patient level differed by risk profile
- Pts with “Frail” and “Complex care needs” received individual care and support from a case manager, a social worker, and community nurse
- Home visits 1-2x/ month
- Review medical files, medications, and self-reported levels of frailty & case complexity 1/year
- Self-management support and prevention
  - eg community meetings, newsletters, healthy lifestyles abilities
Integrated Care for Older Adults

- Small self-reported improvement in quality of care as reflected (ES $d = 0.19$).
- Most improvement for the “Frail” and “Complex care needs” risk profiles
- No signif advantages for “Robust” risk profile
- Professionals rated Quality and Integration of Care as significantly improved
- Effects most evident for older adults receiving case management

Uittenbroek RJ et al J Gen Intern Med 2016, pp1-8
Integrated care data publications

• Few papers, complex studies, results positive but not overwhelming
• Less funding for health services research
Examples of integrated models in dementia
The Memory Clinic

- 20 or 30 service
- Multidisciplinary assessment and care planning
- Vertical integration with primary care and community services
- Limited evidence of superiority
- Very comprehensive assessment, good planning, post-diagnostic services
- Excellent training, research base

The Dementia CGs’ Program

- Ten day program for patients and CGs
- Intensive, comprehensive, multidisciplinary
- Family session – Psychogeriatrician
- Psychological counselling - Psychologist
- Information, education – S/W
- Skills training – OT
- Social Services – Welfare Officer
- Physical care – Registered nurse
- Involvement of patient & extended family

¹Brodaty and Gresham (1989), Brit Med J; 299: 1375-1379
Dementia Carers Program: survival at home over 7 years

- Decreased CG psychological morbidity 12m
- Person with dementia stayed at home longer
- Saved money

Brodaty & Gresham BMJ 1989
Brodaty+ Int Psychoger 2001
Brodaty et al IJGP 1997

(Odds ratio 5.03, 1.73-14.7)
Tailored Activity Program

- In-home training for CGs to manage BPSD
- 4-month (8 sessions) occupational therapy intervention tailored based on neuropsychological and functional testing
- Fewer problem behaviours (specifically for shadowing and repetitive questioning)
- Greater participant activity engagement
- Caregiver benefits (fewer hours on duty)
- Cost-effective

CAPABLE trial

- Community Aging in Place - Advancing Better Living for Elders: pt-directed, team-based intervention 5-month in-home services by an outreach worker, an Occupational Therapist, a Registered Nurse, and a handyman
- Community-dwelling older adults with functional limitations, dually Medicare & Medicaid eligible
CAPABLE trial

• 79% of participants improved their self-care
• On average, the number of self-care tasks that participants had difficulty with were halved
• Decrease in depressive symptoms similar to that of anti-depressant medication

Szanton et al. JAGS 2015
Regular Early Assessment Post-Discharge (REAP) (Cordato N et al)

- Prospective RCT, NH residents recently discharged from hospital
- REAP intervention: monthly coordinated specialist geriatrician and nurse practitioner assessments within residents’ NHs for 6m
- 43 NH residents → REAP intervention (n=22) or control (n=21) groups
REAP intervention

• REAP group had almost 2/3 fewer hospital readmissions (p=0.03; Cohen’s d=0.73) and half as many ED visits than controls

• Total costs were 50% lower in the REAP intervention group

Cordato N et al, in preparation
Prevention of dementia

- Physical exercise → Exercise physiology
- Cognitive exercise → Neuropsychologist
- Diet → Dietitian
- Smoking → Quitline
- Blood pressure, cholesterol → GP
- Diabetes → diet, exercise, GP, endocrinology
- Midlife obesity → diet, exercise, GP
Prevention of dementia

- Physical exercise $\rightarrow$ Exercise physiology
- Cognitive exercise $\rightarrow$ Neuropsychologist
- Diet $\rightarrow$ Dietician
- Smoking $\rightarrow$ Quitline
- Blood pressure, cholesterol $\rightarrow$ GP
- Diabetes $\rightarrow$ diet, exercise, GP, endocrinology
- Midlife obesity $\rightarrow$ diet, exercise, GP
Prevention of dementia?

- Hearing loss
- Socialisation
- Oral health
Hearing loss
Hearing loss and incident dementia

- Lin 2011   RR 2.32 (1.32-4.07)
- Gallacher 2012  RR 2.67 (1.38-5.17)
- Deal 2016    RR 1.55 (1.10-2.19)
- Peripheral hearing loss associated with significant risk for dementia
- Follow-ups 9, 12 and 17 years
Correcting hearing loss

• No evidence that correcting hearing loss prevents cognitive decline
• Mechanism unclear
  – Less cognitive stimulation
  – Less socialisation
Brain health & social isolation
Socialisation and dementia

• The association of dementia risk with less socialisation is of same magnitude as dementia associations w. late-life depression (OR: 1.85); & AD with physical activity (1.82)
• What is mechanism?: Use it or lose it? Less stress? Better health behaviours? Better access to health services?

Social network and AD pathology

- 89 older people, no known dementia, Rush Memory and Aging Project, annual evaluation → autopsy
- Social network size – no of people they saw monthly, Cognitive function, AD pathology - amyloid load and tangles (density of PHFs)
- More disease pathology, worse cognition
  (Bennett DA, Lancet Neurology 2006)
Social network and AD pathology

- Social network size modified association between pathology and cognition function (p 0.016)
- Similar modifying association w. tangles (p 0.001)
- Social networks may modify relationship of AD pathology to level of cognitive function
- Controlled for cognitive, physical, and social activities, depression, chronic diseases

(Bennett DA, Lancet Neurology 2006)
Oral health
Oral health diseases

- Diseases highly prevalent in elderly
- Associated with greater physical frailty, medical comorbidities, polypharmacy, cognitive impairment & functional dependence
- Lead to pain, impaired general health and reduced quality of life, affect, mood, behaviour, self-esteem and social interaction
- Associated with adverse health outcomes e.g. cardiovascular & respiratory disease, diabetes

Improving oral health

• Educational interventions for nurses &/or residents, focusing on knowledge and skills related to oral health management have potential to improve residents’ oral health

• Two reviews this year – lack of evidence

Seigel E et al, J Nutr, Aging & Health 2016
Albrecht M et al. Cochrane review 2016
Improving oral health

- Pilot study (n = 8), 12 hours training nurses
- Dentist, oral hygienist, nurses, resident, family
- Assessed saliva, pH, devised daily oral health care plans, supervised over 10 weeks
- Compliance with oral health care plans was very high and untrained nurses were able to follow the multiple scheduled interventions

Deutsch A et al, submitted
Integrated care in LMIC
Cuba’s public health system

- ≈ 500 polyclinics integrate range of services under one roof each serving 30k-60k people
- Social, environmental, economic and medical
- Clinics in factories, schools, etc
- Visit every family ≥ 1/yr
- Cross-government policies, cooperation
- Impressive life expectancy and low infant mortality

Thanavampalle Mandal, India

- Deprived rural area, Total Health
- Mobile clinics → basic health care to 104 villages
- Targeted care for chronic diseases
- Health education, yoga classes
- Food, nutrition for pregnant mothers, children
- Water, sanitation infrastructure

Future of integrated care

- Use of IT
- Participatory health
- E-health records
- Registries
- Revolution in e-technology
  – Wearable monitoring devices
- Precision medicine
  - Omics revolution – genomics, etc
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Safety

- Drugs
- Medical abuse, neglect
- Safety vs autonomy
The bio-psycho-social framework

**Socio-environmental**
- Adequate space
- Lighting
- Secure grounds
- Appropriate stimulation

**Biological**
- Intrinsic
  - Genes
- Extrinsic
  - Sensory impairments
  - Pain
- Chemical changes
- Frontal pathology
- Basic needs (hunger, thirst)
- Medication

**Psychological**
- Humour therapy
- Music, singing
- Volunteers
- Intergenerational engagement

**Interpersonal**
- Individualised activities
- Engagement
- Pleasurable events
- Person-centred engagement

**Interpersonal**
- Volunteers
- Intergenerational engagement

**Psychological**
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  - Genes
- Extrinsic
  - Sensory impairments
  - Pain
- Chemical changes
- Frontal pathology
- Basic needs (hunger, thirst)
- Medication
Altered Pharmacokinetics In Elderly *Start low …..go slow*

- Increased bioavailability, lower plasma albumin and less protein binding
- decreased clearance by liver and kidney
- fat stores usually increased, elimination of lipid-soluble drugs slower
- overall: higher steady-state plasma levels for any given dose in older patient
Drug Rx in older people

• Multiple drugs - multiple interactions
• Compliance eg forgetful patient, practical difficulties (vision, arthritis)
• ↑ susceptibility to side effects
  - orthostatic hypotension, falls, # femur
  - glaucoma, prostatism, cardiac disease
• Anticholinergic load
• Informed consent
  – 6.5% in one study of NHs and 1% in HALT
Antipsychotics for BPSD

- Meta-analysis from 13 studies:\n  - Mean ES in Rx = 0.45
  - Mean ES in placebo = 0.32

- Side effects:
  - Sedation
  - Dizziness
  - Falls
  - Orthostatic hypotension
  - Anticholinergic
  - Weight gain
  - Stroke\(^2\)
  - Death\(^3\)

1 Yury C & Fisher J, Psychotherapy and Psychosomatics 2007
3 Schneider L, 2005
Continuing vs stopping anti-psychotics in dementia patients?

Ballard 2008

- 12 months RCT, continuous use vs placebo
- For most AD pts, withdrawal → no detriment
- Continuers: ↓ verbal fluency (p<.002); ↑mortality
- Subgroup, pts with more severe symptoms might benefit from continued Rx

Devanand 2012

- Pts who responded for psychosis or agitation
- Discontinuation → higher rate of relapse
The HALT study

Halting Antipsychotic use in Long-Term care

• A single arm 12-month longitudinal study in 24 aged care facilities of at least 60 beds in urban and rural NSW
• Resident participants assessed ≈ 4 weeks & 1 week prior to deprescribing
• Re-assessed 3, 6 and 12 months later
HALT Protocol

Education:

• GPs (academic detailing)
• Train the trainer model, 3-day workshop for nurse champions
• Champions trained residential care staff
• Community Pharmacists engaged with dispensing pharmacies
Resident flow

- 150 completed pre-baseline (10 ineligible/ 1 revoked)
- 134 completed baseline (4 died, 2 dropped out)
- 133 started deprescribing
- 125 completed deprescribing
- 133 completed 3 months follow-up
- 117 completed 6 months follow-up
- 104 completed 12 months follow-up
Represcribing antipsychotics

**Regular antipsychotics**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
<td>14/125</td>
<td>11.2%</td>
</tr>
<tr>
<td>3-6 months</td>
<td>10/114</td>
<td>8.8%</td>
</tr>
<tr>
<td>6-12 months</td>
<td>3/100</td>
<td>2.4%</td>
</tr>
<tr>
<td>Total</td>
<td>27/125</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

98/133 in trial or 74% successfully deprescribed
Neuropsychiatric symptoms

Mean Total NPI over time

- T1 = Pre-B
- T2 = Baseline
- T3 = +3m
- T4 = +6m
- T5 = +12m
Agitation (CMAI)
Other safety issues

• Abuse
  – Physical, psychological
  – Neglect
  – Medical abuse – neglect, restraint

• Falls, gait

• Driving

• Autonomy vs protection
Conclusions

• Ageing population world, esp. Asia
• High prevalence psychiatric disorders
• Mental health workforce globally
  – Psychiatry in general
  – Old Age Psychiatry
• Training in Old Age Psychiatry
• Old age mental disorders – not linear
• Integrate Our Challenge
Conclusions

- Good psychogeriatric care must be integrated
- Integration must include the patient and the family as partners if not directors
- Integration is vertical, horizontal and circular!
- Better integration should reduce costs
- Key components are structure, organisation and communication
- Safety must always be considered
At IPA, we bring the full spectrum of geriatric mental health to light...
...all issues, all disciplines, all around the world!
Thank you

www.cheba.unsw.edu.au

www.dementiaresearch.org.au

Thanks to Karolina Krysinska, Liesbeth Aerts and Katrin Seeher

h.brodaty@unsw.edu.au