

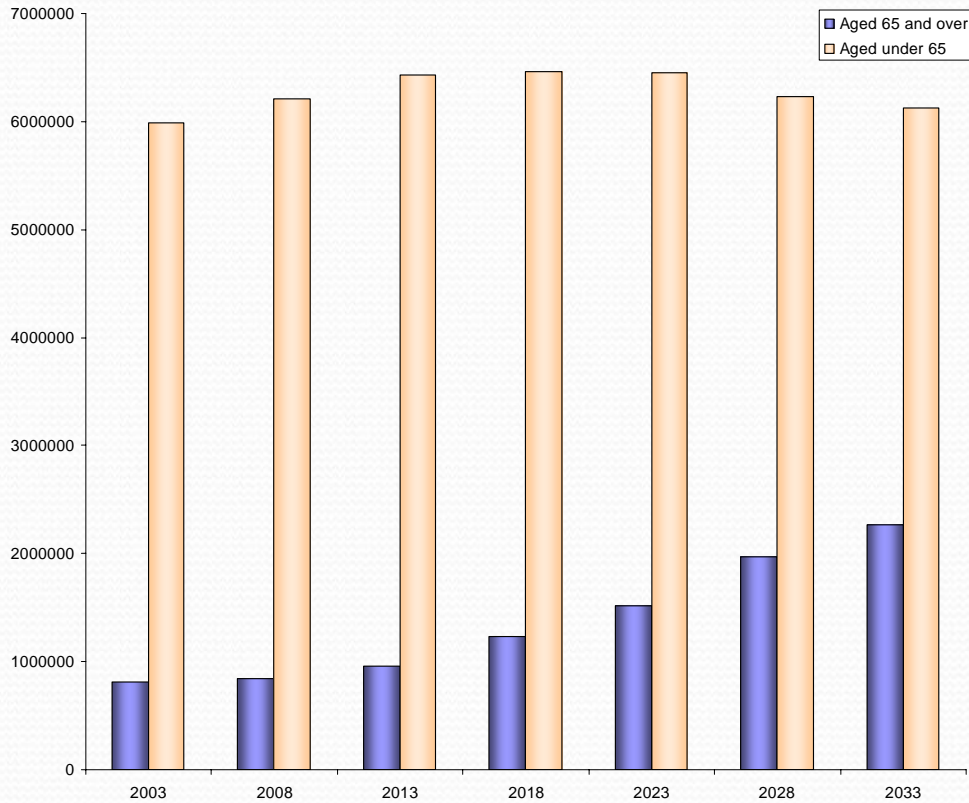
Models of Care for Mild Depression and Dementia in the community

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Outline

- Some background data
 - Mental Health Care Needs of the older population
- Existing services
- Models of care
 - Evidence of effectiveness
- Optimization of care
 - Potential for change

Population Projection 2003-2033



Major Mental Disorders in Late Life

- Dementia
 - Age related prevalence
 - Global neural degeneration with cognitive impairment and behavioral disturbances
 - Impact on person and caregivers
- Depression
 - Prevalent mental disorder that affects function, cognition and physical status
 - Associated with suicide
 - Multiple medical co-morbidity

Mental Health Care Needs

- Psychiatric symptoms
- Cognitive Impairment
- Behavioral abnormality

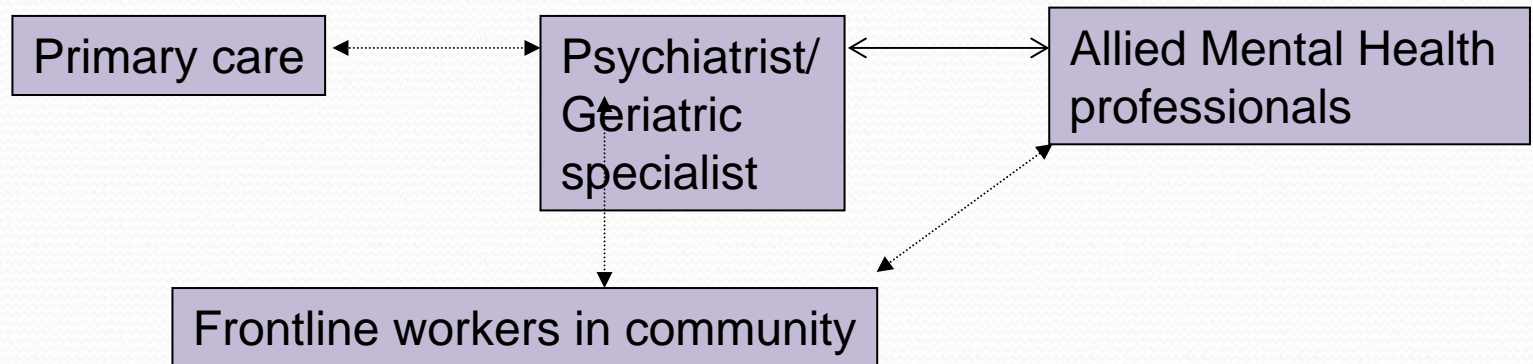
Mental Health Care Needs in older community

- Psychiatric symptoms
- Cognitive Impairment
- Behavioral abnormality
- Functional dependency
- Medical co-morbidity
- Assistance in basic care
- High caregiver burden

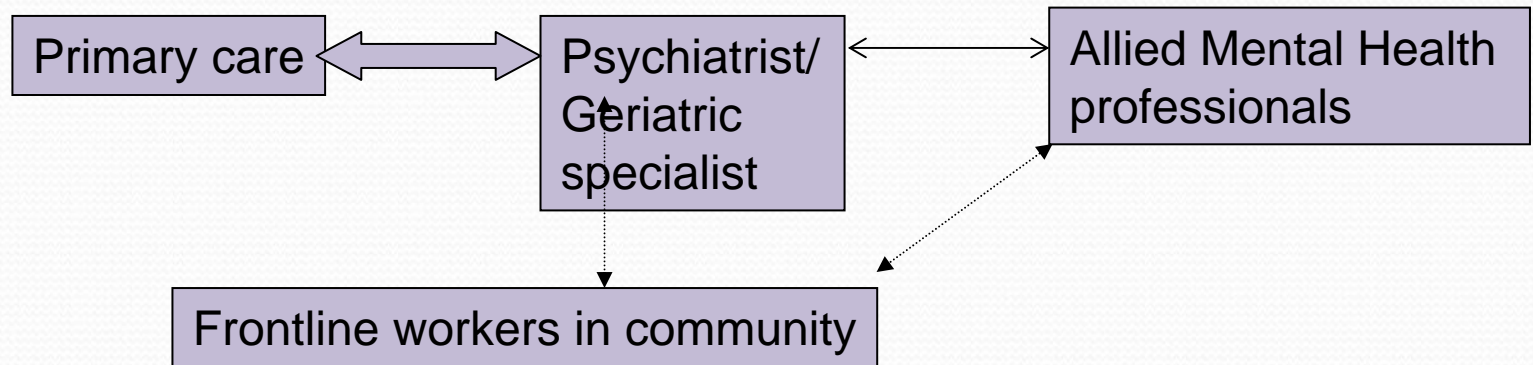
Characteristic of services

- Psychiatric symptoms
- Cognitive Impairment
- Behavioral abnormality
- Functional dependency
- Medical co-morbidity
- Assistance in basic care
- High caregiver burden
- Care from different disciplines
- Tiered model

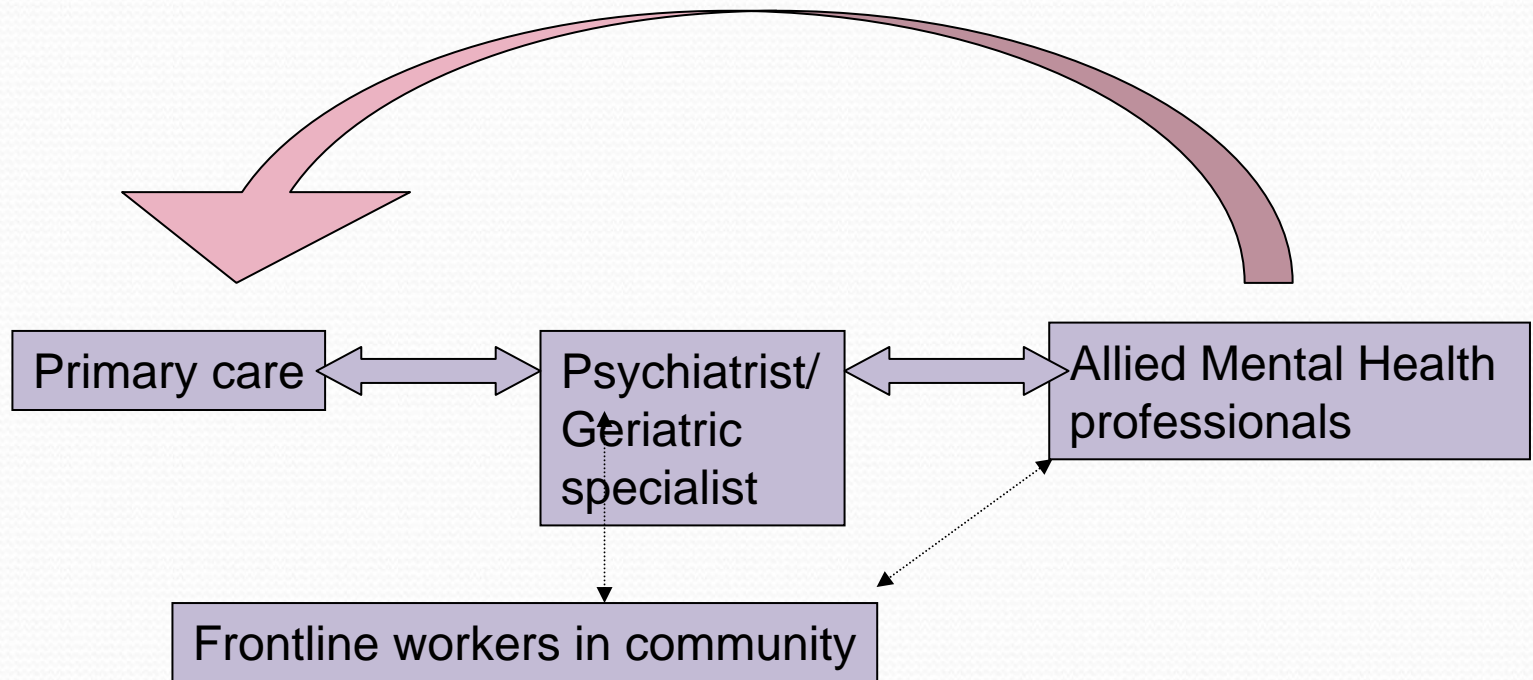
Current Service Model



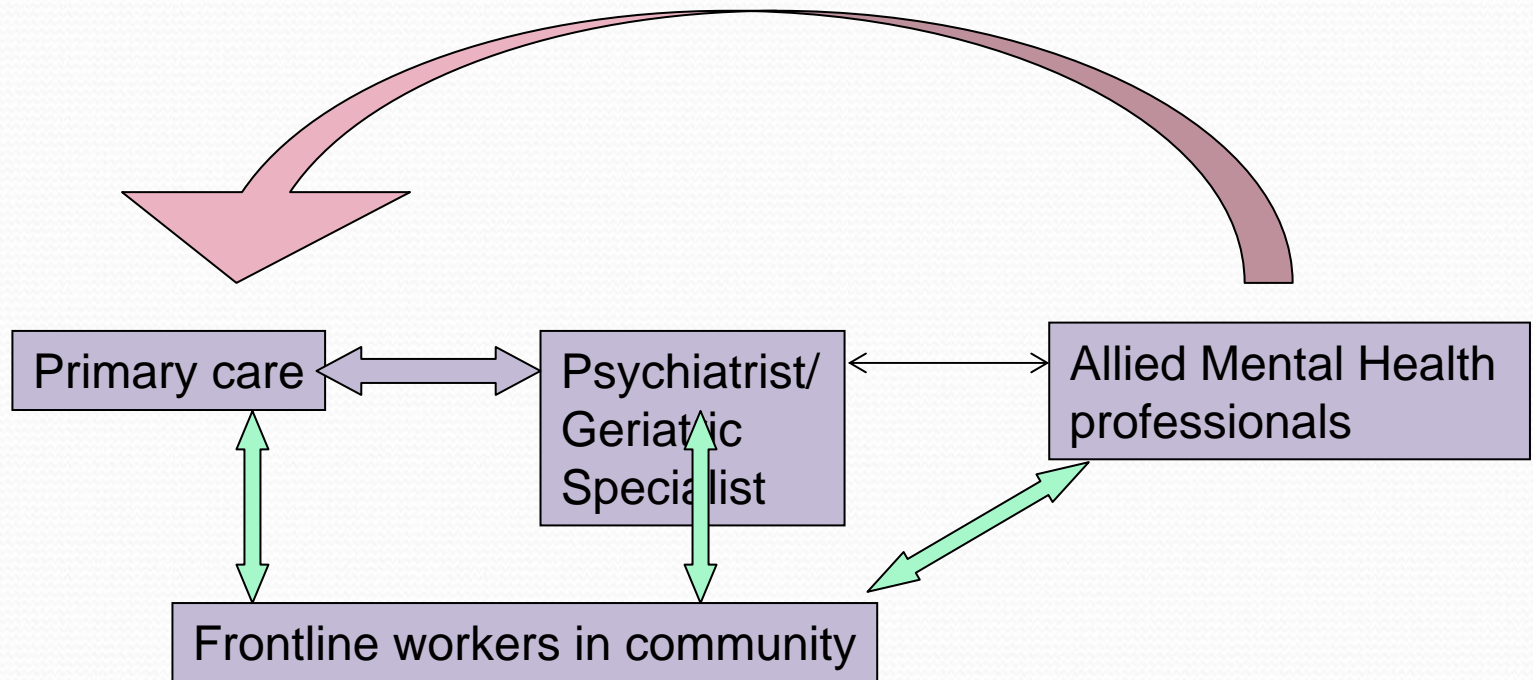
Gaps and Limitation??



Gaps and Limitation??



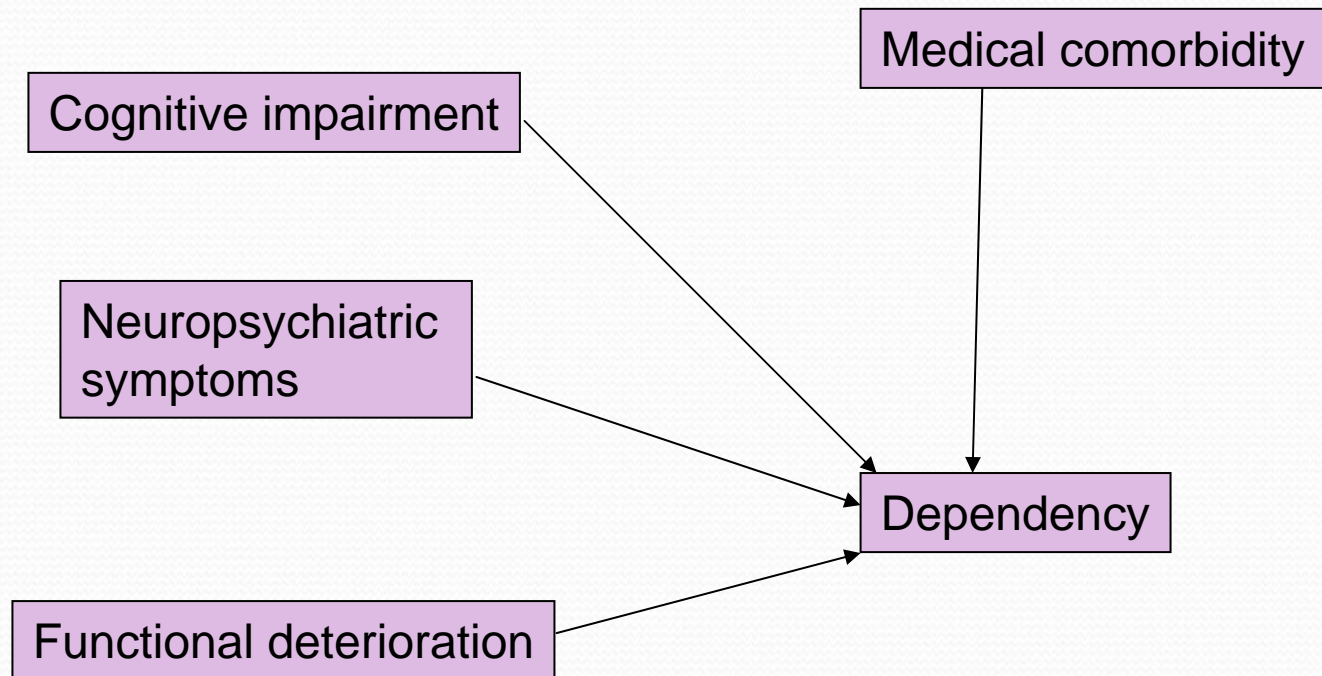
Gaps and Limitation??



Care for dementia in the community

Illness characteristics
Evidence based intervention

Illness characteristics –implication on care



Burden of care

- Carer burden
- Early institutionalization
- Cost of care (COSID-Canadian Outcome study in Dementia)
 - Annual cost of care about \$14000 per patient.
 - 28% due to care directly associated with behavioral symptoms
- Predictors Study
 - 1 point increased in Blessed Dementia Rating Scale Score (BDRS), increased direct cost by 7.7%
 - Total direct cost x2 from year 1 to year 4.
 - Home care costs were 20.8% lower than institutional care.

Herrmann et al., Int J Geriatr Psychiatry, 2006;Zhu et al., Neurology 2006



Utilization of community services

- 3 year follow up of 4,761 dementia caregivers from 9 areas in the US.
- Early utilization of home help services delayed institutionalization.

Gaugler et al, Gerontologist, 2005.

Case management and specialist mental health services

- Intensive case management in a community based mental health service
- 43 matched control and experimental pairs
- Experimental group
 - Significant improvement in social function, reduced carer stress and needs.
 - Higher cost of care
 - Lower rate of institutionalization at 2nd year

Challis et al., Int J Geriatr Psychiatry, 2002

Collaborative care for AD

- 153 subjects randomized to receive collaborative care management (Intervention, n=84) or usual care (n=69).
- A multi-disciplinary team led by an APN integrated into primary care.
- Intervention group had
 - Increased accessibility to ACEI and antidepressants ($p < 0.05$).
 - Fewer neuropsychiatric symptoms ($p = 0.01$).
 - Improvement in caregiver distress.
 - No difference in depression, cognition, ADL and rates of hospitalization.
- Collaborative care in primary care resulted in improvement in QOL and BPSD.

Callahan et al., JAMA, 2006.

Community Based Occupational therapy

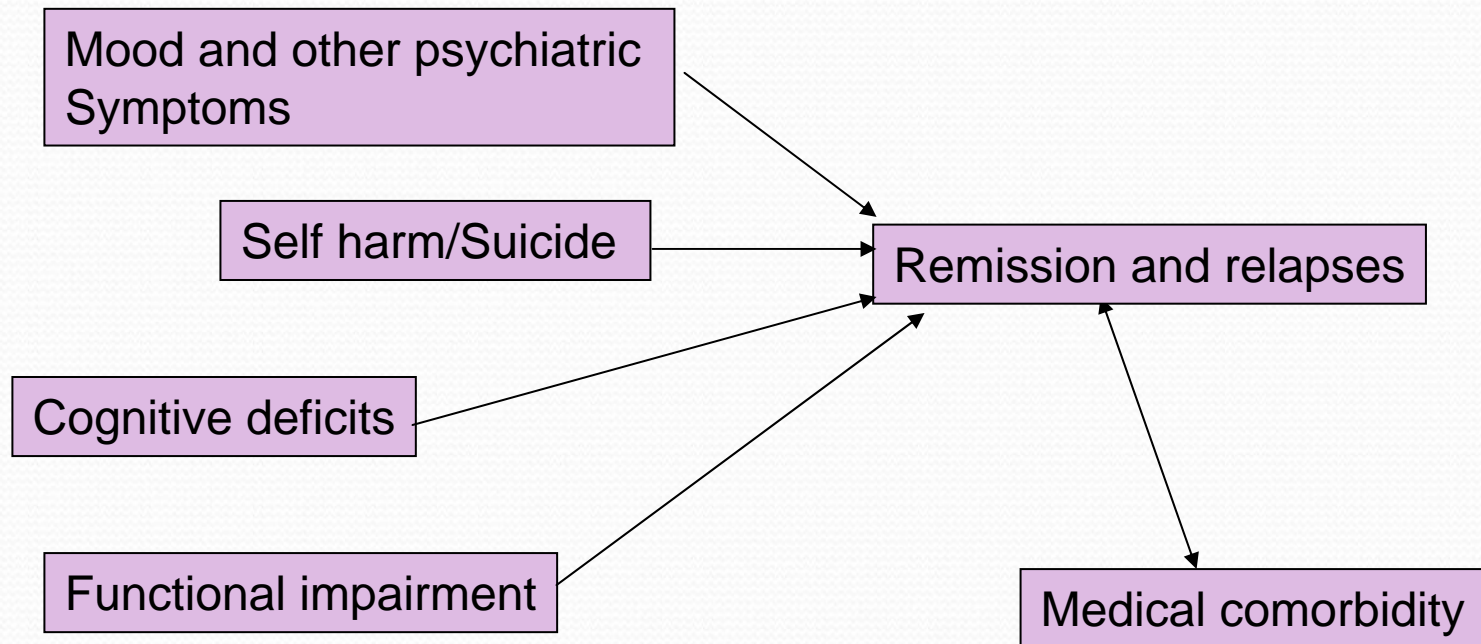
- 135 participants with mild to moderate dementia
- 10 sessions of community OT
- Single blind RCT with assessment at 6 weeks and 3 months.
- Better functioning scores ($p < 0.0001$).
- Significant difference in Depression scores
- Cost Effectiveness analyses with average savings of €748 (€279 versus €621) per patient-caregiver over 3 months.

Graff et al., BMJ, 2006 and 2008; Graff et al., J Gerontol A Biol Sci Med Sci 2007

Care for depressive disorder in the community

Core service characteristics
Evidence based intervention

Illness characteristics –implication on care



Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)

- 1801 patients were randomly assigned to the IMPACT intervention (n = 906) or to usual care (n = 895).
- 18 primary care clinics from 8 health care organizations in 5 states in the US.
- Intervention - 12 months to a depression care manager who was supervised by a psychiatrist and a primary care expert
 - Education, care management, and support of antidepressant management
- At 12 months, the IMPACT group had
 - greater reduction in depressive symptoms (odds ratio 3.45, $p < .001$).
 - greater rates of depression treatment (OR, 2.98, $P < .001$),
 - lower depression severity ($p < .001$),
 - less functional impairment ($p < .001$)
 - better quality of life ($p < .001$)
- Cost effectiveness analysis, the IMPACT group had
 - 107 (95% confidence interval [CI], 86 to 128) more depression-free days over 24 months.
 - Higher total outpatient costs were USD \$295 (95% CI, -\$525 to \$1115).
 - Incremental outpatient cost per depression-free day was USD \$2.76 (95% CI, -\$4.95 to \$10.47).
 - A lower mean total health care cost at 4 years (\$29422 versus 32785).

Unutzer et al., JAMA 2002; Katon et al., Arch Gen Psychiatry, 2005

PRISM-E Integrated Care and Enhanced Specialty Referral Models

- PRISM-E Primary Care Research in Substance Abuse and Mental Health for the Elderly
- Older primary care patients with depression
- Intervention – Integrated Care (mental health services co-located with primary care) versus Enhanced Specialty Referral (physically separate mental health clinics)
- 1531 patients recruited.
- Outcome at 6 months,
 - similar remission rate and symptom reduction.
 - Greater reduction in dementia severity in enhanced referral group.
- Proximity of mental health services to primary care improves engagement.



Potential for Optimization

Address the basics..

- Our older community is
 - Deprive of education when young
 - Lower literacy level
 - Lacking of retirement benefits
- Our primary care needs enhancement
 - Lack of specialized family physicians
 - Public private interface
- Our psychiatric services
 - Is overload
 - Limited allocation for further training of medical and allied health professionals
- Our community partners
 - Is overload
 - Requires training opportunities for caring of mentally ill elders



Optimizing Models of Care

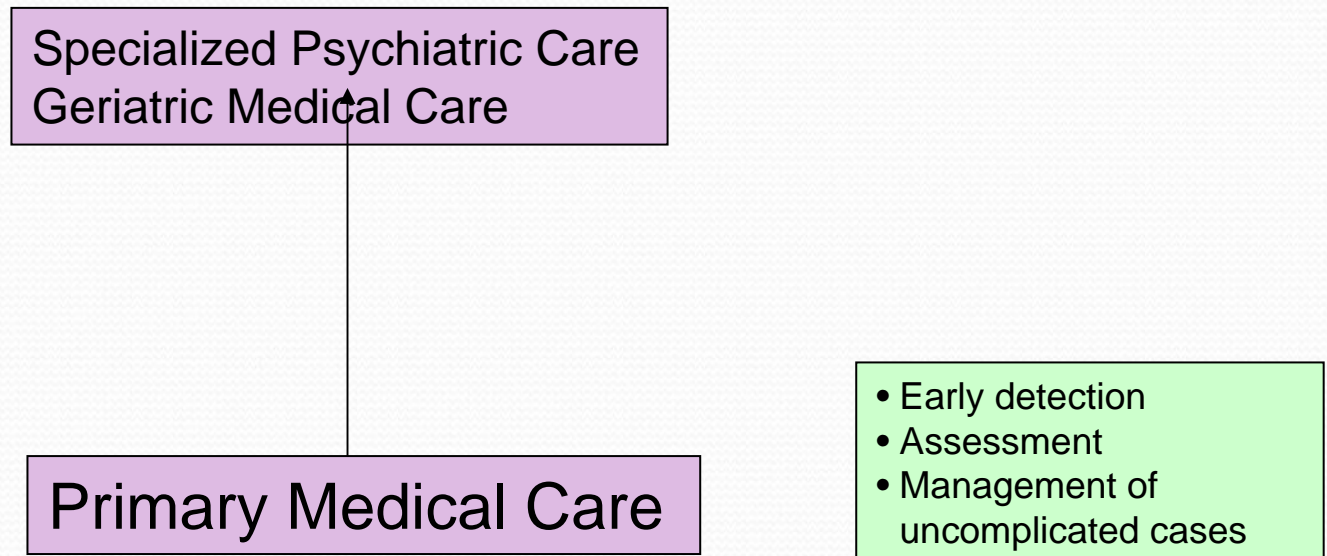
Primary Medical Care

Optimizing Models of Care

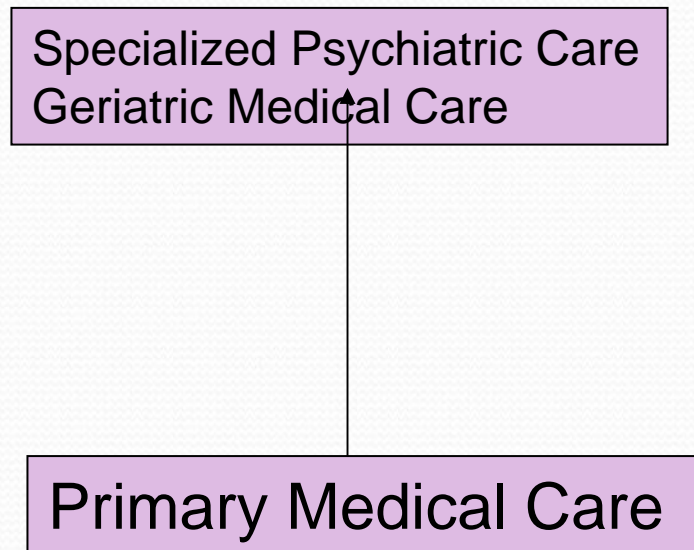
Primary Medical Care

- Early detection
- Assessment
- Management of uncomplicated cases

Optimizing Models of Care



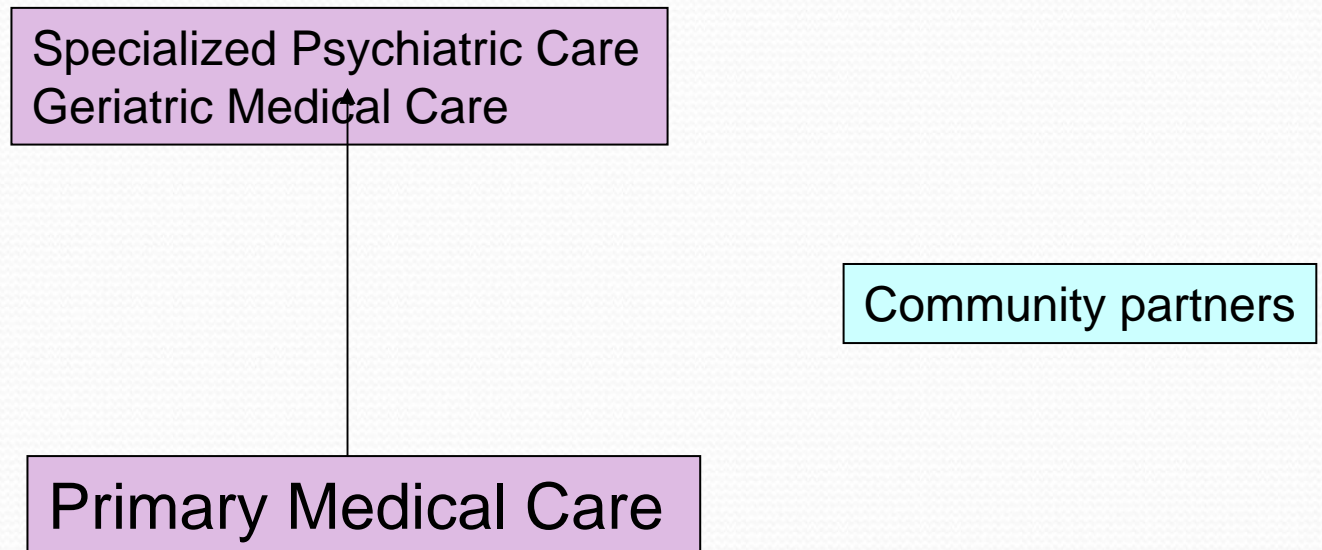
Optimizing Models of Care



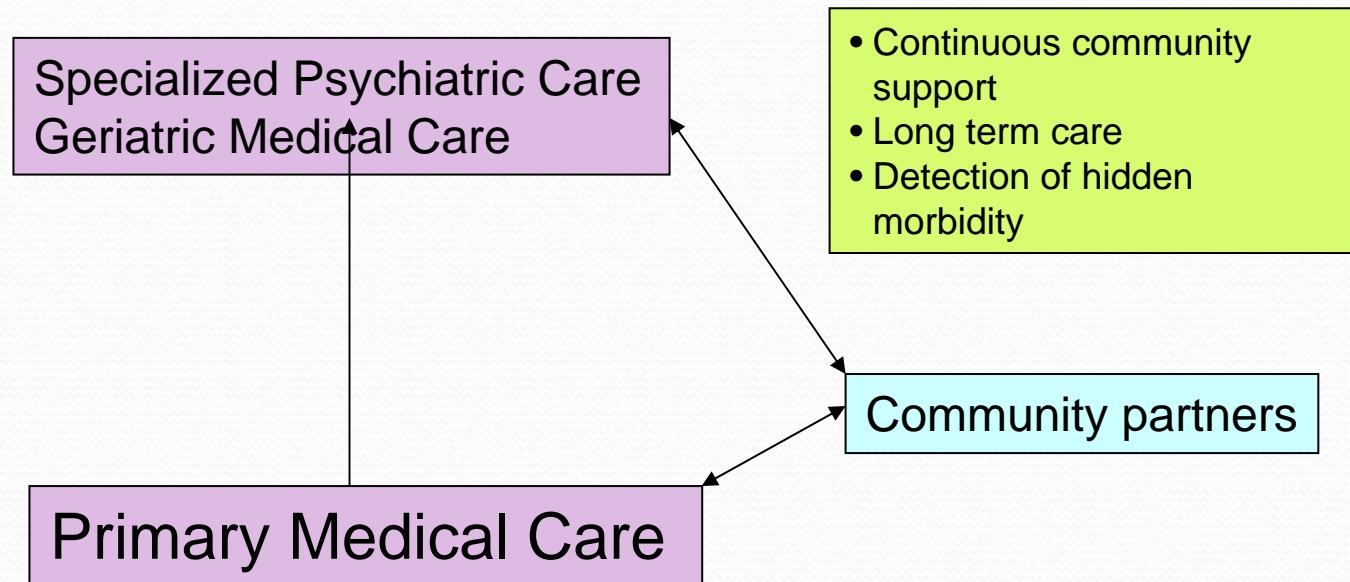
- Assessment and Management of complicated cases
- Advice on treatment protocols
- Advice on crisis intervention

- Early detection
- Assessment
- Management of uncomplicated cases

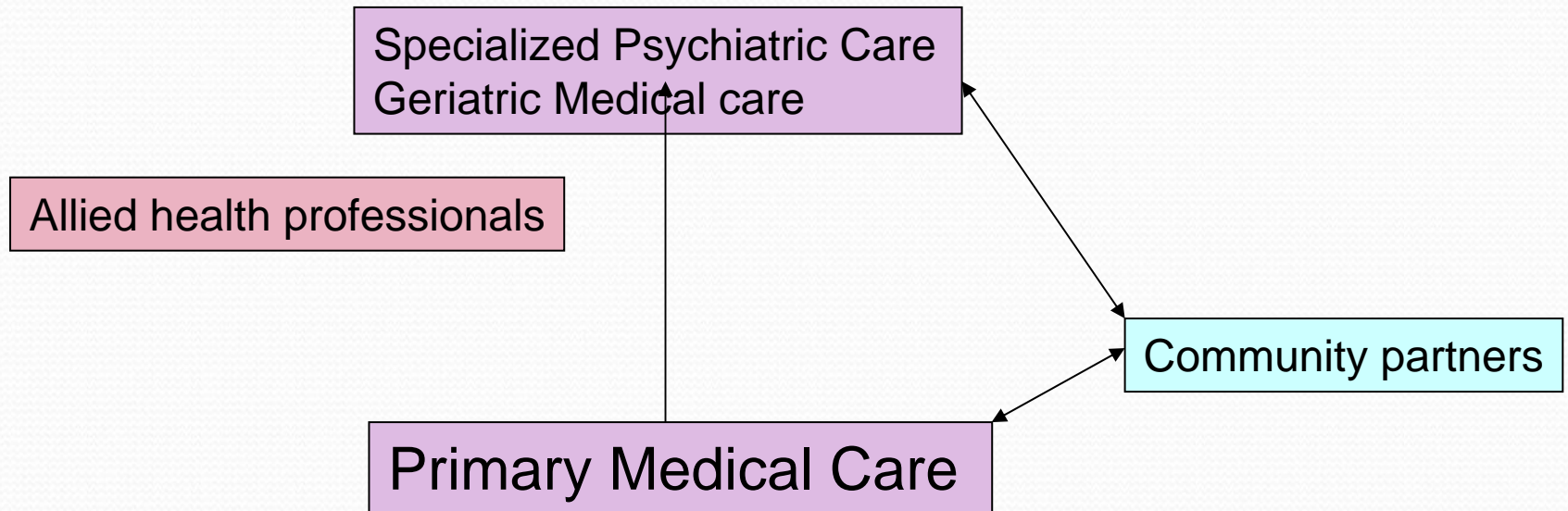
Optimizing Models of Care



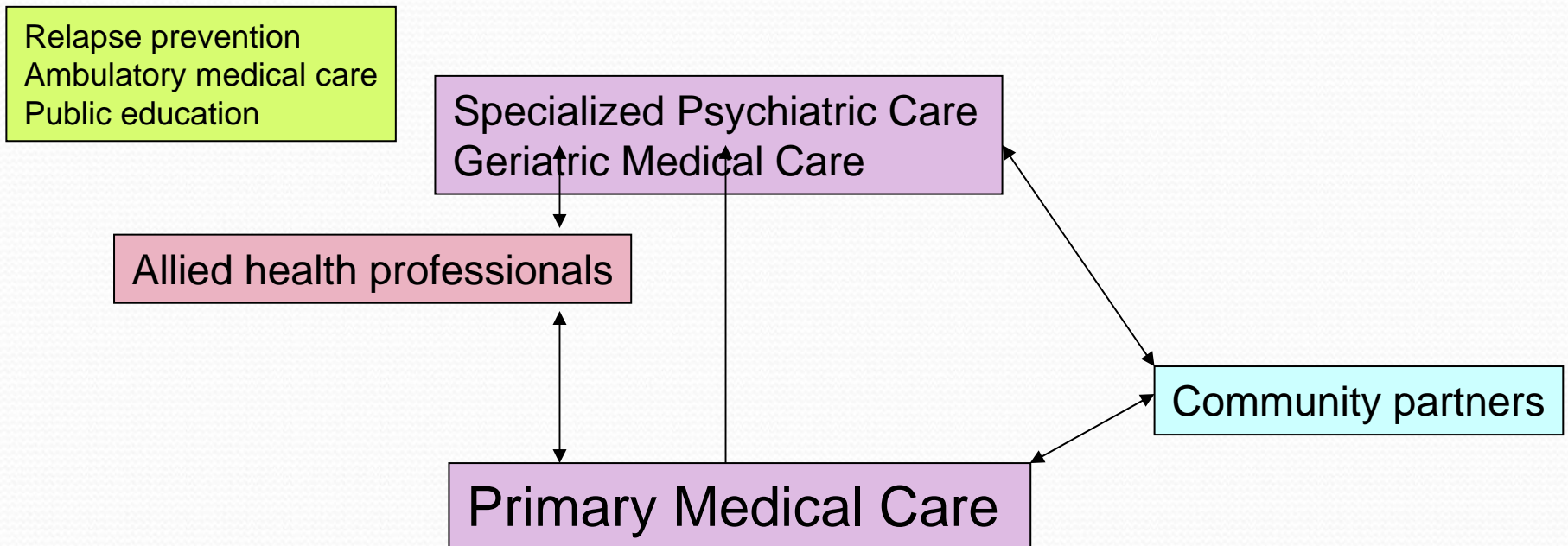
Optimizing Models of Care



Optimizing Models of Care



Optimizing Models of Care





To achieve a better model of care..

- Our community needs
 - Dedication for providing health care for underprivileged community
 - To assume better understanding about depression and dementia
 - A central governmental policy to coordinate and organize efforts from different parties



Thank You