Older Persons Mental Health

Thursday 16 May 2024

Education Centre, TPCH

Dr Caroline Clancy | GPLO – Mental Health, Metro North Health & Brisbane North PHN

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Metro North Health | Queensland Government

Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.

Program

6.00pm	**Dinner and Networking**
6.30pm	**GPLO update & Healthy Ageing Team service overview** Dr Caroline Clancy | GPLO Leisa Tocknell | Manager, Healthy Ageing Team, Brisbane North PHN
6.50pm	**Mental Health in the Older Person** Dr Conor O'Luanaigh | Consultant Old Age Psychiatrist, Deputy Director Continuing Mental Health Services, TPCH
7.20pm	**Could it be Dementia? Alzheimer's disease update** Dr Chrys Pulle | Staff Specialist Geriatrician & Director Internal Medicine Dementia Research Unit, TPCH; Chair of Dementia Trials Australia
7.50pm	**Case study analysis** Dr Conor O'Luanaigh & Dr Chrys Pulle
8.20pm	**Q&A and close**

Activity ID: 836048

RACGP CPD

Educational Activities	Measuring Outcomes	Reviewing Performance
1.5 hours	00 hours	0.5 hours

your care navigator

Essential information | 24/7 support | Healthy ageing needs | About | Search

Support for healthy ageing

Your home, your health, your way.
Connecting you to the support services you need in the North Brisbane and Moreton Bay region.

With the help of health professionals, carers and older people in the region, we identified the following key needs for healthy ageing.

What if I'm outside of the North Brisbane and Moreton Bay region?

Dementia

Information, services and resources providing support for people living with dementia, carers and health professionals

Find support

Physical health

Information, services and resources to keep you active and healthy

Find support

Mental health

Information, services and resources to support you with general and specific mental health and wellbeing needs

Find support

Social connection

Community programs and resources to keep you socially engaged

Find support

Nutrition

Information, programs and resources to help you prepare and eat healthy, happy foods

Find support

Digital skills

Resources supporting you to stay up to date with the technology that will help you navigate services and stay connected

Find support

SOCIAL HEALTH CONNECT
AT FOOTPRINTS COMMUNITY

Helping you to manage your social health and improve connection!

footprints community
BETTER TOGETHER

WHAT IS SOCIAL HEALTH CONNECT?

Social Health Connect supports people aged 18+ in the Kilcoy and Caboolture regions who are experiencing social isolation and loneliness.

The program will help you address barriers that may impact on your ability to improve your social health, community participation and connection.

Barriers include:

- Finances
- Housing
- Transport
- Physical health barriers
- Mental health barriers
- Limited social supports and networks
- Language barriers.

Interpreter

You can ask for an interpreter.
It is FREE.

SOCIAL HEALTH CONNECT TEAM

The Footprints Social Health Connect team is:

- Highly skilled
- Professional
- Warm.

The Footprints Social Health Connect team:

- Supports people in the local Kilcoy and Caboolture regions with practical guidance for an engaging and meaningful life
- Supports people to develop person centred goals plans
- Supports people to build independence and resilience to improve and manage their health and wellbeing
- Links people to local groups, activities or social opportunities that align with their individual interests
- Links people to services that can support them to address barriers to social participation e.g. financial supports, carer supports, My Aged Care and transport supports
- Provides an easily accessible referral pathway and strongly encourage referrals from General Practitioners and Health Professionals.

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HEALTHPATHWAYS

Depression in Older Adults

See also:

- Antidepressants for Older Adults.
- Depression in Adults

Red flags

- Suicide risk
- Hopelessness
- Self-neglect e.g., reduced oral intake

Background

About depression in older adults

Assessment

Practice point

Suicide risk

Always assess risk of suicide in depression.

1. Consider risk factors for depression in older adults and arrange screening accordingly.
2. Ask depression screening questions. If the answer to any of the questions is yes, then further assessment is indicated to see if major or clinical depression is present.
3. Consider using depression scales:

Medications for Dementia

Cognitive Impairment and Dementia

This pathway is about gradual or sub-acute onset of cognitive impairment. See also: Behavioural and Psychological Symptoms of Dementia (BPSD) | Delirium

Dementia Support Services

See also Respite Services

Behavioural and Psychological Symptoms of Dementia (BPSD)

5 Minute Neurological Exam for Patients with Possible Dementia

Behavioural Disturbance in Older Adults

Cognitive Impairment and Dementia

This pathway is about gradual or sub-acute onset of cognitive impairment. See also:

- Behavioural and Psychological Symptoms of Dementia (BPSD)
- Delirium

Background

About cognitive impairment and dementia

Assessment

1. Screen patients at moderate risk for cognitive impairment and dementia, or who have experienced a change in their cognition. Population screening is not recommended. [1]
2. Take a collateral history from both the patient and an informant who has been documenting the onset, progression, fluctuations, and time frame of symptoms. Consider providing a Short IQCODE for family to complete.
3. Take a careful history covering the Five Domains of Dementia [3]:
    1. Cognitive decline is usually the first symptom to appear. This may be more noticeable to family members or carers, so collateral history is vital.
    2. Functional decline that is a result of cognitive decline.
    3. Psychiatric symptoms
    4. Behaviour changes which represent a change from how the person would previously behave.
    5. Physical changes – more likely to be seen in later stages.

GP Psychiatry Support Line

ENQUIRIES

1800 16 17 18

Monday - Friday
Excluding public holidays

7am to 7pm (AEST)
Australian Eastern Standard Time

Advice is available regarding all age brackets of patients, including children and young adults

This is NOT a triage or referral service

This is NOT an emergency service
In case of emergency, please ring 000

This service is for GPs only

Email Enquiries:
admin@gpsupport.org.au

BOOK A SESSION ONLINE

My Mental Health Services **Map**

Access to a greater range of mental health services in North Brisbane and Moreton Bay

Access an expanded range of mental health, alcohol and other drug, and suicide prevention services commissioned by Brisbane North PHN. Most services below can be accessed using the My Mental Health Services eReferral. There is no cost to the client. Some services have eligibility and exclusion criteria.

For acute/hospital presentations, please contact **1300 MH Call - 1300 64 2255** or if an emergecy, contact **000**.

	Low intensity			Mild/moderate intensity		Moderate intensity	High intensity		Crisis services
SERVICE	**IUIH Social and Emotional Wellbeing (Institute for Urban Indigenous Health) 1800 254 354** Provides an integrated social health model, including primary mental health services, alcohol and other drug treatment services and suicide prevention services								
	Richmond Fellowship Queensland - New Access 1300 159 795	**World Wellness Group - Problem Management Plus** 07 3333 2100	**Peach Tree Perinatal Wellness - Sunshine Parenting Program** 0468 449 430	**headspace** Caboolture 07 5428 1599 Nundah 07 3370 3900 Redcliffe 07 3897 1897 Indooroopilly 07 3157 1555 Strathpine 07 3465 3000	**Change Futures: Psychology in Aged Care Wellbeing Program** 07 3857 0847	**Brisbane MIND** 1800 752 235 Healthcare/pension card required	**ASHA** 07 3283 8769	**Mental Health Hubs** **Communify:** The Recovery and Discovery Centre, inner north Brisbane 07 3510 2777 **Neami:** The Living and Learning Centre, Strathpine 07 3493 6780 **Stride Hub:** Caboolture 07 4593 0500	**Safe Spaces** **Communify** 07 3004 0101 **Neami** 07 3493 6710 **Stride** Caboolture 07 5232 1590 **Redcliffe Youth Space** 07 435 827 817
AGE	**12 years and older**	**18 years and older**		**12 - 25 years**	**65 years and older**	**All ages including children 0 - 11**	**12 - 25 years**	**18 years and older**	**All ages**
DESCRIPTION	Supports people to tackle day-to-day pressures and set practical goals (6 session coaching programs designed by Beyond Blue).	For people who identify as culturally and linguistically diverse to help manage stress and adverse situations (Group, phone and face-to-face sessions).	Mothers of infants aged 0-12 months experiencing mild postnatal depression and/or anxiety symptoms (6-week group program).	Provides early intervention mental health services and assistance in promoting young peoples' wellbeing.	For residents of aged care facilities. Provides group and individual support to people over the age of 65.	Short term psychological therapy for those who cannot access the universal service *Better Access*. Eligible clients must identify in one of the following under serviced groups: • children 0-11 years • culturally and linguistically diverse communities • LGBTIQ+ communities • people who have experienced trauma or abuse • people at risk of suicide • residents of Bribie Island and Kilcoy	Provides mobile outreach support to vulnerable young people in the Moreton Bay north region. Please contact the service directly for referral pathways.	Delivering integrated clinical and non-clinical services for people with severe mental illness. Service types: • care coordination (including mental health nursing) • psychological group therapy • one-on-one psychosocial support.	Safe Spaces provides people experiencing emotional distress, friendly and welcoming support, in a safe environment, as an alternative to emergency departments. Safe Spaces open from 5.00 pm –9.00 pm on weekdays and participate in a coordinated calendar of opening hours amongst the 4 spaces, over the weekends.
REFERRAL	GPs can complete a referral to these services through the My Mental Health Services eReferral via the rediCASE GP Integrator. Referrals can also be made by the My Mental Health Services Referral eLink available at phnbnws.redicase.com.au/#!/referral/create. Self-referrals can be made directly with the provider or by contacting Head to Health Service Navigators on 1800 595 212. For further information about referral pathways, please visit www.mymentalhealth.org.au or contact the Head to Health Service Navigators.								No referral required.

metronorth.health.qld.gov.au

Queensland Government | Virtual Ward
Metro North Health

Search...

About the Virtual Ward | Health professionals | COVID-19 | Monkeypox

Home » Health professionals

Health Professionals

If you are a Queensland Health employee, please refer to the Metro North Virtual Ward Intranet Page (QH network only) available on QHEPS to access the internal referral form.

The Metro North Virtual Ward (VW) is an additional telehealth service that complements the current Virtual Emergency Department, Covid Virtual Ward, and Hospital-in-the-home services available within the Metro North Health region. Given the success of the virtual care model, the Metro North VW can now admit and manage patients with conditions other than COVID.

The VW can assist GP's by providing an inpatient equivalent admission for eligible patients.

On admission patients will be provided with team-based care via regular phone calls and/or video consults. The ward is based at the Royal Brisbane and Women's Hospital, from 0700 to 1930, 7 days a week, with overnight access to medical support. The patients will have access to medical, nursing, pharmacy, and social work support.

What can Virtual Ward provide?

Monitoring determined by patient's primary illness and co-morbidities.

Where required, patients will be provided with the following monitoring equipment free of charge and delivered to their home:

- Oxygen saturation probe
- Blood pressure monitor
- Thermometer
- Facilitation of relevant investigations i.e.- Blood tests, medical imaging including MRI, ECG, Echo
- Facilitation of Specialist opinion
- Pharmacy review
- Referral to Allied Health

Which patients are eligible for admission to the VW?

Patients who require a brief period of monitoring and treatment which would otherwise require them to stay in hospital.

Patients at risk of deterioration, which if detected early, can be managed at home with the aim that hospital admission be avoided.

Patients where daily review in between planned GP review would be helpful.

Examples of conditions that may be suitable for admission include:

- COVID
- community acquired pneumonia, infective exacerbations of asthma and other chronic obstructive airway conditions
- infections including cellulitis, osteomyelitis, UTI
- severe hypertension without neurological red flags for short term monitoring, medication adjustment
- hyperglycaemia without ketoacidosis for short term monitoring, medication adjustment.
- electrolyte abnormalities requiring monitoring
- supratherapeutic INR for short term monitoring
- serendipitous lumps to expedite investigation and Specialist review.

How to refer your patients to VW?

Phone **07 3074 2109** in hours (0800-1700hrs) or phone RBWH switchboard out of hours on **07 36468111** and ask to speak to the Virtual Ward Consultant.

If your patient is accepted, please complete the VW referral form (available as Best Practice template or PDF) and email MN-VirtualWardAdmin@health.qld.gov.au.

How to monitor your patients progress?

You can review your patient's daily progress via the Health Provider Portal/ Viewer.

A discharge summary will be sent at the end of the admission.

If you would like to contribute further information at any stage about your patient, please phone the Virtual Ward Consultant on 07 3074 2109.

Metro North Virtual Emergency Department

Factsheet for General Practitioners

Metro North Health has developed a Virtual Emergency Department (MN Virtual ED) service to provide Queensland General Practitioners (GPs) with access to specialist emergency medicine advice, by telephone or video conferencing.

The MN Virtual ED consultant can assist you with advice, support and access to HHS services:

- This service is available to GPs across Queensland and can involve either a consultation about a patient or a joint consultation with the patient.
- Advice and support are available for any patient at any age with any condition.
- MN Virtual ED consultants can help you to manage your patient in the community by:
  - Providing specialist advice for ongoing management
  - Facilitating access to HHS based community services such a community nurses and HITH
  - Facilitating access to an outpatient specialist review.
- MN Virtual ED consultants can provide specialist advice to assist you in accessing inpatient services
  - Telephone advice from sub specialists
  - Urgent outpatient "Rapid Access Clinic" review
  - Direct review and admission by subspecialty teams for "known patients" bypassing the ED
  - Facilitated access to ED and other services when required.
- MN Virtual ED has access to existing online clinical information systems such as 'The Viewer'.

NOTE:

- **For life-threatening emergencies call triple zero (000) and request Ambulance Services.**

  The Virtual ED is not intended to be used for patients experiencing a life-threatening emergency.

How to access our Virtual ED service:

Call 1300 847 833 (1300 VIRTED)

Monday to Sunday 8 a.m. – 10 p.m.

Virtual ED is aware that your time is precious.

You will be connected to an experienced emergency nurse. **Please have the following information ready:**

1. Your name and phone number
2. The patient's name, date of birth, hospital number (if available) and brief description of the problem
3. The practice phone number

The experienced ED nurse will be accessing previous hospital information on your patient while you consult with the medical staff.

The MN Virtual ED consultant will speak with you immediately whenever they are available. During busy times they will call you back as soon as possible. MN Virtual ED recommends you ask your patient to sit in the waiting room for a short period until both medical practitioners are available.

- If you request a face-to-face consultation and you have a computer with a camera or a smartphone, the Virtual ED team will send you an appointment link.

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GP & QAS Virtual Emergency Department

Open: 7 days (8am-10pm Monday to Sunday)

Patients should use our Patient Virtual ED service.

METRO NORTH VIRTUAL ED

- While the consultation is taking place, MN Virtual ED staff may contact your practice for further patient details if required, to complete the registration process.
- During the consultation a management plan will be agreed and later documented by the MN Virtual ED staff. These notes will be uploaded into the 'The Viewer' which is freely available for GPs who have registered for access.
- The following day, you will be contacted via email for feedback about the service and the patient will be contacted if necessary.

The MN Virtual ED service is currently operating from **Monday to Sunday 8 a.m. – 10 p.m.**

You will be notified of any extended or changed operating hours via the Brisbane North Primary Health Network GP Bulletin. Please make sure you have subscribed: https://brisbanenorthphn.org.au/news-events/newsletters

The MN Virtual ED service can be used for*:

- Asymptomatic hypertension
- Deep Vein Thrombosis (DVT)
- Diabetic patient with high BSLs
- Fever in children
- Low back pain
- Minor sports injuries incl minor head injuries
- Resolved TIA
- Soft tissue infections/cellulitis
- Urinary tract infection
- Vasovagal syncope
- Vertigo
- Viral Gastroenteritis
- Viral illness (including COVID-19)
- Wounds

*Please note this is not an exhaustive list, these are examples of some conditions where our Virtual ED consultants can assist. If you are unsure whether MN Virtual ED can assist, please feel free to call and speak with one of friendly staff.

Further information is available on the MN Virtual ED webpage Virtual Emergency Department (ED) - Metro North Health

Metro North Clinical Advice Line

Connecting GPs directly to Metro North specialties.

The Metro North Health Clinical Advice Line connects local GPs to specialist advice from hospital and community clinicians. There are two pathways:

1. Phone line
2. Written request for advice.

The range of adult specialities currently available to support patient care in the community includes:
(This list will expand over time so keep coming back for the latest advice services available)

1. Phone advice

Specialty	Catchment*	Exclusion Criteria
General Medicine and Rapid Access Clinic	TPCH	• Excludes Cardiology, Heart Failure or Respiratory Conditions • Excludes Residential Aged Care residents (Call RADAR - 1300 072 327)
Haematology	Metro North	• Excludes Patients under 16 years
Heart Failure Service and Rapid Access Clinic	Redcliffe TPCH	• Excludes New heart failure patients • Excludes Patients seen by another heart failure service
Inflammatory Bowel Disease	Redcliffe Caboolture	• Excludes Patient anticipated to require surgical input
Metro North Persistent Pain Centre/ Tess Cramond Pain and Research Centre Clinical advice available Tuesday – Friday 9:00am – 12:00pm	Metro North Central Queensland Central West Darling Downs West Moreton	• Excludes patients under 16 years • Excludes outside catchment
Metro North Virtual Ward	Metro North Central West Norfolk Island	• Excludes patients under 16 years • Excludes Residential Aged Care residents (Call RADAR - 1300 072 327)
Healthy Ageing Assessment Rehabilitation Team (HAART)	Kallangur Satellite Hospital	Patients may be ineligible if: • Currently accessing equivalent services in public or private sector • Reside outside of catchment area • Medically unstable requiring inpatient assessment or currently an inpatient • Only require therapy for maintenance of chronic condition • Residential aged care facility residents
Rapid Access to Community Care	Metro North	• Excludes Patients under 16years • Excludes Acute mental health, alcohol or drugs related. • Excludes Residential Aged Care Facility Residents (Call RADAR - 1300 072 327)
Sexual Health	Metro North	• Excludes Patients under 14 years
Sleep Disorders	TPCH Caboolture Redcliffe	• Excludes Patients seen by another Sleep Unit
Termination of Pregnancy	Metro North	• Excludes Outside Metro North referral catchment
Vestibular Rapid Access Service	TPCH	• Out of catchment for TPCH

Catchment** – **where the patient would usually be referred for a face to face specialist outpatient clinic appointment.

Note: If you think your patient is new to any of these services on the page, please ensure your patient is aware you are seeking advice and they consent to their demographic details, including Medicare number, being provided to Metro North Health at the time of the call.

Call the Clinical Advice Line, Monday to Friday 8:30am to 4.00pm on

1800 569 099

Note: this is for GPs only and the phone line is not open to patients.

Other advice lines and services for GPs can be found in our Services contact list (PDF)

Clinical Advice Line
1800 569 099
Open Monday to Friday
8.30am – 4.00pm

Note: This is for GPs only and the phone line is not open to patients.

Want to learn more?

For more information, please call the advice line or email MNH_SpecialtyAdviceLine@health.qld.gov.au.

The team can also undertake engagement sessions with interested GPs (Virtual or Face to Face).

Request for Advice (RFA)

2. Written request for advice

GPs can seek advice via the written "request for advice" (RFA) via GP Smart Referrals (GPSR) for the specialties listed below. Details of how to send the RFA in GPSR and how the response is provided via the Request for Advice function on GPSR information sheet. (PDF)

Specialty	Catchment*	Exclusion Criteria
General Medicine	TPCH	• Cardiology, Heart Failure or Respiratory Conditions • Residential Aged Care residents (Call RADAR)
Metro North Persistent Pain Centre/ Tess Cramond Pain and Research Centre	Metro North Central Queensland Central West Darling Downs West Moreton	• Excludes patients under 16 years • Excludes outside catchment
Paediatric Medicine	Redcliffe	• Out of catchment for Redcliffe
Rheumatology	Redcliffe	• Out of catchment for Redcliffe
Urology	RBWH	• Out of catchment for RBWH

Catchment – where the patient would usually be referred for a face to face specialist outpatient clinic appointment.

Please do not request urgent advice via this method. If there are no in-catchment services that offer Request for Advice for your patient, the Service will show as 'Out of Catchment'. In this instance it is recommended that a referral is created to an appropriate service within catchment for the patient.

Initial Assessment and Referral Decision Support Tool (IAR-DST) training

Useful tool to complement clinical judgement when recommending mental health support

IAR-DST is a specific decision support tool that provides clinicians with an estimate of the intensity of mental health response that a person requires. This aid can assist in confirming your clinical judgment, and help ensure the person in distress is connected with the right care as soon as possible.

$300 payment available to GPs and GP registrars

GP and patient benefits

- Improve efficiency of mental health consultation
- Consistency of patient experience
- Reduce medico-legal risks
- Refer appropriately into local services

CPD points 2023

1 hour Reviewing Performance and 1 hour Educational Activities through RACGP
2 hours CPD for ACRRM

RACGP CPD 1.0 00 1.0

ACRRM CPD ACCREDITED ACTIVITY 2023-2025

Training

Brisbane North PHN offers training sessions to help general practitioners and GP Registrars understand how to use the IAR decision support tool and provide you with all the information you need to use the tool in a way that suits your practice.

Workshop 1: 30 minute self-paced webinar (pre-reading) via online learning platform
Workshop 2: 1.5 hour webinar (workshop 1 must be completed prior to workshop 2)

Register for IAR training

Register using the QR code or visit our website:
https://brisbanenorthphn.org.au/practice-support/iar

For further information, please email iar@brisbanenorthphn.org.au or phone 07 3490 3484

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Healthy Ageing in Brisbane North

Healthy Ageing

Overview

Supporting people to live and age their way in the community

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Healthy Ageing Team

Healthy Ageing Projects

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CHSP Services

Care Finder Program

Community Care Projects

Residential Aged Care Projects

Healthy@Home Aged Care Consortium

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- A collaboration of 10 service providers, four peak organisations, 3 former service providers and Brisbane North PHN as the Consortium lead/backbone organisation
- Provides entry level (Commonwealth Home Support Programme) aged care services to approximately 9,000 older Australians annually across the Brisbane North PHN region
- healthy@home also has a collaboration for impact mission to actively influence policy changes and support the broader aged care sector through a range of initiatives and projects

healthy@home

Care Finder Program

- This activity supports our PHN to establish and maintain a network of Care Finders to provide specialist and intensive assistance to help people understand and access aged care services and connect with other relevant supports in the community
- Primary target populations: people experiencing or at risk of homelessness, people identifying as LGBTIQ, Forgotten Australian or care leaver, people who are socially isolated, people from CALD communities, people with communication challenges, people living with a cognitive impairment
- Services commenced on 1 January 2023 with full services in place from 30 April 2023

For more information contact:

Anu.Manoharan@brisbanenorthphn.org.au

Community Care Projects

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Commissioning early intervention initiatives to support healthy ageing and ongoing management of chronic conditions

- Supports senior Australians to live at home for as long as possible through commissioning early intervention activities and models of care for chronic disease management that support healthy ageing and reduce pressure on local health services
- Commissioned activities include intergenerational programs, social prescribing, driving cessation program for people from CALD communities, first nations early intervention initiative

- Current project funding until 30 June 2025

Community Care Projects

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Expansion of Greater Choice for At Home Palliative Care

- Develop and implement new and innovative projects or expand and build on existing activities with a focus on improving the awareness, access and coordination of at home palliative care in our region
- Initiatives include developing a community pharmacy action plan to improve access to palliative medications, developing a disability action plan to improve access to in-home palliative services, developing training on end-of life conversations, facilitating regular Brisbane North Community Palliative Care Collaborative meetings
- Recent launch of the Living and dying well for people with disability: palliative and end of life knowledge framework
- Current project funding until 30 June 2025

For more information contact:

Caroline.Irle@brisbanenorthphn.org.au

Community Care Projects

Your Care Navigator' website

- The Your Care Navigator website increases access to local information, support and services for older people, their carers, families and their health care providers
- It is designed to empower the community to be more proactive in navigating their own healthcare
- Information topics include: dementia, physical health, mental health, social connection, nutrition and digital skills

Residential Aged Care Projects

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Enhanced out of hours support for residential aged care

- People living in residential aged care facilities can experience rapid health deterioration during the after-hours period, but immediate transfer to hospital is not always clinically necessary. This activity supports our PHN to address any awareness or utilisation issues of available local out of hours services among participating RACFs in our region.
- The intended outcome of this activity is to help reduce unnecessary hospital presentations among RACF residents Current funding until 30 June 2025

For more information contact:
Tracey.ingram@brisbanenorthphn.org.au

Residential Aged Care Projects

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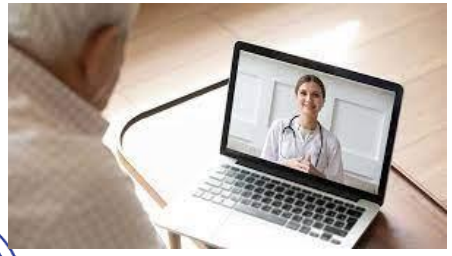
Support RACFs to increase availability and use of telehealth care for aged care residents

- This activity is to support participating Residential Aged Care Facilities (RACFs) in our PHN region to have the appropriate virtual consultation facilities and technology so their residents can access clinically appropriate telehealth care with primary health care professionals
- RACFs can access grants to purchase telehealth equipment, improve their internet connectivity and access training and support to enhance utilisation of telehealth consultations
- Current project funding until 30 June 2025



Residential Aged Care Projects

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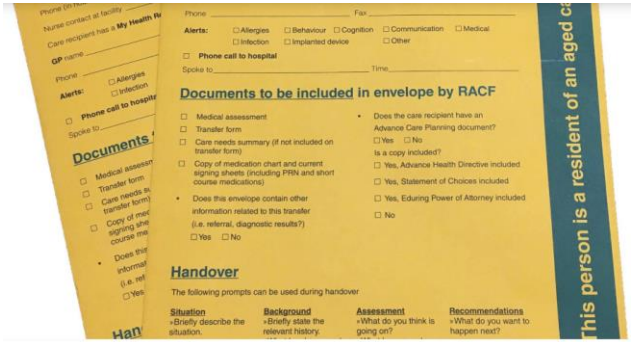
Strengthening communication during clinical handovers

- Poor or absent clinical handover can have serious consequences for older people
- The Yellow Envelope is a joint initiative of Brisbane North PHN and Metro North Hospital, developed as an intermediary tool to help in the transfer of clinical information between residential aged care facilities and hospitals
- The Yellow Envelope features prompts to ensure important information is included during the handover process

For more information contact:
Tracey.Ingram@brisbanenorthphn.org.au



Questions?

Mental Health problems in Older adults

Dr. Conor O'Luanaigh MRCPsych FRANZCP MFPOA

Consultant Old Age Psychiatrist

The Prince Charles Hospital

Mental Health Problems in Older Adults

- Depression – unipolar and bipolar, early onset and late onset
- Anxiety
- Adjustment disorders
- Psychosis – early onset and late onset
- Loneliness
- Delirium
- BPSD

Challenges

- ‘Atypical’ presentations
- Medical co-morbidities
  - Frailty
  - Falls
  - Neurodegenerative conditions
  - Pain
- Polypharmacy – interactions, side effects etc
- Ageism

Case 1

- Maria – 76 yo widow
- Presents following collapse and possible overdose
- Poor appetite
- No energy
- Reduced level of functioning
- Denies being depressed but says she is sick – thinks she might have cancer.
- Wants to go home – denies being suicidal

Late onset depression

- Not differentiated in diagnostic manuals (DSM)
- However numerous studies indicate the following
    - **Hypochondriasis**
    - **More somatic symptoms**
    - **Less dysphoria and guilt**
    - In severe episodes, catatonic symptoms and nihilistic delusions not uncommon
    - Cognitive symptoms may be more prominent (pseudo-dementia)

- sleep and appetite are harder to rely on due to other physical factors which may affect these .
- Loss of some kind can play prominent aetiological role
- Apathy – consider vascular aetiology/contribution
- If cognitive symptoms present – will need follow up post resolution of depression as may be harbinger for future dementia

Late onset depression – management

- Beware of myths – i.e too old to do therapy!
- CBT – good evidence base
- Exercise
- Socialisation
- Medications
- ECT

Medications

- Start low – give at least 3 weeks before increasing dose. After increase dose wait another 3-4 weeks before deciding on further increases
- SSRIs – usually first line however…
    - Beware of hyponatraemia – v common with all SSRIs
    - Citalopram / escitalopram – lower maximum recommended dose in older adults due to increased risk of arrhythmias.
    - Fluoxetine /fluvoxamine – interact with numerous drugs thru C450 enzymes -.eg. Warfarin; alprazolam..
- Consider mirtazapine as suitable alternative first line – start at 7.5-15mg.
    - Helps with sleep
    - Aids appetite
    - Anxiolytic
    - Less likely to cause hyponatraemia
    - Is more sedating at lower doses due to preferential binding to histamine receptors at low doses.

Medications

- Generally avoid TCAs due to anticholinergic and arrhythmia side effects.
- Venlafaxine – usually 2nd line treatment (or first if clear melancholic depression with prominent anergia.)
    - Monitor blood pressure – can cause raised BP
    - Nausea and headaches common side effects – should resolve 5 days after starting.
- **Avoid benzos – medium to long acting benzos such as diazepam and oxazepam accumulate – higher risks of falls and cognitive impairment, while shorter acting ones such as alprazolam have higher addictive quality and higher risk of acute confusion.**
- if agitation very prominent , preferable to use v low dose antipsychotic such as quetiapine 25mg or olanzapine 2.5mg.
- Refer to Old Age Psychiatrist if not responding to above…

Use of lithium

- For patients have been on lithium for most of their adult life - ++caution about ceasing.
- Monitor eGFR
- Usually preferable to reduce dose and keep eGFR >30 rather than ceasing altogether.
- Lithium levels are not reliable indicators either for effect or toxicity
- I usually aim for a level of 0.6 if manic episodes are main issue and 0.3 if depressive episodes are main issue.
- Best to seek advice from both Older Adult Psychiatrist and Nephrologist if eGFR continues to decline and it is necessary to transition to different agent.

Case 2

- Noel 78 yo presented initially with agitation and pacing. No reported sadness. But loss of interests very prominent. Reports that he is not right. Has history of hypertension and dyslipidaemia. Treated with antidepressant and low dose antipsychotic. Agitation /pacing resolved. Family report that he no longer does anything – continues to be very apathetic and generally reports non-specific anxiety.

Vascular Depression

- Increasingly recognised subset of incident late onset depression
- Associated with microvascular ischaemia (particularly subcortical and in circuits involving frontal lobe and basal ganglia)
- Apathy – prominent feature
- Cognitive impairment (executive dysfunction and reduced processing speed)
- Significant loss of function
- Poor response to conventional treatments /dosing – may require high doses/ augmentation strategies

Case 3

- Jane is 84 year old woman
- Recently transitioned to RACF due to falls and not being safe living alone
- Previously fiercely independent
- Presents low in mood
- Started on antidepressant but no better

Adjustment Disorder

- The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- These symptoms or behaviours are clinically significant, as evidenced by one or both of the following:
  - Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
  - Significant impairment in social, occupational, or other important areas of functioning.
- The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
- The symptoms do not represent normal bereavement.

Tips for diagnosis of AD

- Identifiable major stressor and context of presentation
- ++distress
- +loss /reduction in function
- **Magic wand test – removal of stressor – resolution of disorder – i.e. absence of significant cognitive distortions**

Why is Adjustment Disorder important to recognise?

- Poor response to medications

- Responds well to problem solving therapy and CBT

Case 4

- Harry – 78yo recently separated.
- Feels he cannot cope .
- Complains of low mood.
- GP started on venlafaxine and augmented with mirtazapine several weeks later after no response.
- Harry feels he can't go on and presents to ED complaining of suicidal thoughts

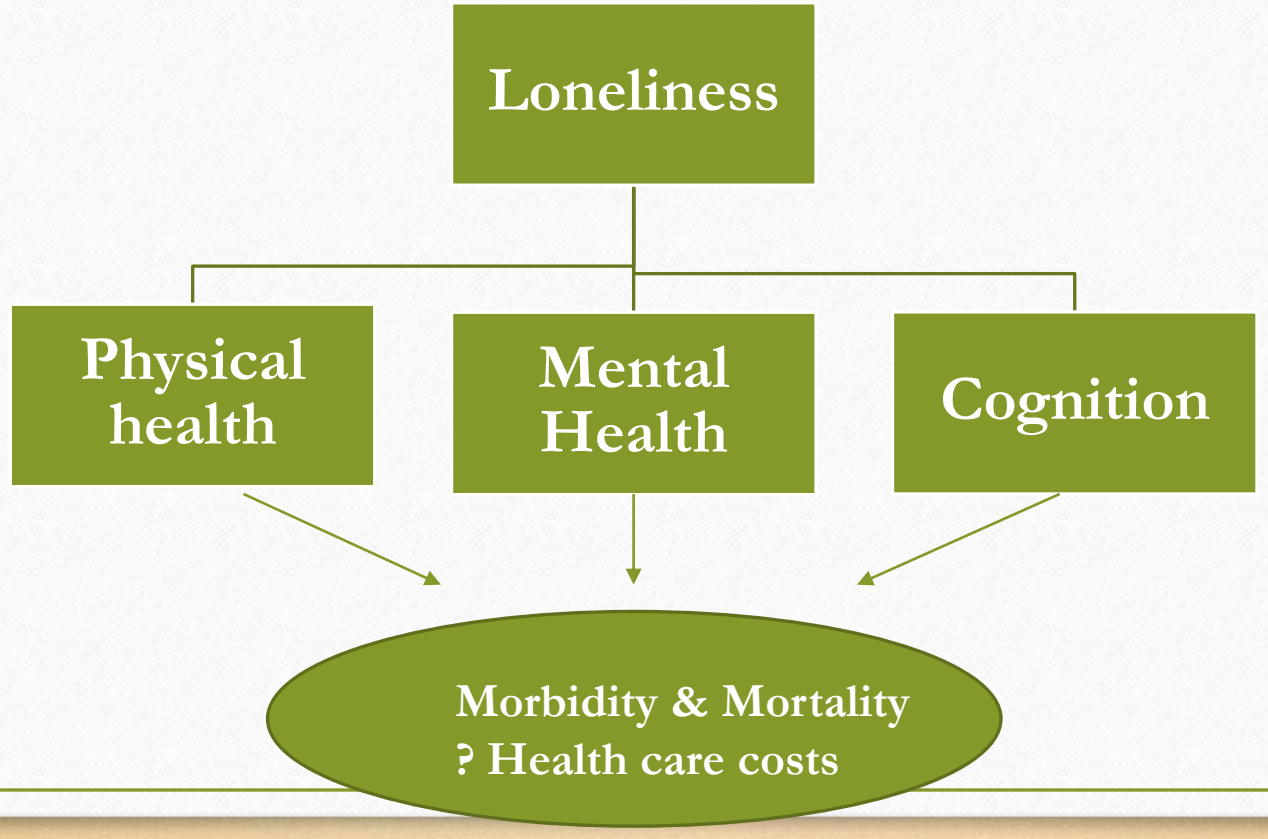
Case 5

- Frank – 90 yo widower x 10yrs. Misses wife greatly. Enjoys cards and piano. Frequently thinks of death. Has chronic pain. Says he prefers his own company. Admitted to hospital after calling ambulance informing them that he had taken overdose.

Loneliness

- 5-16% in British community studies of older adults
- > 50% of nursing home residents reported frequent loneliness
- Not the same as social isolation
- Loss of attachment figure
- Bereavement, reduced physical health , F>M (?), Pain , personality factors.

WHY IS LONELINESS A PROBLEM?



Management of loneliness

- Again like adjustment disorders – poor response to medications
- Socialisation – works for some forms of loneliness
- Pet therapy
- CBT – to address underlying cognitive distortions
- Societal factors – breakdown of neighbourhoods, ghettoization of nursing homes - ? Target for public health measures – prevention may be better than cure.

Case 6

- Anne – 87yo lives with daughter. Independent for ADLs but daughter helps her with shopping, bills, meal prep etc. Has history of hypertension, osteoarthritis, IHD. Following recent medical admission with chest pain (subsequently cleared) she became increasingly paranoid in persecutory way about her daughter – convinced she was trying to take her home and money from her. Also believed that she was trying poison her. No fluctuations in her mental state and no evidence of acute confusion. Mood otherwise ok when not in daughter's company!

Case 7

- Edith – 91 yo nursing home resident. Still quite functional. Independent for ADLs . However several month history of bizarre reports – believes the NH management are shooting laser beams through her windows – sees lights. Also has ‘overheard’ other nurses talking about a missing child that one of them has abducted. Increasingly preoccupied and agitated. Medically quite well apart from recurrent UTIs. Has poor hearing and should wear hearing aids.

Late onset psychosis

- Prevalence of around 1%
- Two spikes in terms of age of onset
  - – mid 50s (more akin to delusional disorder or paranoid schizophrenia but without the negative symptoms); Family history may be present
  - 70s onwards (very late onset) – more associated with organic changes to brain and sensory changes (reduced hearing /eyesight). Less genetic component
- Low dose antipsychotic medications (eg. risperidone 0.5mg, olanzapine 2.5mg)
- Consider pre-existing physical health/mobility/falls risk in relation to choice of antipsychotic.
- Rule out delirium – should be no significant attentional disruption

Schizophrenia

- Patients with chronic schizophrenia ‘age’ at more rapid rate
- Increased mortality and morbidity
- Increased risk of metabolic and cardiovascular diseases
- Poor health literacy
- Smoking
- Need for assertive treatment and management of medical comorbidities.

Delirium

- Acute confusional episode
- Fluctuations
- Impaired attention
- Often but not necessarily disoriented
- Visual hallucinations
- Perplexed
- Other psychotic symptoms

Delirium

- Usually multifactorial
- Often no clear cause found
- **Normal bloods and urine does not outrule delirium**
- Check medications – opiates, benzos, steroids and anticholinergics (many antihistamines, antidepressants, cardiac meds)
- Collateral from staff – look for fluctuations in mental state – usually worse at night

Delirium

- Assess attention
  - Can they follow conversation or are they losing track easily
  - Are they very distractible
  - Months of the year in reverse order
- Can be prolonged

Delirium

- Address reversible/treatable factors
- Reorientation
- Safe environment
- Avoid benzos
- If have to use medications – low dose haloperidol or risperidone is preferable (0.5mg for either of them)
- Evidence for their use is controversial – recent study indicated that worse outcomes seen with use of antipsychotic, however these were in ICU delirium patients.
- No evidence that they 'treat' the delirium, and no evidence that the delirium will resolve quicker.
- Rationale for their use is to reduce risk of harm to patient or others .
- Very important to cease antipsychotic as soon as delirium resolved.

Dementia

- >300,000 Australians living with dementia
- In next 10 yrs expected to rise by a third.
- 2050 – close to 1,000,000.
- Estimated 1.2 million Australians caring for someone with dementia
- third greatest source of health and residential aged care spending within two decades, -around 1% of GDP
- Total direct health and aged care system expenditure on people with dementia was at least $4.9 billion in 2009-10
- Australia faces a shortage of more than 150,000 paid and unpaid carers for people with dementia by 2029
- In high income countries only 20-50% of people with dementia are recognised and documented in primary care
- If dementia were a country, it would be the world's 18th largest economy

Types of Dementia (commonest)

- Cognitive impairment of *with associated* secondary functional impairment
- AD – Commonest – temporo-parietal
- VD – most tend in fact to be mixed AD/VD – Patchy memory loss with executive function prominent
- DLB – increasingly recognized -tempero-parietal, visual hallucinations, parkinsonism, fluctuations
- PDD – Parkinson's with significant executive dysfunction
- FTD – pre-senile – memory can be intact.

BPSD

- Behavioural & Psychological Sequelae of dementia

- Most frequent symptoms :
  -Personality Change
  -Anxiety
  -Depression
  -apathy
  -Behavioural problems/disturbance

BPSD

- **Behavioural symptoms include:** restlessness, physical aggression, verbal disruption, agitation, wandering, intrusiveness, culturally/socially inappropriate behaviours, sexual disinhibition, hoarding, cursing & shadowing.

- **Psychological symptoms include:** Anxiety, depressed mood, hallucinations, misidentifications & delusions

BPSD

- AD – anxiety, depression, pacing, searching behaviours, agitation,
- VD/Mixed VD/AD- depression, psychosis including visual hallucinations, aggression, disinhibiton
- DLB – prominent early visual hallucinations – often of small sized people.
- FTD – disinhibition, aggression, impulsivity

Importance of Behavioural Symptoms

- Affect up to 80% of AD patients[1]
- Associated with significant suffering for patient and caregiver[2]
- Associated with substantial financial costs[4]
- Common cause of nursing home placement[2]
- Link to hospitalisation[3]
- Correlation between behavioural disturbances and impairments in activities of daily living (ADLs)[5]

[1]Jost & Grossberg, 1996; [2]Magai et al. 1995; [3]Zubenko et al. 1992
[4]Beeri et al. 2002; [5]Mortimer et al. 1992

Presence of Behavioural Symptoms Predicts Faster Disease Progression

- Strong link between the presence of certain behavioural symptoms in AD and worsening disease.
  - Agitation, hallucinations and wandering are associated with faster cognitive deterioration and death[1–4]
  - Aggressive behaviour and sleep disturbance are predictive of faster cognitive deterioration[5]
  - Paranoia, hallucinations, activity disturbances and extrapyramidal signs are predictive of faster functional decline[5]

[1]Miller et al. 1993; [2]Moritz et al. 1997
[3]Walsh et al. 1990; [4]Lopez et al. 1999; [5]Mortimer et al. 1992

Treating BPSD - some dilemmas

- **Why (have they occurred)**
- **What (are we treating)**
- **Who (are we treating)**
- **Which intervention/s**
- **Where**
- **When not to treat**
- **When to stop**
- **Whether benefits > cost**

Assessment

- History especially collateral - ++NB
  - Triggers/recent changes
  - Environmental factors
  - Medications especially recent changes
  - Infections
  - Oral intake
  - Pain
  - Constipation
  - Diurnal patterns to behaviour?

Assessment

- **Low index of suspicion for delirium**
  - Often superimposed on dementia
  - usually multifactorial
  - Commonest – infection and medications
  - Always address these as prority
  - Remember even if bloods/urine normal still can be delirium

Assessment

- Examination
  - Difficult – look out for
  - Inattention/distracted
  - Mobility – presence of parkinsonism
  - Blood pressure
  - Head bruising /evidence of falls
  - Unrecognized sites of skin infection
  - Fluctuations
  - Responding to unseen stimuli
  - Environmental factors

Management – *Primum non nocere*

- Address reversible/treatable factors
- Address environmental factors
- Address carer factors
- Make use of liquid/dissolvable medication
- If AD/DLB – use AChEIs
- AD – Mild to Severe AChEI +memantine
- Antipsychotics – cautious use – low doses – discuss with family.
- Avoid use of benzos if possible

Non pharmacological treatments

- Evidence – studies small, loosely designed and poorly reported
- O'Connor et al. (2008) – reviewed nonpharmacological interventions under strict criteria (pts had dementia, comparison with another treatment/control, randomisation, N>10, statistical analysis, blinding).
  - 25 papers found.
  - Interventions: music, carer education, sensory enrichment, family presence, bathing techniques, aromatherapy, recreation, relaxation.

Non Pharmacological treatments

- Aromatherapy
  - Lavendar oil – 20% decrease in agitation
  - Lemon balm – 35% decrease in Cohen-Mansfield
- Bathing
  - Trigger for agitation and aggression – fear, embarrassment, discomfort, pain
  - Bed baths – 50% decrease in agitated behaviour

Medication Issues Rx BPSD:

- Any alternative non-pharm approach?
- No licenced treatment, v few RCTs
- Bolam rule: actions considered acceptable if a representative body of opinion would have acted in a like manner.
- Low dose or PRN initially
- Consent and capacity
- Covert administration

Dementia Drugs

- Donepezil, galantamine, rivastigmine and memantine
- No difference in efficacy between the three AChEIs
- Rivastigmine comes in patch format
- Aim for therapeutic dose.
- DLB – AChEIs are 1st line tx for psychosis
- No evidence for benefit in VD
- DOMINO trial - Donepezil + memantine vs. donepezil/memantine + placebo in terms of cognition and behaviour[1]
- Memantine – useful for reducing BPSD [1]

[1]**Howard et al 2012; NEJM**

Cholinesterase inhibitors

- Link b/w behavioural disturbances in pts with dementia and cholinergic abnormalities.
- Improve cognition and function in pts with AD.
- Improvement of agitation and aggression.
- Other behavioural sxs likely to respond to ChEIs – apathy, depression, aberrant motor behaviour (Gauthier et al 2010, Feldman et al 2005).

Antidepressants

- Used for depression (Cornell scale) and agitation.
- Depression - newer antidepressants better (SSRIs, SNRIs) – efficacy, side effect profile.
- Agitation – mixed results.
- Recent evidence (Banerjee et al. 2011) – sertraline and mirtazapine no better than placebo and increased SEs.
- Judicious use of antidepressants required – important to recognise depression if present.
- Sertraline and citalopram – similar efficacy to haloperidol or risperidone respectively in agitation (Gauthier et al. 2010).

Anticonvulsants

- Poor tolerability and questionable efficacy of valproate and carbamezepine (Gauthier et al. 2010).
- Valproate – conflictual results - increased risk of mortality 9.8% (Kales et al. 2012) and SEs (thrombocytopaenia, somnolence).
  - Short term efficacy and tolerability
- Carbamezepine – modest efficacy in agitation (Tariot et al 1998, Olin et al 2001).
- Limited data – Konovalov et al (2008) - further studies required, some benefit in pts with dementia, but not recommended for routine use at this stage

Analgesia

- Recent studies showing that pain is not adequately recognised, assessed and managed.
- Some evidence that treating pain may lead to decreased behavioural disturbances (agitation) in pts with dementia.
- Husebo et al (2011) – stepwise protocol in pts showed that agitation severely reduced in group receiving analgesia, and significant benefit in severity of neuropsychiatric symptoms. Paracetamol only was used in 68% of patients.

Antipsychotics

- Antipsychotics – used to treat restlessness, agitation, aggression and psychotic symptoms.
  - SEs – metabolic syndrome, cardiovascular QTc, sedation, falls.
  - Blackbox warning 2005 – sudden death, stroke
  - Risperidone – only med listed on PBS for BPSD.
  - Others – olanzapine, quetiapine, aripiprazole
    - No evidence for clozapine, paliperidone, ziprasidone
  - More evidence for AP use for aggression, rather than psychosis.

Antipsychotics

- (Kales et al 2012) investigating mortality among AP in pts with dementia:
  - Haloperidol – greatest mortality rate 20% (older, sicker, longer LOS, comorbid delirium), quetiapine has the lowest (8.8%) – but less effective.
  - All AP had increased mortality risk 1.5 times on average for the first 120 days (haloperidol – first 30 days).
  - Olanzapine, risperidone – best evidenced based options.

Antipsychotics

- Risk vs benefit
- Ethics
- Select agent based on its pharmacological profile and patient's clinical condition and ease of administration
- All antipsychotics – associated with increased morbidity and mortality ->X3 CVAEs
- DLB – quetiapine/amisulpiride
- Regular preferable to PRN
- Avoid IM

Older Persons Mental Health Team

- Metro North consists of RBWH OPMHS; TPCH OPMHS and RedCab OPMHS
- TPCH team consists of 1.4 FTE Consultant, 2x FTE registrars, 6x FTE clinicians (nurses, social workers, OT and neuropsychologist)
- Community team sees people in their home , NH and in clinics
- Inpatient unit (non-aged specific – 8 beds, but regularly we will have 12 inpatients at any one time)
- However good relations with geriatric services means that for people with significant frailty, falls risk, mobility issues admissions to medical wards can be facilitated to treat primary mental health disorder.

Referring to OPMHT

- Currently referrals go to central acute care team
- However, I would encourage addressing referrals to my name/OPMHT as can be fast-tracked to us.
- Urgent referrals (i.e need to be seen within couple of days) will generally be seen by acute care team initially and then transitioned to OPMHT once assessed and deemed to need further care.
- Less urgent/ non acute referrals will generally be seen within 4 weeks.
- focus is on recovery model and referral back to GP once stable for some months - At any one time we are managing 170+ older adults

Working together

- Keep in contact -please inform us of any changes in medical condition or treatments (medical or psychiatric).
- Happy to always talk on phone – can be contacted directly through switch.

Alzheimer's disease: A clinician’s perspective

Clinical aspects of Dementia and Current Research Trials

Dr Chrys Pulle, M.B.B.S., FRACP
Chair, Dementia Trials Australia
Clinical Director, Internal Medicine
Dementia Research Unit
The Prince Charles Hospital, Brisbane, Australia

Impact of dementia in Australia

Between

386,200 - 472,000

people are **living with dementia**

27,800

people under 65 are living with **younger onset dementia**

Predicted to be over

849,000

people living with dementia **by 2058**

5x

length of hospital stay on average than the general population

Younger onset dementia cases expected to rise to

39,000 **by 2050**

3rd

leading cause of **disease burden** in Australia

2nd

leading **cause of death** for Australians and **leading cause of death** for **women**

$3 billion

annually to manage **disease burden** of dementia

People affected by dementia in Australia

Affects

1 in 12

Australians aged **65 and over**

40%

of those aged **90 and over**

Nearly

2 in 3

of those affected are **women**

28%

of those living with dementia were born in a **non-English speaking country**

3-5x

more common among First Nations people

About Carers

Up to **337,200**

unpaid carers of people living with dementia in the community

1 in 4

carers need access to more **respite care**

1 in 2

unpaid carers are caring for their **partner**

Nearly **half** of all carers provide

60 hours of care

or more each week on average

1 in 2

carers reported **financial impacts** since since providing care

National Dementia Action Plan 2023-2033

National Dementia Action Plan

Vision

Australians understand dementia - people living with dementia and their carers have the best quality of life possible and no one walks the dementia journey alone.

Objective	Focus Area
1: Tackling stigma and discrimination	1.1 Expanding dementia awareness and reducing stigma 1.2 Creating inclusive communities and environments for people living with dementia, their carers and families
2: Minimising risk, delaying onset and progression	2.1 Risk factors for dementia are well understood 2.2 People are aware of what they can do to delay the onset and slow the progression
3: Improving dementia diagnosis and post-diagnostic care and support	3.1 Recognising and acting on early signs and symptoms 3.2 Quality and timely diagnostic services 3.3 Post diagnostic care and support
4: Improving treatment, coordination and support along the dementia journey	4.1 Quality care and ongoing support as a person's needs change 4.2 Care and support during and after hospital care 4.3 End of life and palliative care
5: Supporting people caring for those living with dementia	5.1 Recognising carers and assisting carers in their role 5.2 Increasing access to carer respite services
6: Building dementia capability in the workforce	6.1 A skilled dementia aware health and aged care workforce 6.2 Organisational culture supports quality dementia care
7: Improving dementia data and maximising the impact of dementia research and innovation	7.1 Advancing dementia research and innovation 7.2 Translating dementia research into practice 7.3 Improving dementia data and information systems 7.4 Collection of data for monitoring improvement

Principles

Dementia care is:

- **directly informed, and evaluated** by the views of people living with dementia, their carers and families
- **person centred** and focused on **quality of life**
- appropriate and **accessible to all people,** including priority population groups and people from diverse backgrounds
- **culturally safe** for First Nations peoples
- evidence based and **outcomes focused**
- coordinated, **integrated** and planned

No two dementia experiences are the same

Most people will interact with the following systems
at some time over the course of their journey

Primary care

General practitioner (GP) and allied health practitioners such as physiotherapist, psychologist and speech pathologists

Medical specialists

Geriatricians, psychogeriatricians, and neurologists are commonly involved in diagnosis and ongoing support

Aged care system

Such as transition care after a hospital stay, respite services while their carer takes a break, home services, residential care

Community/social supports

Such as the National Dementia Support Program (for counselling or peer support) or Dementia Behaviour Management Advisory Service

Pallative care

To manage the end of life process

Hospital System

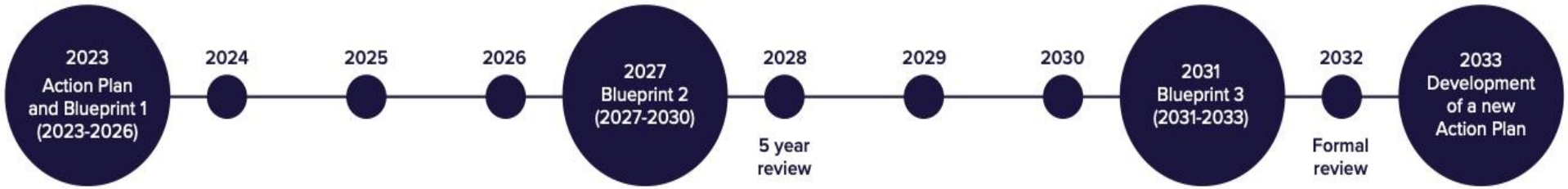
To treat or manage dementia related or other medical issues

National Dementia Action Plan 2023-2033

National Objectives

- Tackling stigma and discrimination
- Minimising risk, delay onset and progression
- Improving dementia diagnosis
- Better treatment, coordination and support along the dementia journey
- Supporting people caring for those living with dementia
- Building dementia knowledge and skills in the workforce
- Improving dementia data and maximising the impact of dementia research and innovation

Yearly Action Plan Report Cards



Principles

- **Directly informed** by the views of people living with dementia, their carers and families
- Focused on **Quality of life** for people living with dementia, their carers and families
- Appropriate for, and **accessible to, all people,** including priority population groups and people from diverse backgrounds
- **Culturally safe** for Aboriginal and Torres Strait Islander peoples
- Evidence based and **outcomes focused**
- Coordinated, **integrated** and planned

Vision

Australians understand dementia, people living with dementia and their carers have the best quality of life possible and no one walks the dementia journey alone

Key partners

Australian Government and state and territory governments
Health and aged care service providers and professionals
Researchers
Community members

Accountability

National Centre for Monitoring Dementia
World Health Organisation reporting
Annual Report Cards and 5 year formal review
Central body of Australian Government and state and territory government representatives

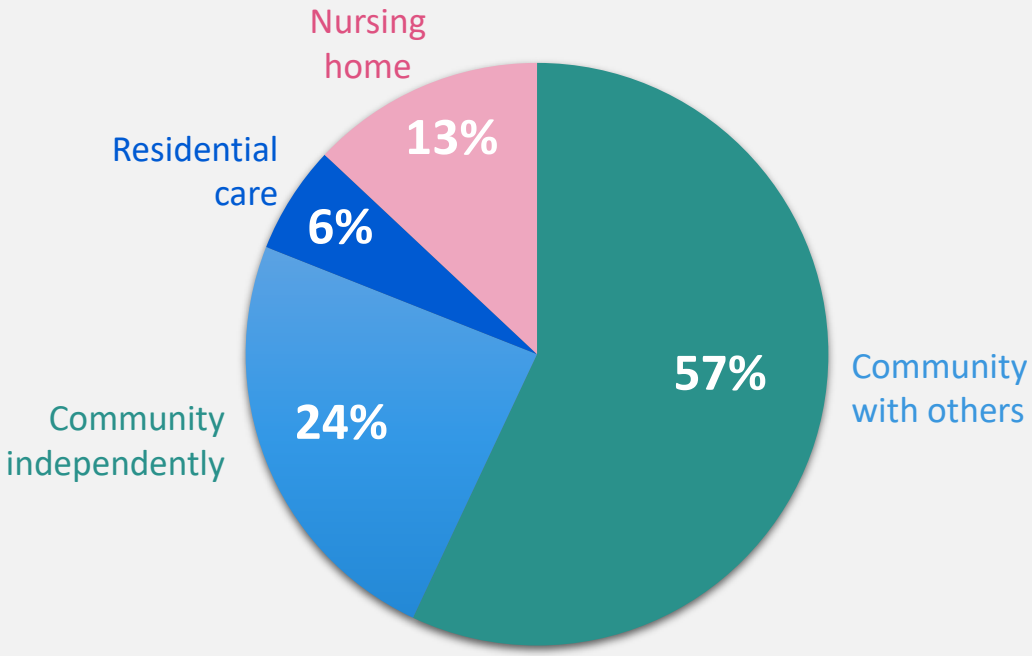
AD has a devastating impact on patients

On average, patients with AD live **~4–8 years** from dementia symptom onset, with some patients living as long as 20 years[1]

AD is a leading cause of disability, and **patients live in a state of dependence**[1]

AD is **the 6th most burdensome disease or injury in the US***,[1]

Living arrangements of people with all-cause dementia in the US[2]



*Disease or injury burden was measured in DALYs, which is the sum of the number of years of life lost due to premature mortality and the number of years lived with disability, totalled across those with the disease or injury3
AD, Alzheimer's disease; DALY, disability-adjusted life-year; US, United States
1. Alzheimer's Association. Alzheimers Dement 2022;18:700–789; 2. Lepore M et al. Living Arrangements of People with Alzheimer's Disease and Related Dementias: Implications for Services and Supports. Available at: https://aspe.hhs.gov/system/files/pdf/257966/LivingArran.pdf (accessed June 2022); 3. Disability-adjusted life years. Available at: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158 (accessed October 2022)

Cognition, function and behaviour are commonly affected by AD

Common symptoms of AD[1–3]

Memory

- Forgets new information
- Misplaces items
- Forgets people, events and eventually their own personal history

Visuospatial ability

- Difficulty planning a route
- Easily lost
- Difficulty dressing

Reasoning & judgement

- Difficulty making decisions
- Difficulty organising thoughts and thinking logically

Behavioural & psychiatric symptoms

- Depression
- Anxiety
- Irritability
- Aggression
- Delusions and/ or hallucinations
- Impulsive, inappropriate behaviour

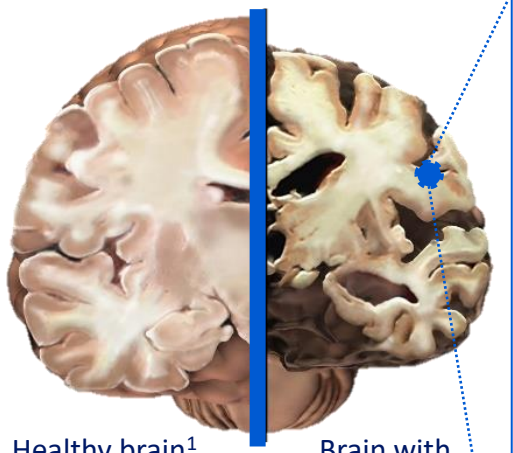
Language

- Word substitutions
- Repetition
- Increased thinning of sentences (echolalia)

AD, Alzheimer's disease

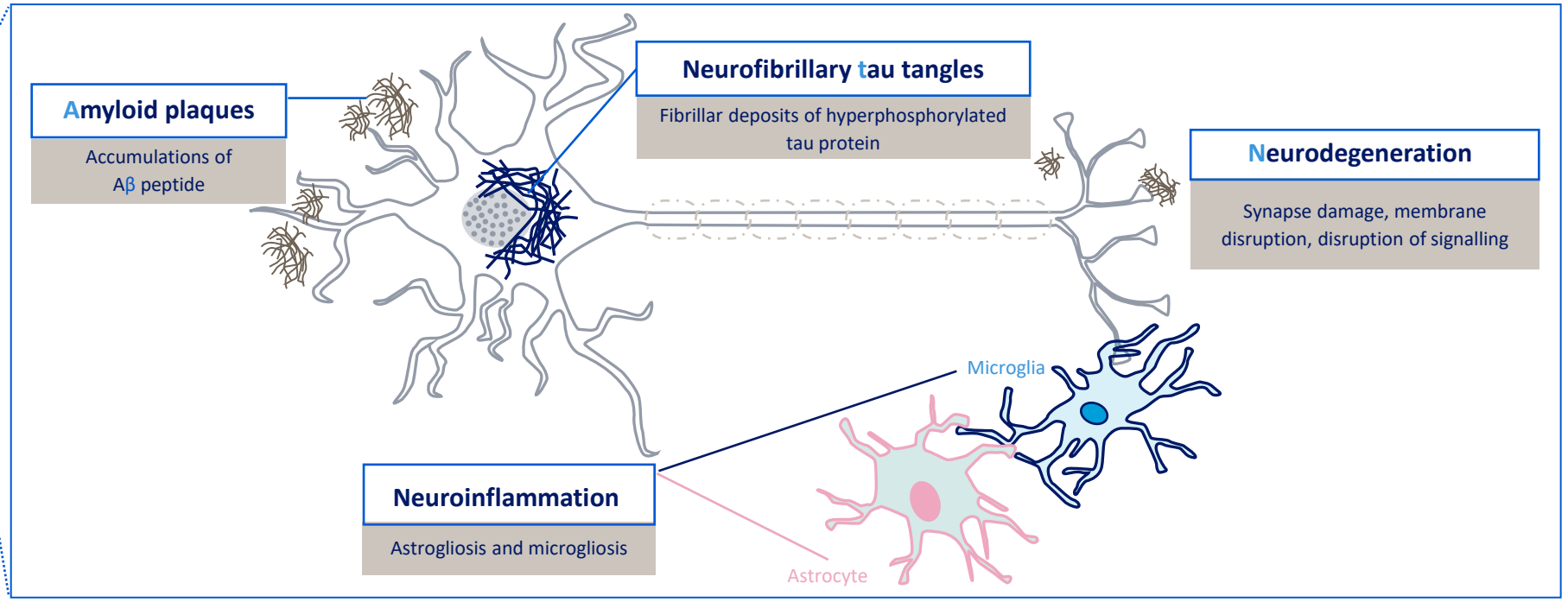
1. Long JM, Holtzman DM. Cell 2019;179:312–339; 2. Alzheimer's Research UK. Symptoms of AD. Available at: https://www.alzheimersresearchuk.org/dementia-information/types-of-dementia/alzheimers-disease/symptoms/. Accessed June 2022; 3. Alzheimer's Society. Symptoms of AD. Available at: https://www.alzheimers.org.uk/about-dementia/types-dementia/alzheimers-disease-symptoms. Accessed June 2022; 4. Ferris SH et al. Clin Interv Aging 2013;8:1007–1014

Key hallmarks of AD include the ATN: amyloid plaques, neurofibrillary tau tangles and neurodegeneration[1–4]



Healthy brain[1]

Brain with severe AD[1]

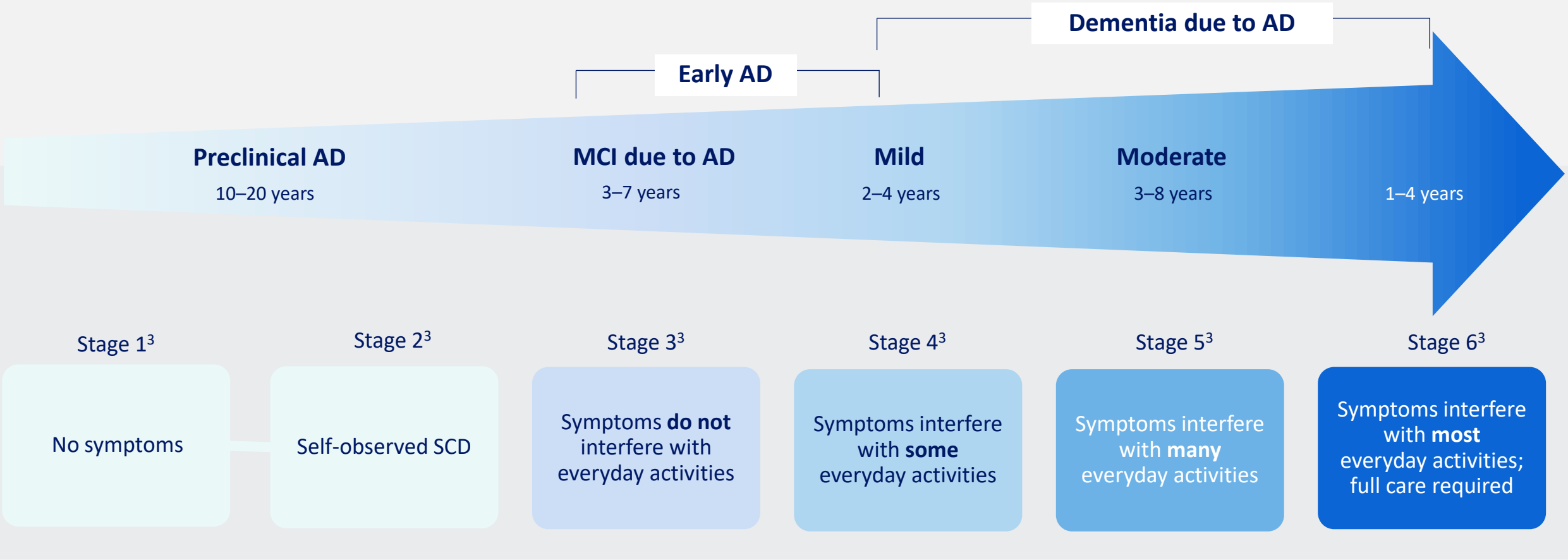


These changes begin years before the onset of symptoms, eventually leading to dementia.[2] Evidence suggests neuroinflammation occurs as a result of amyloid plaque accumulation and is seen as a relevant mechanism in the progression of the neuropathological changes in AD.[3,4]

Aß, amyloid-beta; AD, Alzheimer's disease; ATN, amyloid tau neurodegeneration

1. De Castro AKA et al. Int J Comput Intell Syst 2012;4:88–89; 2. Alzheimer's Association. Alzheimers Dement 2022;18:700–789; 3. Kinney JW et al. Alzheimers Dement (N Y). 2018;4:575–590; 4. Minter MR et al. J Neurochem 2016;136:457–474

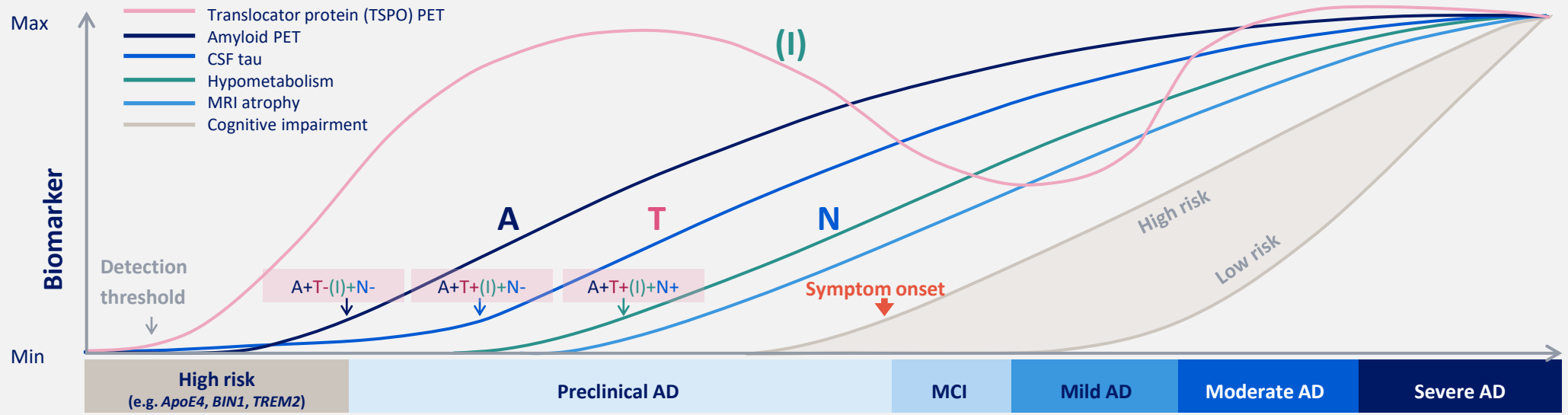
Symptoms of AD gradually develop and worsen as the disease progresses[1,2]



AD, Alzheimer's disease; MCI, mild cognitive impairment; SCD, subjective cognitive decline

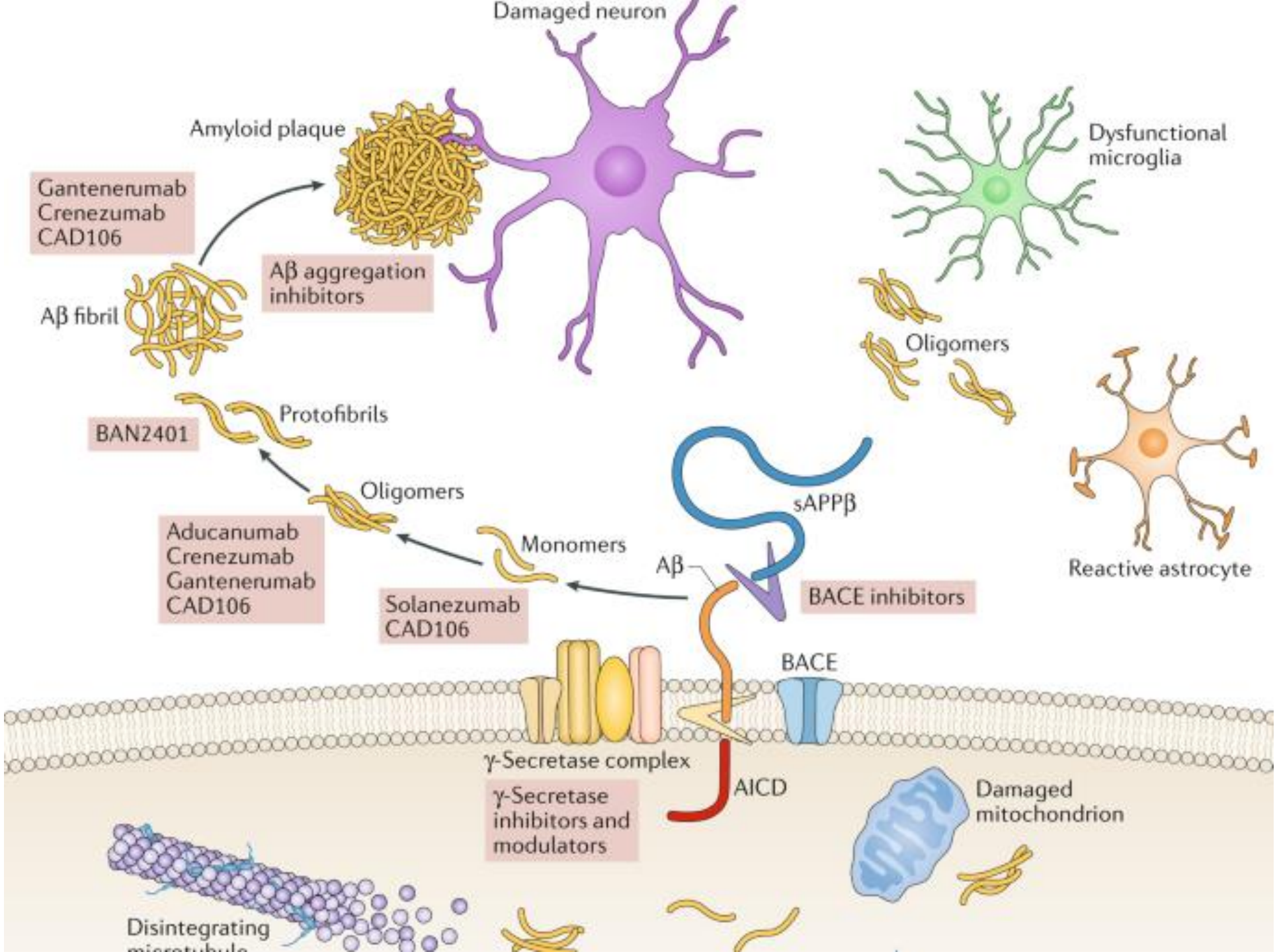
1. The Alzheimer's Association. Alzheimers Dement 2020;10.1002/alz.12068; 2. Aisen PS et al. Alzheimers Res Ther 2017;9:60; 3. Jessen S et al. Lancet Neurol 2020;19:271–278

Pathological changes may begin up to 20 years prior to clinical manifestation of AD[1,2]



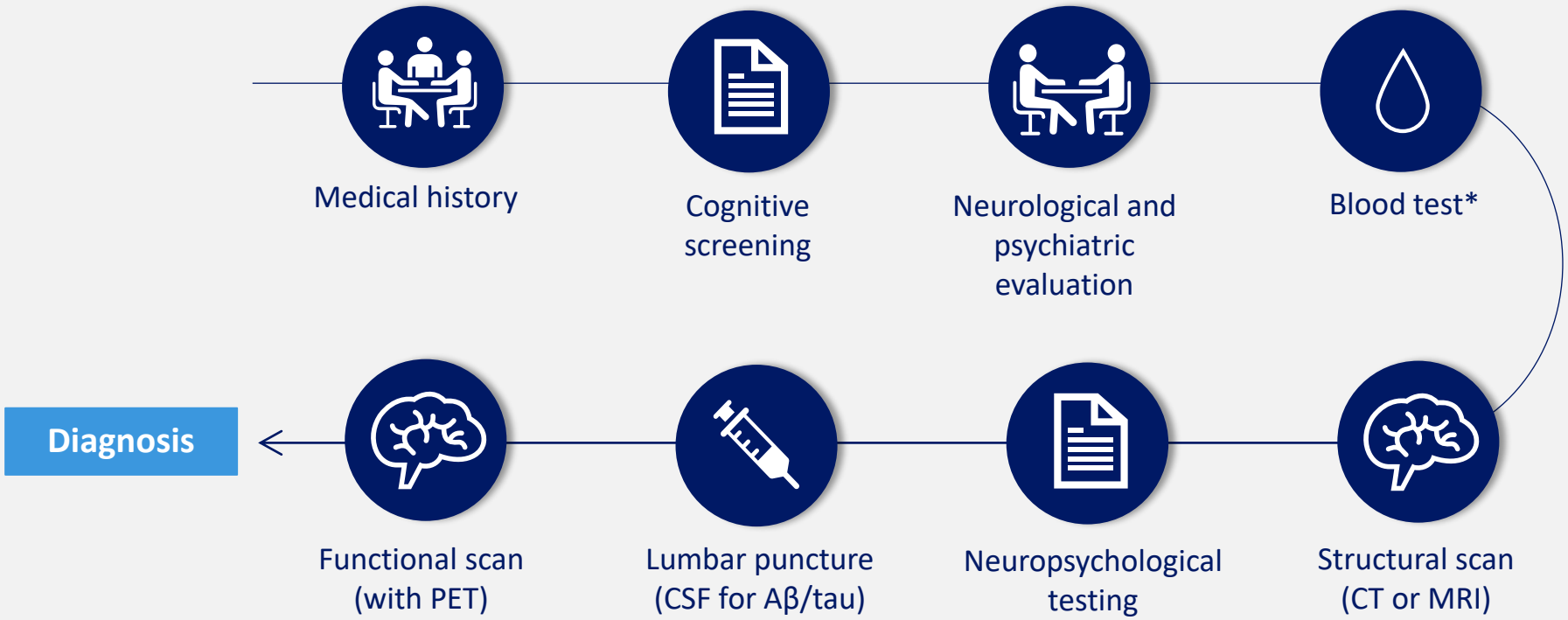
	Amyloid (A)	Tau (T)	Neuroinflammation (I)	Neurodegeneration (N)
Pathophysiology	Aβ monomer, oligomer, protofibrils and plaques	Tau monomer, oligomer, neurofibrillary tangles	Over-activated microglia	Nerve cell death, synaptic loss
Imaging biomarker	Amyloid PET (fibrillary, insoluble, Aβ plaque)	Tau PET (neurofibrillary tangles)	TSPO PET, P2X7 PET	MRI atrophy, FDG PET
CSF biology	Aβ42	p-tau181, p-tau217	sTREM2, YKL40	Total tau, NfL, neurogranin
Blood biomarker	Aβ42/40	p-tau181, p-tau217	GFAP (astroglia)	Total tau, NfL
Risk or causal genes	*ApoE4*, *PSEN1* and *PSEN2*, *ABCA7*	*BIN1*	*TREM2*, *CD33*, *PLCG2*	*CLU*, *PICALM*

Figure adapted from Jack C et al. 2018[3] and Fan Z et al. 2017[4]
Aβ, amyloid beta; AD, Alzheimer's disease; ABCA7, ATP binding cassette subfamily A member 7; ADL, activities of daily living; ApoE4, apolipoprotein E4; BIN1, bridging integrator 1; CD, cluster of differentiation; CLU, clusterin; CSF, cerebrospinal fluid; FDG, fluoro-2-deoxyglucose; GFAP, glial fibrillary acidic protein; max, maximum; min, minimum; MCI, mild cognitive impairment; MRI, magnetic resonance imaging; PET, positron emission tomography; PICALM, phosphatidylinositol binding clathrin assembly protein; PLCG2, phospholipase C gamma 2; PSEN, presenilin; p-tau181, phosphorylated tau at threonine 181; p-tau217, phosphorylated tau at threonine 217; sTREM2, soluble triggering receptor expressed on myeloid cells 2; TREM2, triggering receptor expressed on myeloid cells 2; YKL-40, Chitinase 3-like 1 glycoprotein
1. Aisen PS et al. Alzheimers Res Ther 2017;9:60; 2. Alzheimer's Association Report. Alzheimers Dement 2020;16:391–460; 3. Jack C et al. Alzheimers Dement 2018;14:535–562; 4. Fan Z et al. Brain 2017;140:792–803


Damaged neuron
Amyloid plaque
Gantenerumab
Crenezumab
CAD106
Aβ aggregation inhibitors
Aβ fibril
Dysfunctional microglia
Oligomers
Reactive astrocyte
BAN2401
Protofibrils
Oligomers
Aducanumab
Crenezumab
Gantenerumab
CAD106
Monomers
Solanezumab
CAD106
sAPPβ
Aβ
BACE inhibitors
BACE
γ-Secretase complex
γ-Secretase inhibitors and modulators
AICD
Damaged mitochondrion
Disintegrating microtubule

Patient Journey Experience

The diagnosis of AD is challenging and relies on several steps[1,2]



Generally, in clinical practice, clinical assessment is the predominant way to diagnose AD[2]

**Blood test may be used to exclude aetiologies, such as thyroid hypofunction, vitamin-B deficiencies, certain tumour types and structural changes in the brain vascular pathology*
Aβ, amyloid beta; AD, Alzheimer's disease; CSF, cerebrospinal fluid; CT, computed tomography; MRI, magnetic resonance imaging; PET, positron emission tomography
1. The Alzheimer's Association. Alzheimers Dement 2020;10.1002/alz.12068; 2. Lane CA et al. Eur J Neurol 2018;25:59–70

The Alzheimer's disease patient journey in Australia

MCI due to AD: 0–2 yrs
Mild: 0–3 yrs
Moderate & severe: Up to 7 yrs

Time from initial symptoms to first diagnosis can take 0-5 years

1–6 months

3, 6–9, 12 months

3-18 months

Watch and wait if MCI/prodromal or mild/early (Px/Cx choice)

Caregiver

Behavioural change leads to referral to GP

HCP appointment made

Symptoms are thought to be part of normal aging
- Px/Cx denial
- Memory Issues
- Mood swings
- Confusion
- Loss of interest in normal activities
- Falls
- Loss of insight
- Driving errors

Person with dementia
- Family history
- Cognitive tests (MMSE)
- Physical exam (B12, thyroid function)
- Brain imaging (CT, MRI)

GP*

24.0%

ER & IM

- Lack of resources
- **30.0%** initial consultations to geriatrician/neurologist
- **67.0%** initial consultations to GP

Nurse

Role undefined
Differs between private and public practices and how fundings are allocated in public

Referral
- Long wait times (**3-12 months**)
- Lack of diagnostic equipment/resources

Private individual

Geriatrician**

Neurologist

Diagnosis

Person with dementia
- History
- Cognitive tests (MoCA, MMSE, other)
- Physical exam
- Brain imaging (CT at **2-3 weeks**, MRI at **1–3 months**)
- Biomarker testing (CSF, PET scan not routinely performed)

Geri psych

Neuro psych
- For differential diagnosis of psychiatric disorders
- Behaviour can temporarily be modified with antipsychotic and mood stimulators

57.1%

Function predominantly as diagnostic clinics, although some offer ongoing assessment and care coordination

Publicly-funded memory clinic

Diagnosis

Symptoms worsen

Early intervention improves:
- Cognitive performance & memory
- Aggression & behaviour
- Wandering & getting lost frequently
- Inability to do ADLs
- Memory, diet, executive functioning & health declining
- Loss of interest & insight

Prescribed by specialist and monitored by GP & specialists (regulate dosage)
- **Cholinesterase inhibitors+/-memantine**
- **Lifestyle modifications**
- **Social interaction**
- **Memory-stimulating activities**

Rx

Follow-up

GP

Geriatrician

Neurologist

Ongoing care, including modifying treatment dosage

- NDIS
- Future planning for care setting, finances, etc.

Looking for information and searching for a solution

Planning for the future

Early signs and memory concerns

Seeking a diagnosis

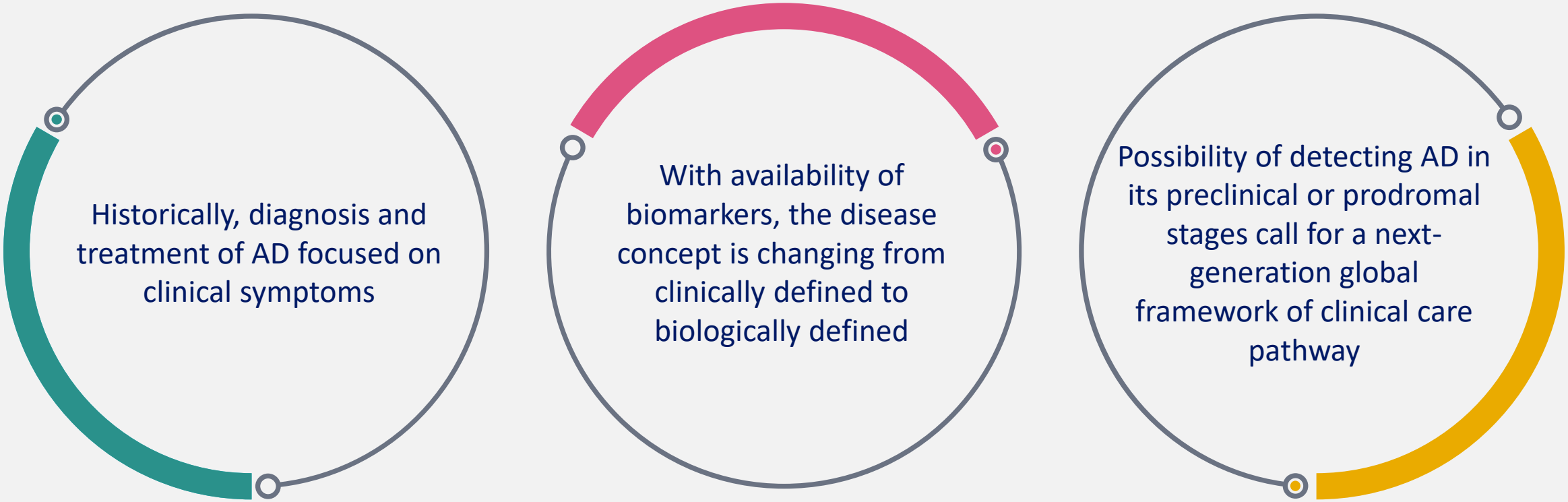
Diagnosis & treatment

Treatment & management

Living with Alzheimer's disease

** Time to diagnosis is 4 months longer in those referred to a specialist. **Younger persons with dementia will be referred to a neurologist for differential diagnosis. ADL, activities of daily living; CT, computerised tomography; CSF, cerebrospinal fluid; Cx, caregiver; ER, emergency room; GP, general practitioner; HCP, health care professional; IM, internal medicine; MCI, Mild cognitive impairment; MMSE, mini-mental state examination; MoCA, Montreal Cognitive Assessment; MRI, magnetic resonance imaging; NDIS, National Disability Insurance Scheme; PET, Positron emission tomography; psych, psychologist; Px, patient; Rx, prescription, yrs, years.*

Need for a next-generation clinical care pathway for AD



Hampel, H., Au, R., Mattke, S. et al. Designing the next-generation clinical care pathway for Alzheimer's disease. Nat Aging 2, 692–703 (2022).

Key steps in future clinical care pathway for AD

First-line diagnostic workup: Primary care

- Primary care setting
- Family & medical history to assess for risk factors for AD
- Physical examination – general & neurological & Routine lab investigations
- Validated clinical assessment tools – MMSE, MoCA, Mini-Cog, IADL/FAQ, NPI-Q
- Use of blood-based biomarkers to better inform referral to AD specialist

Second-line diagnostic workup & therapeutic decision-making: Alzheimer's disease specialist

- AD specialist setting – Neurologist, Geriatrician, Geriatric psychiatrist
- Use of CT,MRI to rule out other causes of dementia
- In -vivo demonstration of AD hallmark pathophysiological changes
- Neuroimaging biomarkers, CSF biomarkers, blood-based biomarkers
- Therapeutic interventions targeting AD-associated pathophysiology

MMSE – Mini-Mental State Examination, MoCA – Montreal Cognitive Assessment, NPI-Q – Neuropsychiatric Inventory Questionnaire, Mini-Cog- -Mini Cognitive Assessment Instrument, IADL – Instrumental Activities of Daily Living, FAQ – Functional Activities Questionnaore

Hampel, H., Au, R., Mattke, S. et al. Designing the next-generation clinical care pathway for Alzheimer's disease. Nat Aging 2, 692–703 (2022).

Future challenges & solutions to AD clinical care

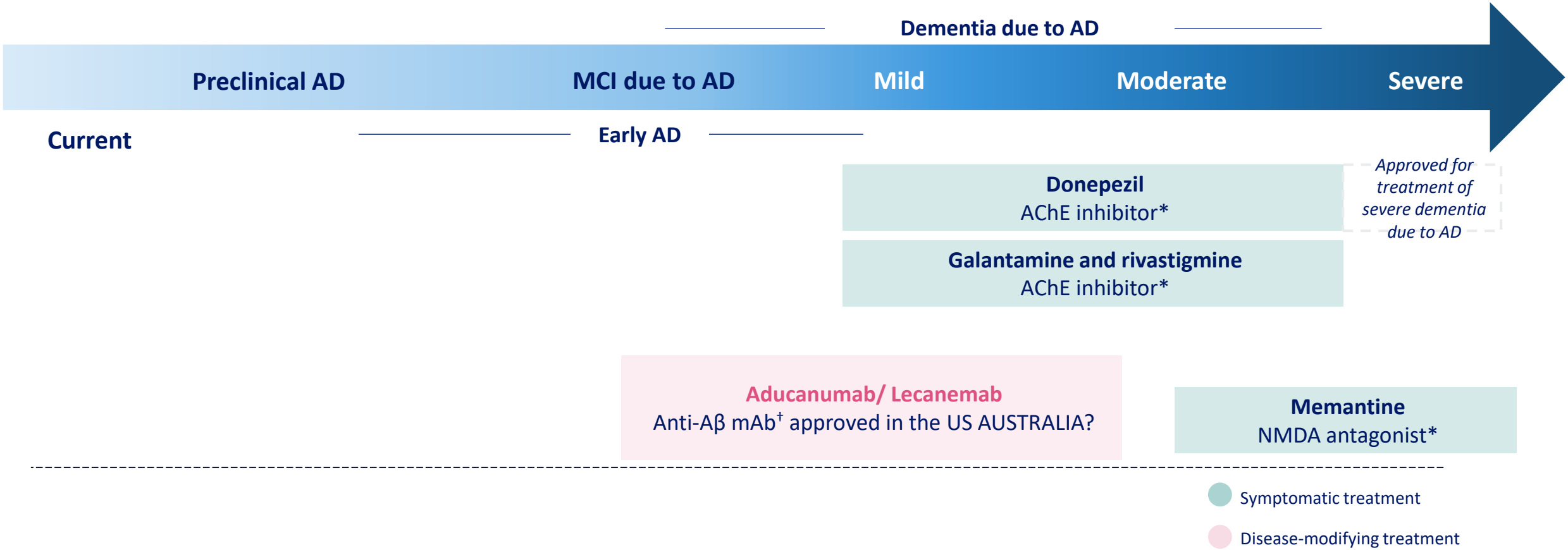
- Strained capacity of Alzheimer's disease specialists.
- Limited coverage of services, especially for routine use of confirmatory biomarker tests.
- Lack of incentive to scale up patient volume due to budgetary considerations.
- Challenges keeping pace with the necessary infrastructure.

- **Primary care is a critical entry point into health care systems with a larger number of general providers compared with specialist services.**
- Better tools are being developed to identify and triage patients in the primary care setting.
- Digital health technologies, including digital cognitive assessments, have the potential to detect early cognitive decline and monitor progression.
- Emerging blood-based biomarkers could be used to enhance the likelihood of AD as the etiology of the observed cognitive decline.

Hampel, H., Au, R., Mattke, S. et al. Designing the next-generation clinical care pathway for Alzheimer's disease. Nat Aging 2, 692–703 (2022).

Medications

Current treatment options comprise generic symptomatic treatments



**Relieves symptoms without targeting the underlying pathology of the disease*
†mAb against amyloid FDA accelerated approval based on biomarker effects
Aß, amyloid beta; AChE, acetylcholinesterase; AD, Alzheimer's disease; FDA, US Food and Drug Administration; GLP-1RA, glucagon-like peptide-1 receptor agonist; mAb, monoclonal antibody; MCI, mild cognitive impairment; NMDA, N-methyl-D-aspartate; US, United States

Are we Ready for New AD therapies?

Confronting Issues for Future AD Therapies Comprehensive Case Management

- Primary Care and Specialist Knowledge
- Potential Increase in Referrals
- Referral Pathways to Infusional Sites
- Implications of APOE4 Genetic testing
- Institutional preparedness for Side Effects and Monitoring
- Safety MRIs capability
- ARIA Management

Next Generation Dementia Care
Public v Private?
Clinical Trial Sites?

Qld Clinical Trial Sites

The Prince Charles
Royal Brisbane
Mater
Gold Coast
Sunshine Coast

Why do people participate in AD clinical trials?

The downside…

- Prospect of being on placebo
- Time and travel commitments
- Regular (and sometimes long) hospital appointments
- Multiple procedures and cognitive assessments

The upside…

- **Self-interest:** Possibility of slowing down cognitive decline
- **Altruism:** To help other people in the future

AD, Alzheimer's disease.

Key messages on clinical trials in AD

Participants and their carers are at the **centre of AD clinical trials**

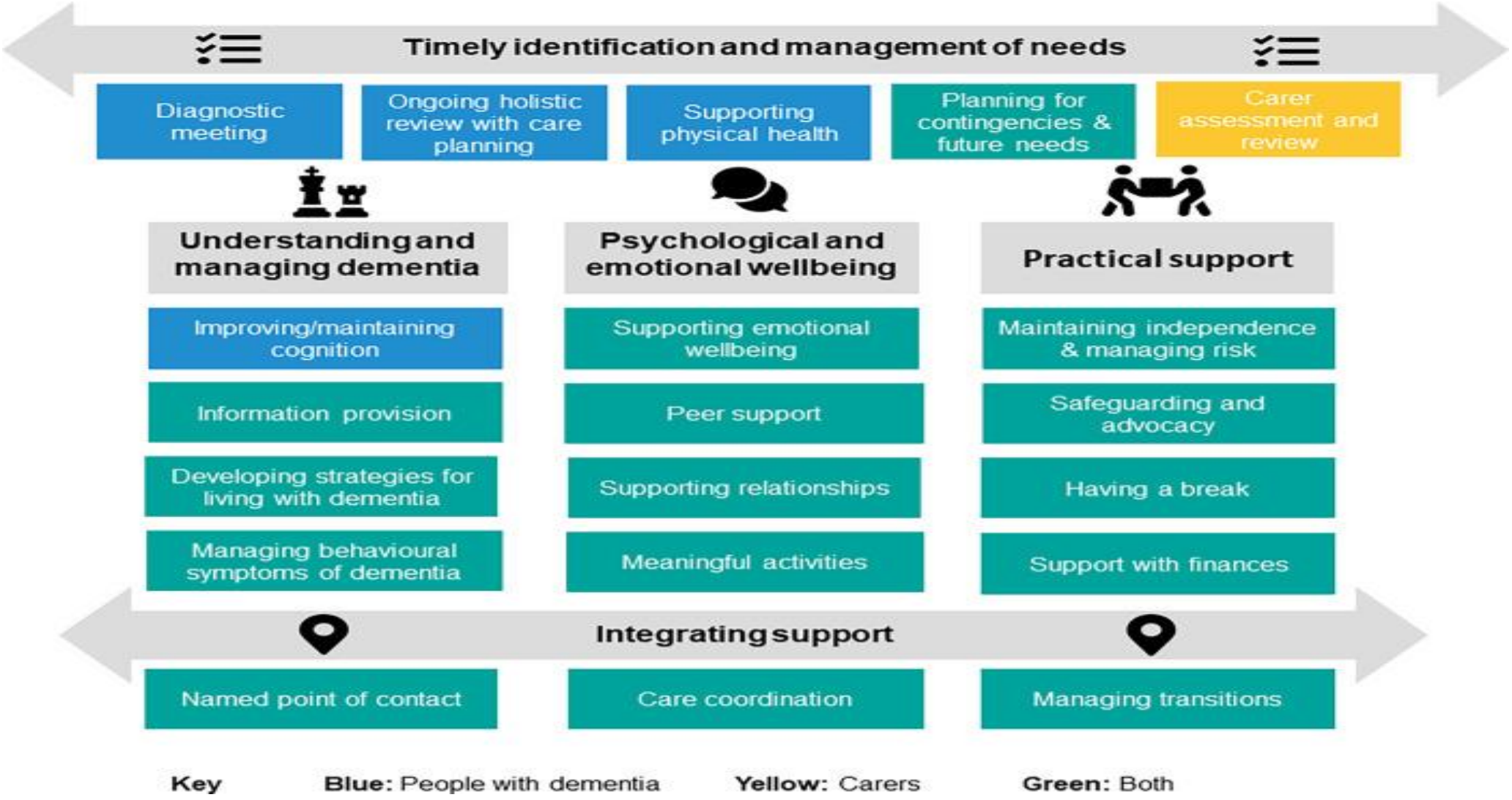
Goal, despite cultural & language differences, is to **treat AD**

Recruit to retain participants and their carers by leveraging available resources

AD, Alzheimer's disease.

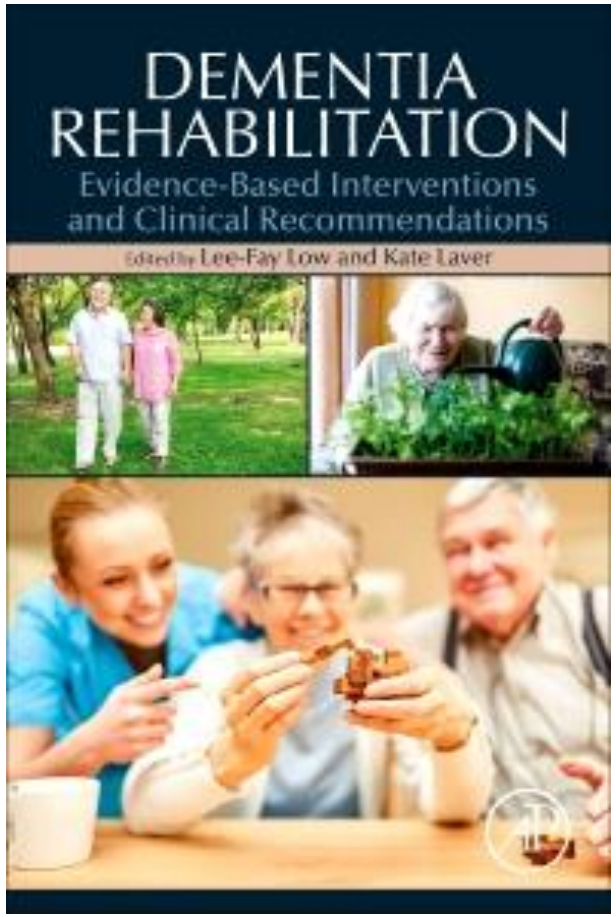
Post Diagnostic Care

Post Diagnostic Care



Evidence for rehabilitation/ re-ablement

- Medications
- Behavioural support
- Carer support
- Cognitive focused interventions
- Occupational therapy
- Exercise
- Psychological interventions
- Peer support
- Speech pathology
- Dementia friendly communities



Forward with dementia

Post Diagnostic Care

- Quality of life
- Lifestyle changes
- Correct Sensory Impairment
- Advanced Care Planning
- Referrals

Dementia Australia®

Forward with dementia

A guide to living with dementia

DEMENTIA ALLIANCE INTERNATIONAL

The global voice of dementia

Alzheimer's QUEENSLAND

Dementia Support Australia

Q & A

Case studies

phn BRISBANE NORTH
An Australian Government Initiative

Metro North Health

Queensland Government

Case Discussion

- Henry 80yo lives with his wife. She has Parkinson's and has become increasingly dependent on him. He has been feeling increasingly carer burdened. Mood deteriorated. Significant anxiety. Feels he can't go on …..
  - Important features from history?
  - Differentials?
  - Management considerations?

Case Discussion

- Started on sertraline and oxazepam
- One week later has had a fall
  - Thoughts…?

Case discussion

- Switched to amitriptyline 100mg
- Not improving
- Seems more tired and perhaps confused
- Feeling increasingly pessimistic but also expressing paranoid thoughts
    - Thoughts? Causes? Management?

Case discussion

- Following discharge from hospital – delirium resolved
- Mood remains flat
- Struggling at home
  - What else needs to be considered
  - What else can be done

Case discussion

- 12months later – his family bring him to see you
- They are concerned that depression is still present
- He is not as active as he was
- Seems more apathetic
- Needing more assistance
    - Thoughts…..

Case Study

78 year old male retired Doctor

- 2 years - Short term memory impairment, Increasing anxiety, Low grade depressive symptoms
- Medical History – IHD, Familial Hypercholesterolemia, GORD, BCC, Irritable Bowel Syndrome
- **Meds**- Aricept 5mg, Memantine 10mg, Micardis 40mg, Rosuvastatin 10mg, Ezetamibe 10 mg, Souvenaid
- **MMSE 26/30** on referral for Clinical Trial
- Enthusiastic to participate in trial

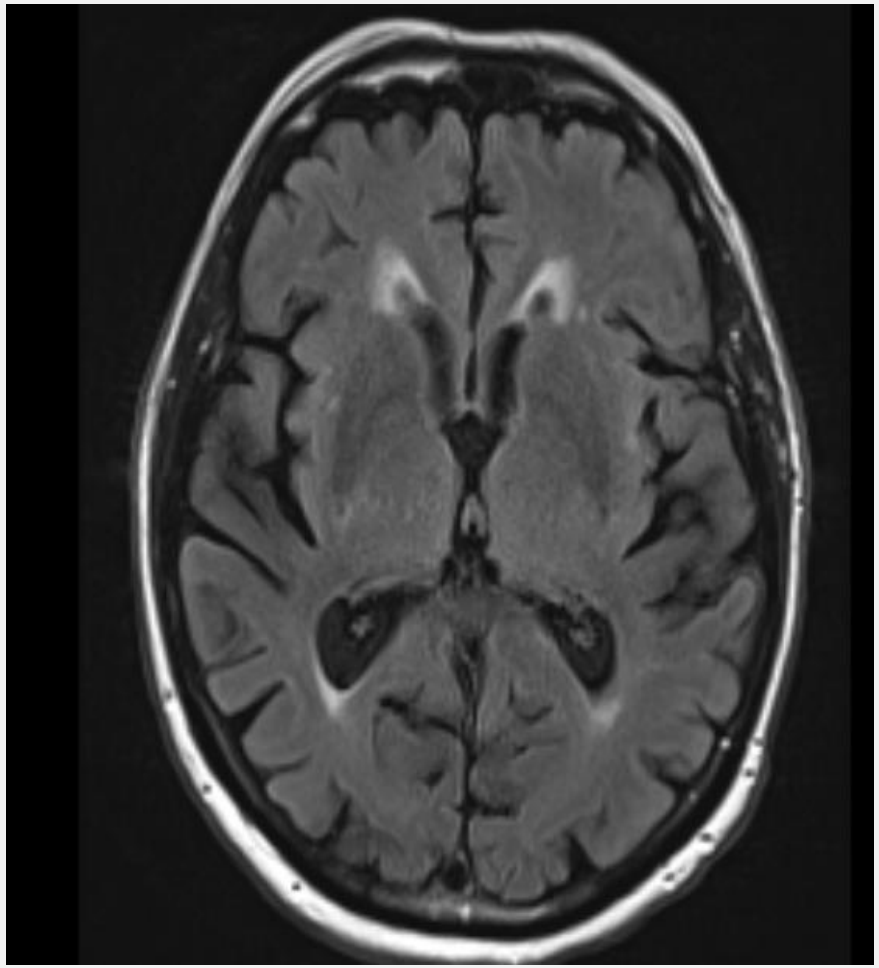
Patient consent obtained.

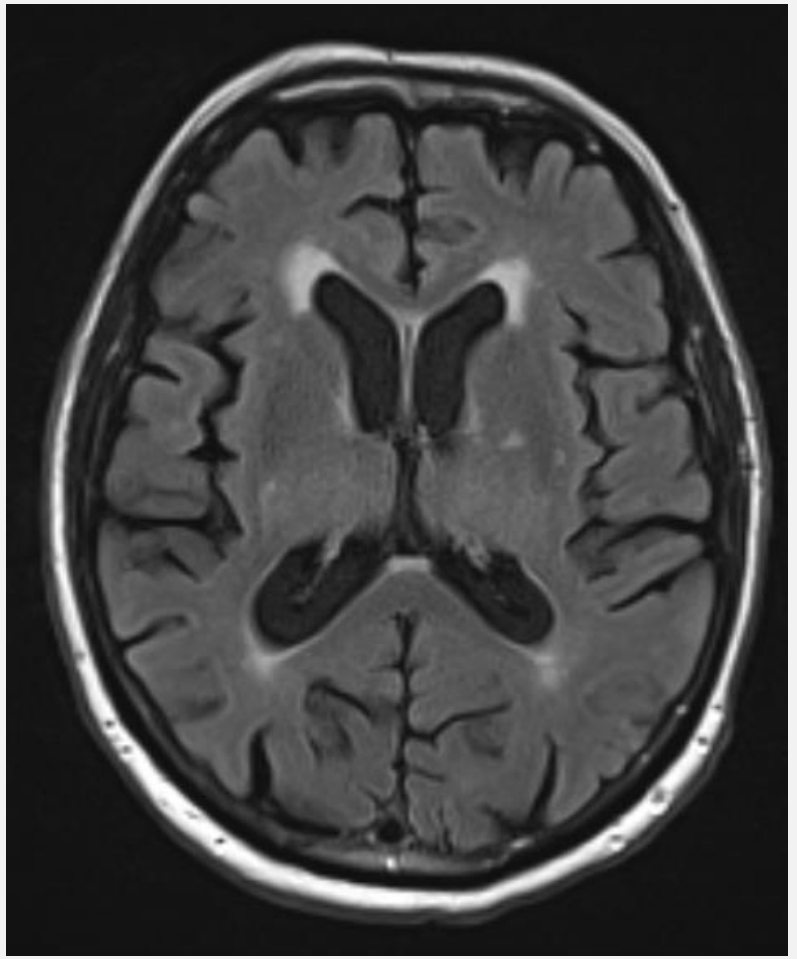
Psychiatric and Social History

- Family history of Alzheimer’s Disease (mother)
- No history of Anxiety/ Depression
- Perfectionist traits, Self reported cognitive decline
- Good relationship with wife and daughter
- Minimal Alcohol, Non Smoker

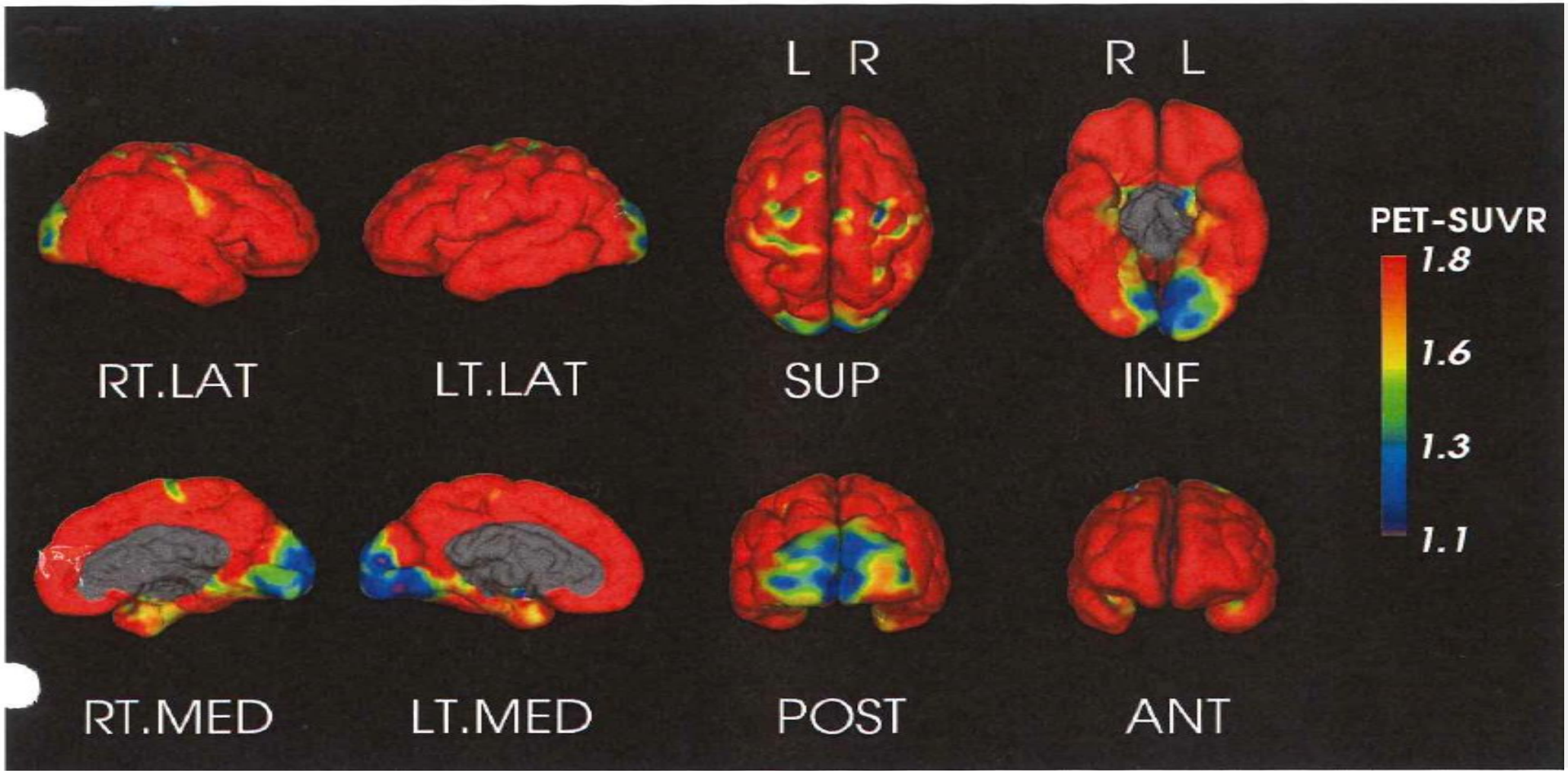
Patient consent obtained.

MRI





PET 18F Florbetaben



Case Progress

- **APOE 4 Positive**, Qualified for Anti Amyloid Trial 18/12
- Continued progressive cognitive decline, Contemplating withdrawal from trial
- **Increasing behavioural symptoms** - Agitation, wandering, verbal aggression
- Moderate to Severe Dementia - **MMSE 15/30**
- **Increasing carer burden. Now contemplating residential care**

Patient consent obtained.

Questions?

phn BRISBANE NORTH
An Australian Government Initiative

Metro North Health

Queensland Government