Recognition and Treatment of Behavioral Symptoms in Older Adults, with a Focus on Depression and Dementia

Thursday, April 29, 2021, 10-11:30am

Dr. Lu will cover:

- Covid-19 and geriatric mental health
- Specific signs of delirium, depression and dementia
- Different types of dementia-related behaviors
- Useful non-pharmacologic interventions
- Indications and expectations of medical intervention, including medications
- How caregivers can help

Brett Lu MD PhD
Associate Professor of Psychiatry, University of Hawaii
Queen's Medical Center
Honolulu, HI USA
brettlu@yahoo.com

Sponsored by

ACL
Administration for Community Living

Catholic Charities Hawai'i
Circle of Care for Dementia

Hale Kū'ike

John A. Burns School of Medicine · University of Hawaii Manoa

Supported in part by grant No. 90ADPI0011-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy. The grant was awarded to Catholic Charities Hawaii for the Alzheimer's Disease Program Initiative.

Geriatric Mental Health in the Time of COVID-19

3 D's in Geriatric Psychiatry:
Delirium, Depression, Dementia

Dementia-Related Behavior and Treatment

COVID-19 Pandemic on Mental Health

General Trends seen:

Increased PTSD (post-traumatic stress symptoms) and depression among COVID patients

Worsening of symptoms among those already with mental illness

Increased depression/stress/anxiety/insomnia among healthcare workers, unpaid caregivers

Risk factors for worsening symptoms include:
female, poor health, relatives with COVID

Vindegaard 2000

COVID-19 Pandemic and the Elderly

Elderly most vulnerable for COVID-related medical complications

Elderly expected to be most susceptible to mental health problems during the pandemic

PSYCHIATRIC NEWS ALERT

The Voice of the American Psychiatric Association and the Psychiatric Community

Older Adults May Be More Resilient During Pandemic Than Younger People

Older adults may be more resilient to the anxiety, depression, and stress-related mental disorders that are being reported by younger adults during the COVID-19 pandemic, according to an article in *JAMA*.

COVID-19 Pandemic and the Elderly

TABLE 1. Respondent characteristics and prevalence of adverse mental health outcomes, increased substance use to cope with stress or emotions related to COVID-19 pandemic, and suicidal ideation — United States, June 24–30, 2020

Characteristic	All respondents who completed surveys during June 24–30, 2020 weighted* no. (%)	Weighted %*						
		Conditions				Started or increased substance use to cope with pandemic-related stress or emotions¶	Seriously considered suicide in past 30 days	≥1 adverse mental or behavioral health symptom
		Anxiety disorder†	Depressive disorder†	Anxiety or depressive disorder†	COVID-19–related TSRD§			
All respondents	**5,470 (100)**	**25.5**	**24.3**	**30.9**	**26.3**	**13.3**	**10.7**	**40.9**
Gender								
Female	2,784 (50.9)	26.3	23.9	31.5	24.7	12.2	8.9	41.4
Male	2,676 (48.9)	24.7	24.8	30.4	27.9	14.4	12.6	40.5
Other	10 (0.2)	20.0	30.0	30.0	30.0	10.0	0.0	30.0
Age group (yrs)								
18–24	731 (13.4)	49.1	52.3	62.9	46.0	24.7	25.5	74.9
25–44	1,911 (34.9)	35.3	32.5	40.4	36.0	19.5	16.0	51.9
45–64	1,895 (34.6)	16.1	14.4	20.3	17.2	7.7	3.8	29.5
≥65	933 (17.1)	6.2	5.8	8.1	9.2	3.0	2.0	15.1

Czeisler 2020, CDC report

Elderly: more coping mechanisms, more resilient, better prevention adherence (PPE, avoid outings), value quality over quantity in social interaction

Vahia 2020

Older Patients and Telemedicine

Table 1. National Prevalence of Telemedicine Unreadiness in US Adults Older Than 65 Years in 2018 by Mode of Telemedicine Visit[a]

Reason for unreadiness	No., millions (%)			
	Video visits	Video visits with social support[b]	Telephone visits	Telephone visits with social support[b]
Any unreadiness	13.0 (38)	10.8 (32)	6.7 (20)	5.5 (16)

Lam 2020

Main reasons for unreadiness:
lack of experience w/ technology, physical disability (hearing/visual…)

Increases with age:

Factor	Percentage unready (survey weighted)
Age, y	
65-74	25
75-84	44
≥85	72

Assessing Older Patients via Telemedicine

Before interview

- Choose an app that is simple, not requiring downloads
  (examples: FaceTime, Zoom)
- Make sure to allot MUCH time for technical issues
  (have an idea of what they see at their end)

Interview

- Minimize noise/distractions/lighting
- Ensure privacy if needed, aware of need for separate interviews
- Make sure camera angle/lighting appropriate

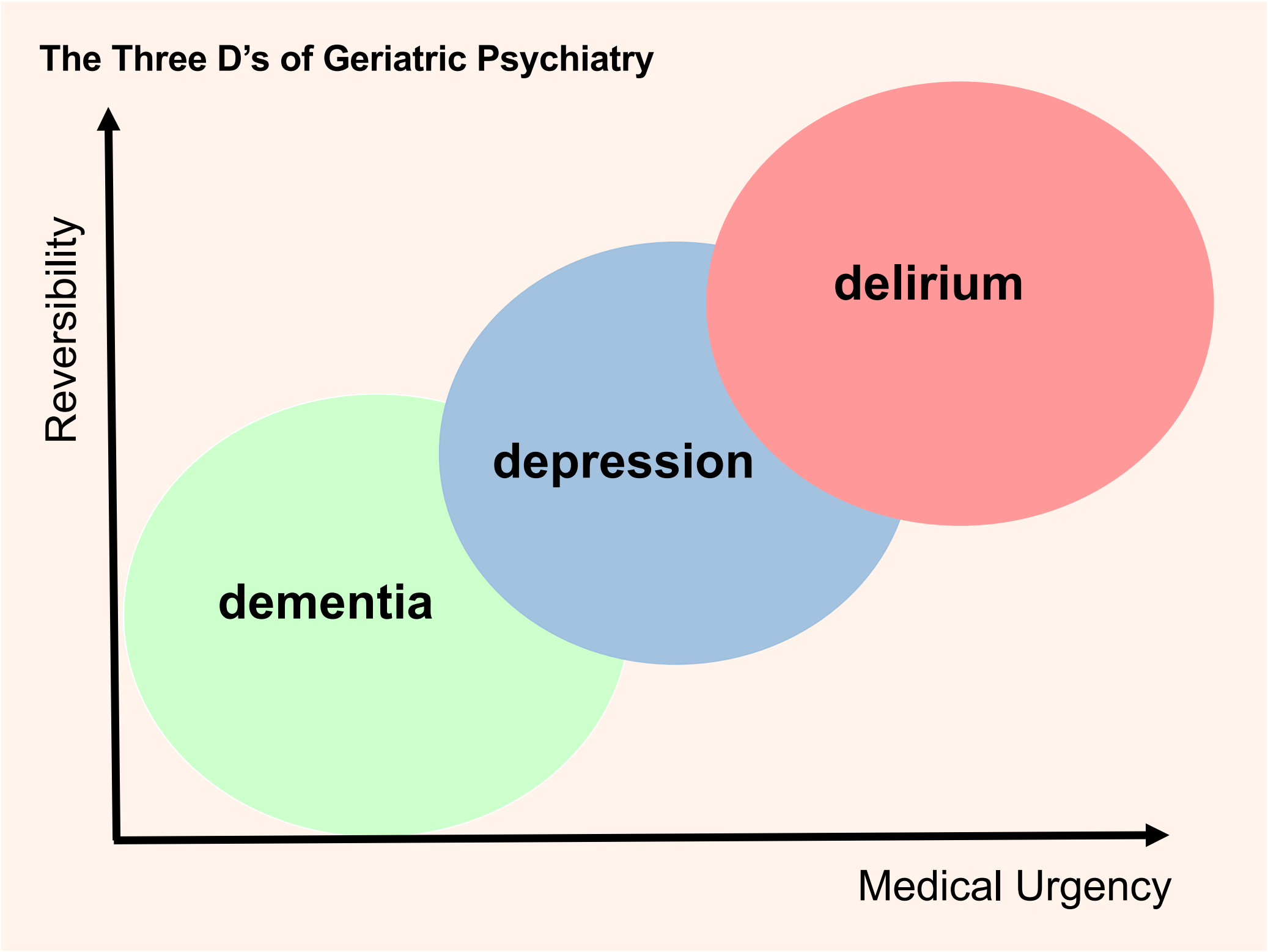
Sensory Impairment (usually hearing)

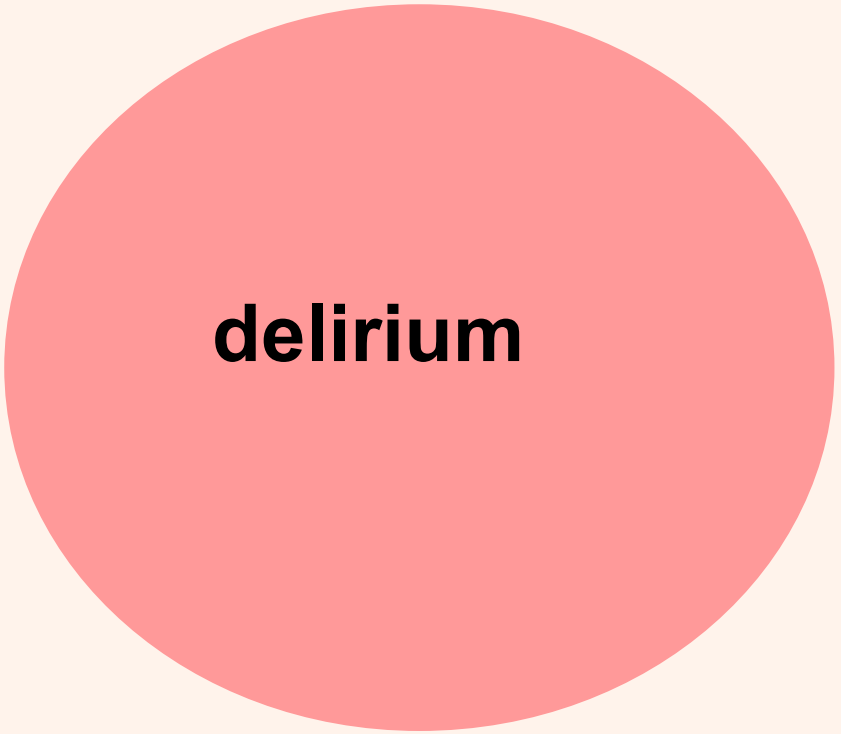
- **Consider using chat function or write questions via shared screen if able to read**
- Headphone
- **Have another person there ask simple questions for you**

Geriatric Mental Health in the Time of COVID-19

3 D's in Geriatric Psychiatry:
Delirium, Depression, Dementia

Dementia-Related Behavior and Treatment


The Three D's of Geriatric Psychiatry
Reversibility
delirium
depression
dementia
Medical Urgency


delirium

Delirium

acute onset (within a few days) of behaviors:

poor attention, bouts of confusion, changing levels of alertness, and psychosis (visual hallucinations, paranoia)

New medical illnesses:

often urine or respiratory infection, heart failure, or stroke

New medications:

hypnotics (benzodiazepines)

pain (opioids)

anticholinergics (incontinence meds, Benadryl)

Alagiakrishnan 2004

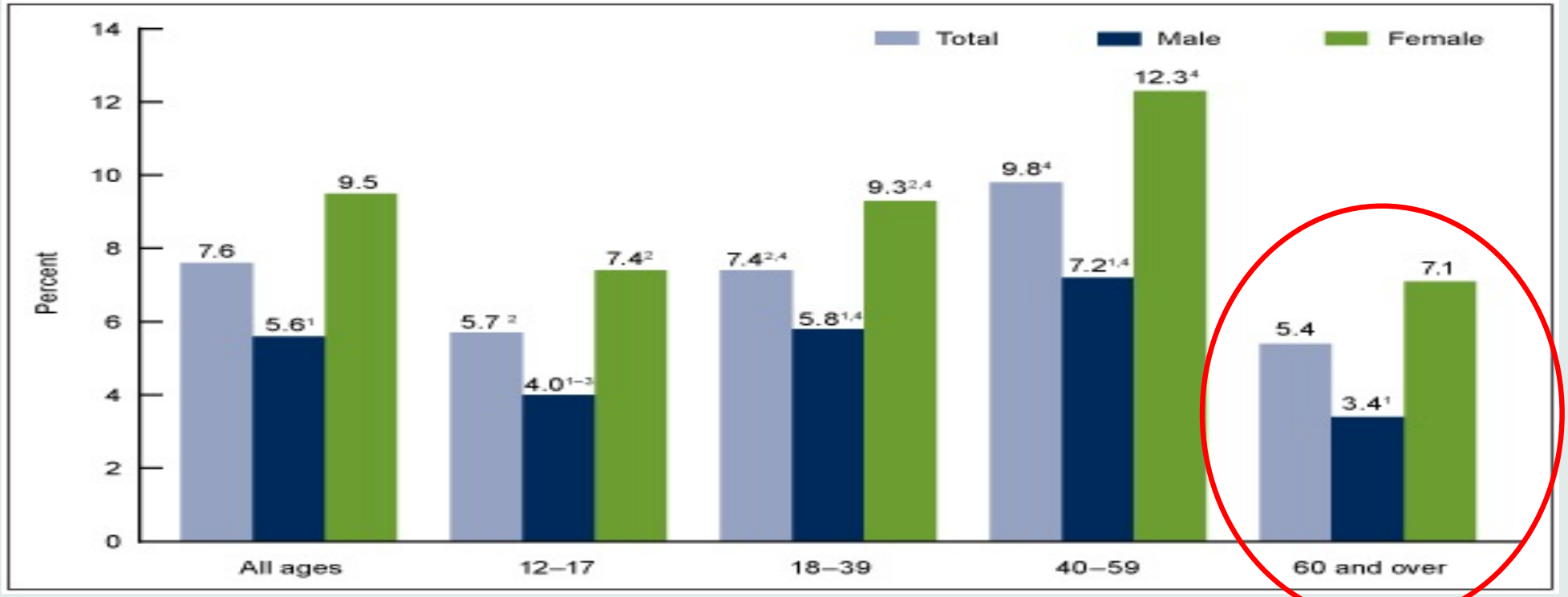

depression

Depression Across the Lifespan

Prevalence decreases with age

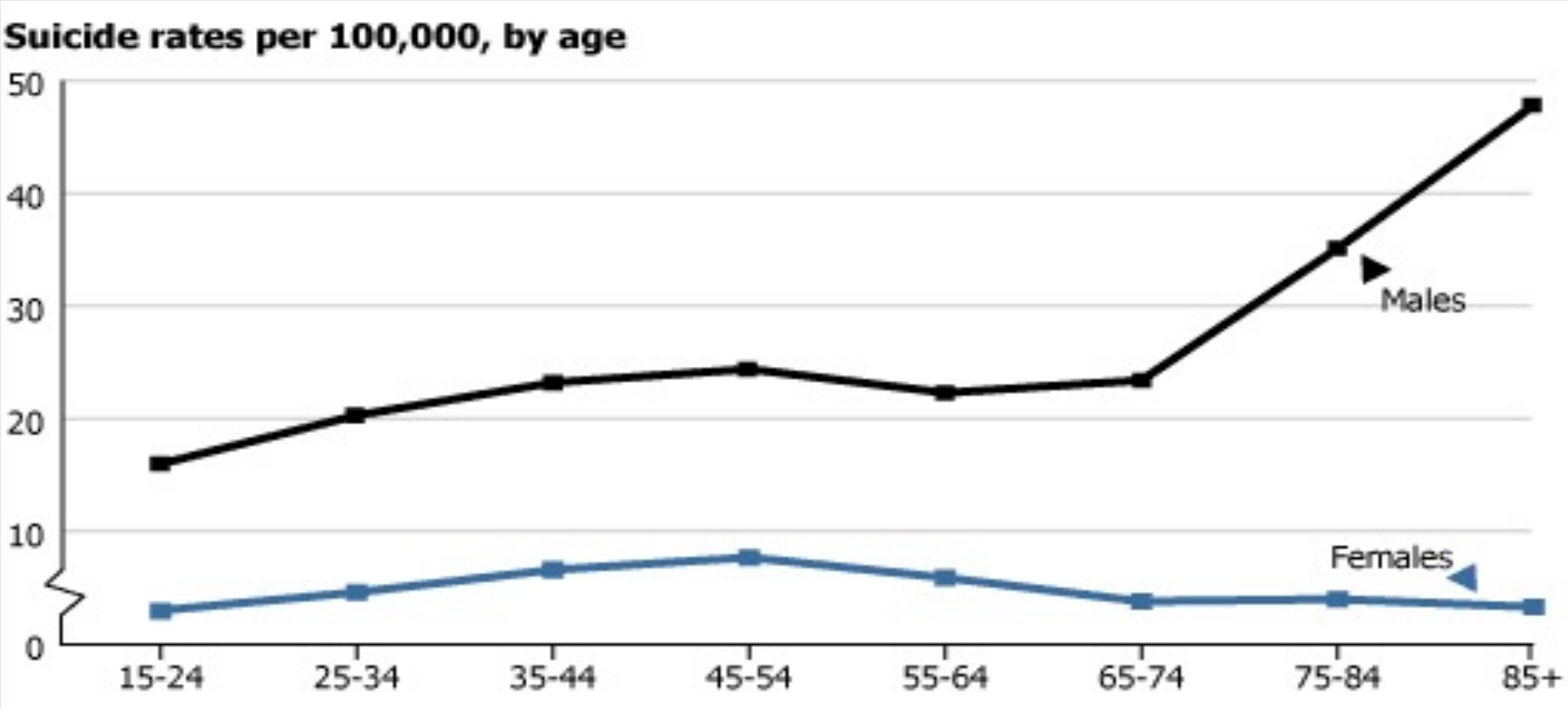
Predictors: Female, poverty, psychosocial stressors

Percentage of persons aged 12 and over with depression by age and gender: US 2009–2012



http://www.cdc.gov/nchs/data/databriefs/db172.htm

Suicide Rates in the US by Age Groups



Females more likely to attempt (X3): overdose
Males more likely to succeed (X4): firearms

Older males: Increased suicide rates shortly after dementia diagnosis, especially in those with mental illness

National Center for Health Statistics, Health, United States, 2005, Seyfried 2011

Depression in Older Patients

Often do not openly state “I am depressed/sad..”:

Irritable, angry/rejecting help/making little effort to engage

Somatic complaints (headache, bellyache, fatigue)

Reporting memory problems (poor attention, pseudodementia)

Sleep difficulties

Fiske 2009, Manepalli 2011

Depression Screeening in Older Patients

PHQ-9, Patient Health Questionnaire
used for different age groups

GDS (15 item short form), Geriatric Depression Scale
more specific for older individuals

CSDD, Cornell Scale for Depression in Dementia
for patients with moderate dementia or worse

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

Guide for Interpreting PHQ-9 Scores		
Score	Depression Severity	Action
0 - 4	None-minimal	Patient may not need depression treatment.
5 - 9	Mild	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
10 - 14	Moderate	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15 - 19	Moderately severe	Treat using antidepressants, psychotherapy or a combination of treatment.
20 - 27	Severe	Treat using antidepressants with or without psychotherapy.

GDS:

To be read out loud to the patient

Not valid for moderate or severe dementia

15-Item Geriatric Depression Scale

Choose the best answer for how you have felt over the past week:

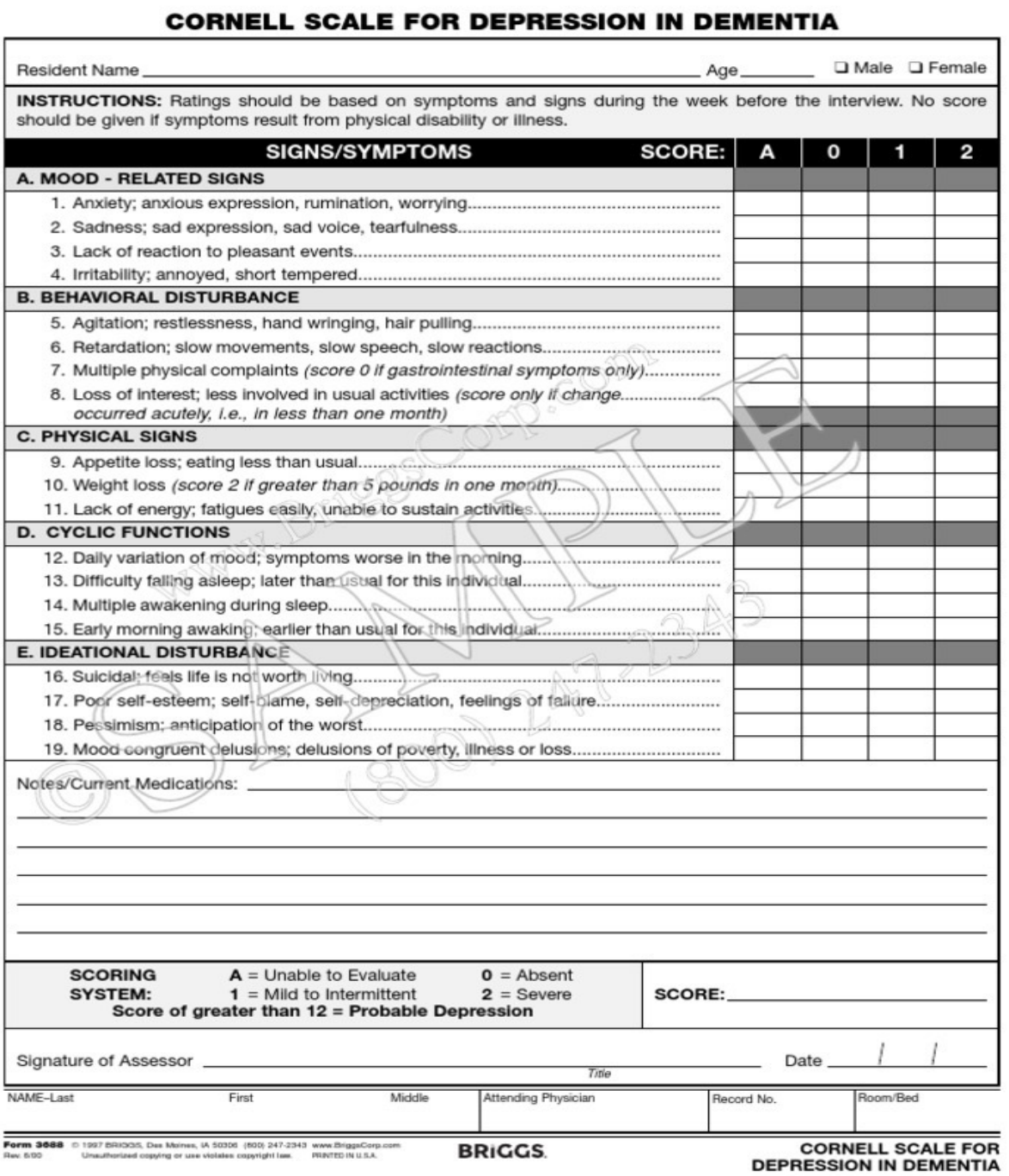
Are you basically satisfied with your life?	Yes/**No**
Have you dropped many of your activities and interests?	**Yes**/No
Do you feel that your life is empty?	**Yes**/No
Do you often get bored?	**Yes**/No
Are you in good spirits most of the time?	Yes/**No**
Are you afraid that something bad is going to happen to you?	**Yes**/No
Do you feel happy most of the time?	Yes/**No**
Do you often feel helpless?	**Yes**/No
Do you prefer to stay at home, rather than going out and doing new things?	**Yes**/No
Do you feel you have more problems with memory than most?	**Yes**/No
Do you think it is wonderful to be alive now?	Yes/**No**
Do you feel pretty worthless the way you are now?	**Yes**/No
Do you feel full of energy?	Yes/**No**
Do you feel that your situation is hopeless?	**Yes**/No
Do you think that most people are better off than you are?	**Yes**/No

Scoring: Bolded answers receive 1 point. A score of more than 5 suggests depression that should be further evaluated clinically.

CSDD:

To be done with a caregiver who knows patient well

for moderate or severe dementia



CORNELL SCALE FOR DEPRESSION IN DEMENTIA

Resident Name _____ Age _____ ❑ Male ❑ Female

INSTRUCTIONS: Ratings should be based on symptoms and signs during the week before the interview. No score should be given if symptoms result from physical disability or illness.

SIGNS/SYMPTOMS	SCORE: A	0	1	2
A. MOOD - RELATED SIGNS				
1. Anxiety; anxious expression, rumination, worrying				
2. Sadness; sad expression, sad voice, tearfulness				
3. Lack of reaction to pleasant events				
4. Irritability; annoyed, short tempered				
B. BEHAVIORAL DISTURBANCE				
5. Agitation; restlessness, hand wringing, hair pulling				
6. Retardation; slow movements, slow speech, slow reactions				
7. Multiple physical complaints *(score 0 if gastrointestinal symptoms only)*				
8. Loss of interest; less involved in usual activities *(score only if change occurred acutely, i.e., in less than one month)*				
C. PHYSICAL SIGNS				
9. Appetite loss; eating less than usual				
10. Weight loss *(score 2 if greater than 5 pounds in one month)*				
11. Lack of energy; fatigues easily, unable to sustain activities				
D. CYCLIC FUNCTIONS				
12. Daily variation of mood; symptoms worse in the morning				
13. Difficulty falling asleep; later than usual for this individual				
14. Multiple awakening during sleep				
15. Early morning awaking; earlier than usual for this individual				
E. IDEATIONAL DISTURBANCE				
16. Suicidal; feels life is not worth living				
17. Poor self-esteem; self-blame, self-depreciation, feelings of failure				
18. Pessimism; anticipation of the worst				
19. Mood congruent delusions; delusions of poverty, illness or loss				

Notes/Current Medications: _____

SCORING SYSTEM: **A** = Unable to Evaluate **0** = Absent **1** = Mild to Intermittent **2** = Severe
Score of greater than 12 = Probable Depression

SCORE: _____

Signature of Assessor _____ *Title* Date ___/___/___

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

BRIGGS.

CORNELL SCALE FOR DEPRESSION IN DEMENTIA

Helping Those with Depression

-offer support/monitoring: video visits, outings

-validate concerns/feelings, empathic listening
(avoid “I know how you feel” or “just get over it”)

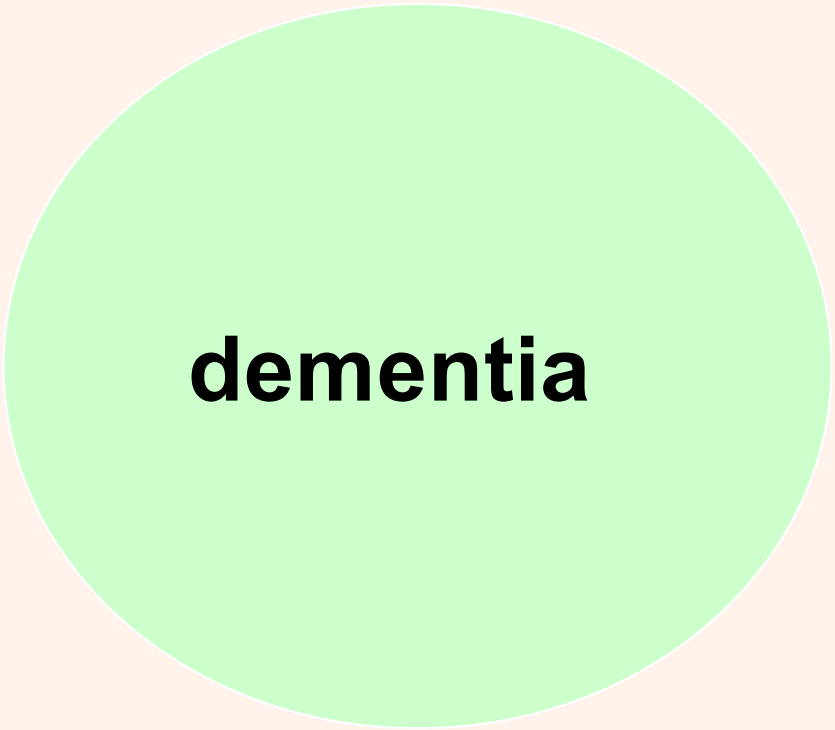
-contact primary care physicians/behavioral health providers. Many offer online therapy sessions

-crisis hotline (24/7)
Oahu 832-3100, neighbor islands 808-753-6879

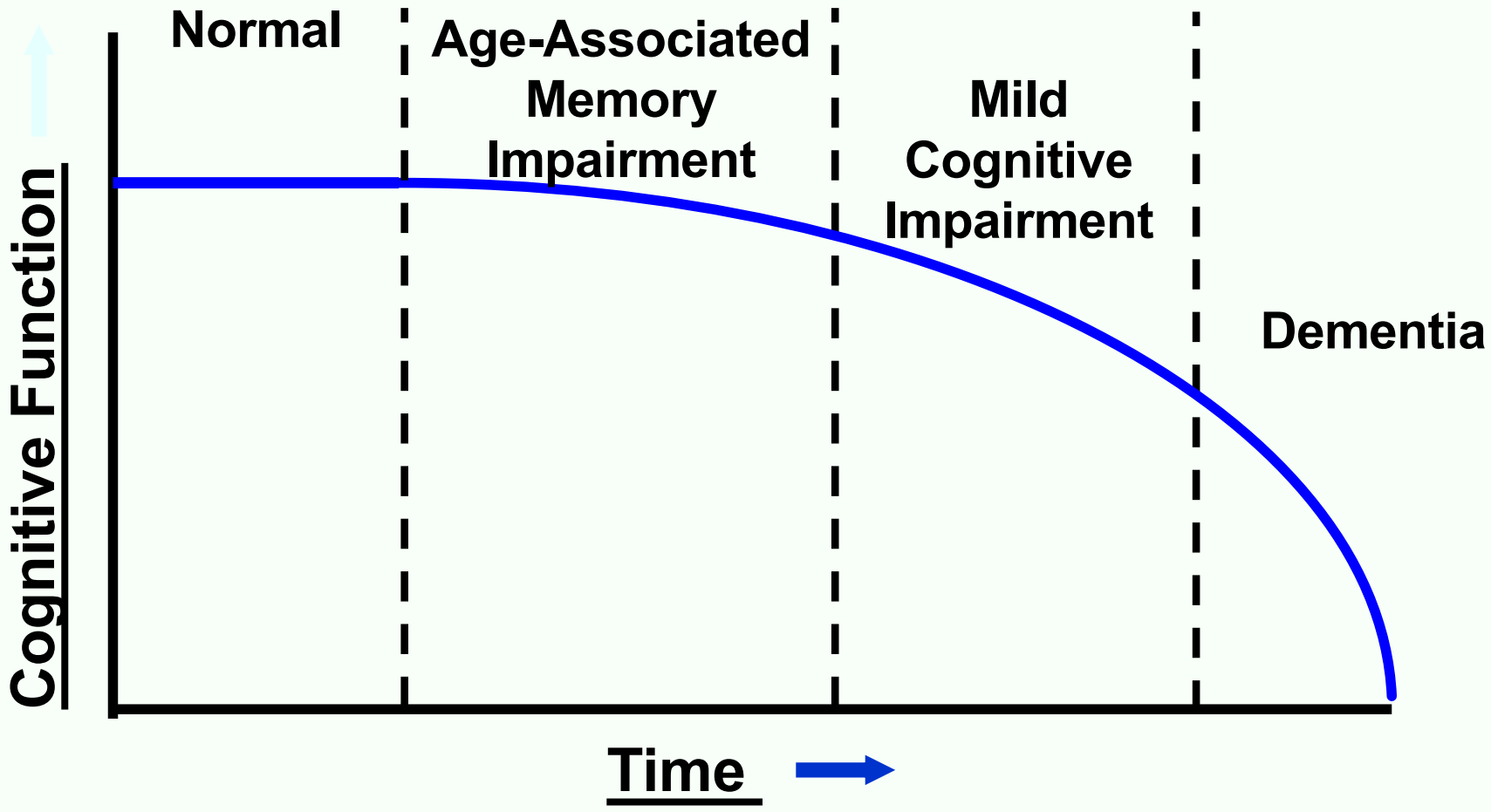
-emergency room/911

Effectiveness of Depression Treatment

	Response	Time needed
antidepressants	~50%	4-8 weeks
psychotherapy	~50%	variable
Antidepressant + psychotherapy	>>50%	<4-8 weeks
More severe symptoms not responding to above:		
TMS (transcranial magnetic stimulation)	50-75%	3-5 weeks
ECT (electroconvulsive therapy)	80%	2-3 week
ketamine, intravenous	65-80%	days-2 weeks
esketamine, intranasal	60+%?	1-4 weeks


dementia

Memory Decline Stages



Stages of Memory Decline

Mild Cognitive Impairment (MCI):

cognitive decline, below 5th percentile on testing

no loss of ADLs (activities of daily living)

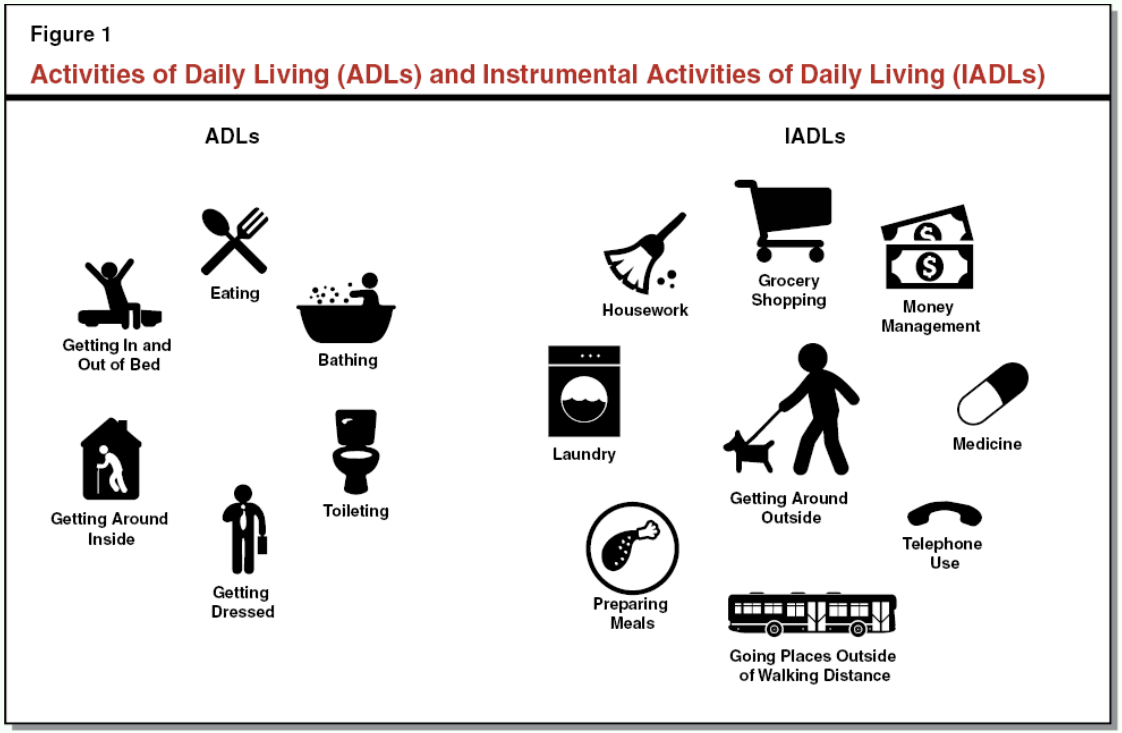
10-15% per year progress to dementia

address reversible risk factors to slow further decline

Dementia:

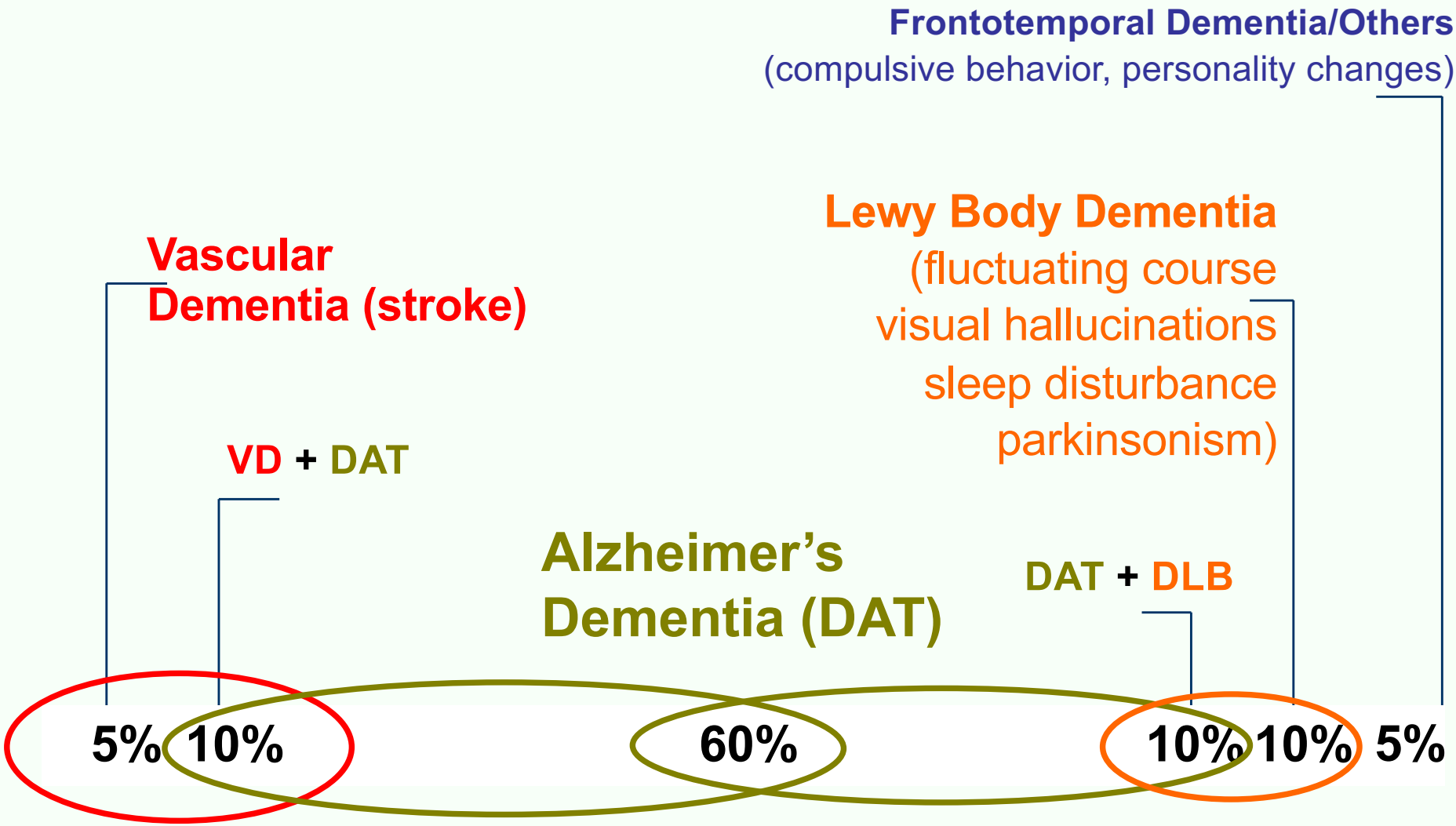
cognitive decline AND

loss of ADLs



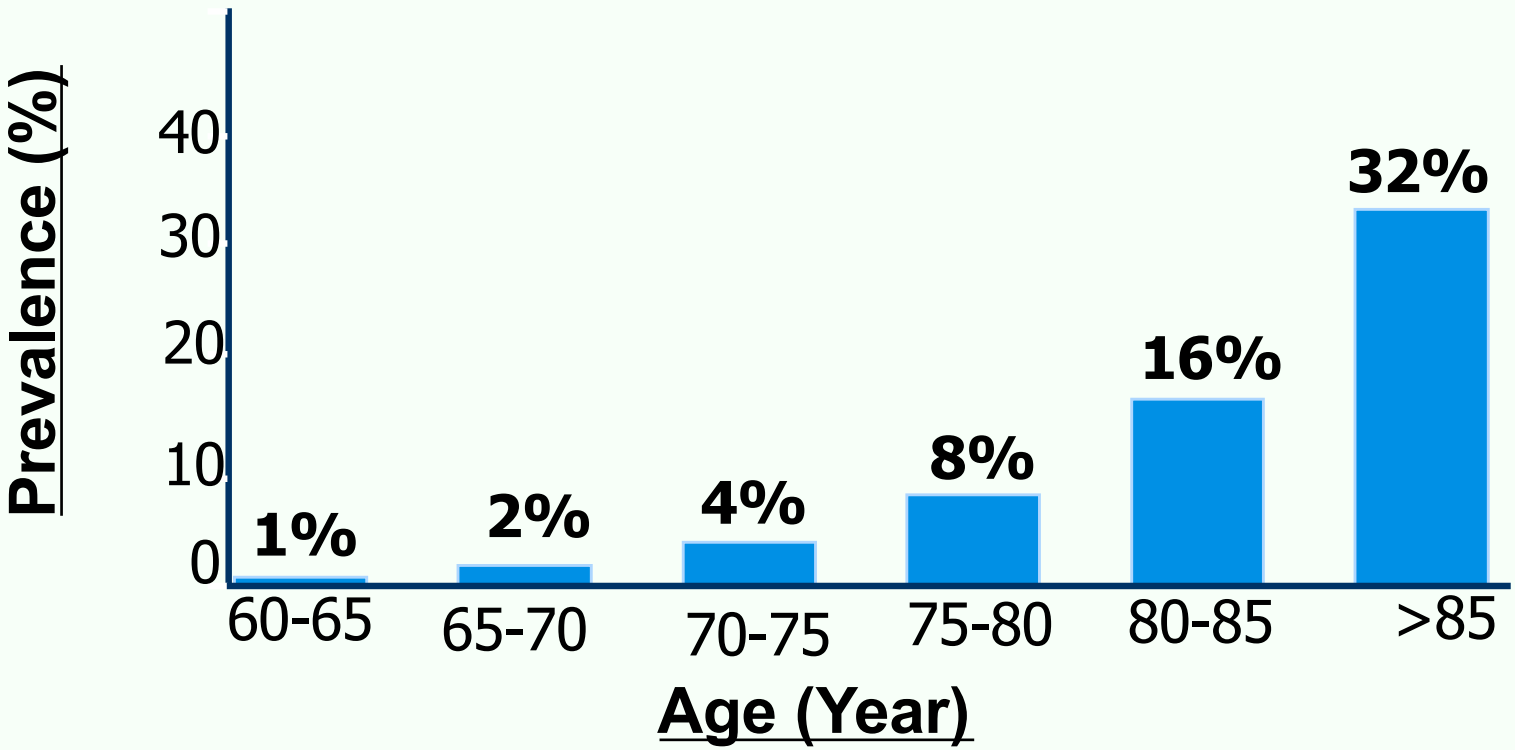
https://lao.ca.gov/Publications/Report/3509

Dementia Types



Barker 2002, Morris 1994, Small 1997

Alzheimer's Dementia



Among age >=65 in US,

2021: 6.2 million
2050: 12.7 million

Alzheimer's Association, 2021

Assessing Memory Decline

-delirium (medically ill, meds)?

-any depression?

-unable to retain new/recent information

  -memory of past events (childhood) often intact

-poorer planning, no longer able to perform previously learned skills not due to physical disability

-loss of IADLS, followed by loss of more basic ADLs

Cognitive Screening Tools

For dementia:

Mini-Cog

screen for dementia, short, anyone can use w/ minimal training

MMSE (Mini Mental Status Exam)

screen for dementia, up to 10min, copyrighted

For MCI:

SLUMS (St. Louis University Mental Status Exam)

better screen for MCI, up to 10min, anyone can use

MOCA (Montrell Cognitive Assessment)

better screen for MCI, up to 15min

license fee

Mini-Cog

-three word recall and a clock draw

-better than PCPs in detecting early dementia

-reliable in those with limited English of education

-less useful for detecting MCI

MINI-COG ™

1) GET THE PATIENT'S ATTENTION, THEN SAY: "I am going to say three words that I want you to remember. The words are
Banana Sunrise Chair.
Please say them for me now." (Give the patient 3 tries to repeat the words. If unable after 3 tries, go to next item.)
old this page back at the TWO dotted lines BELOW to make a blank space and cover the memory words. Hand the patient a pencil/pen).

2) SAY ALL THE FOLLOWING PHRASES IN THE ORDER INDICATED: "Please draw a clock in the space below. Start by drawing a large circle." (When this is done, say) "Put all the numbers in the circle." (When done, say) "Now set the hands to show 11:10 (10 past 11)."

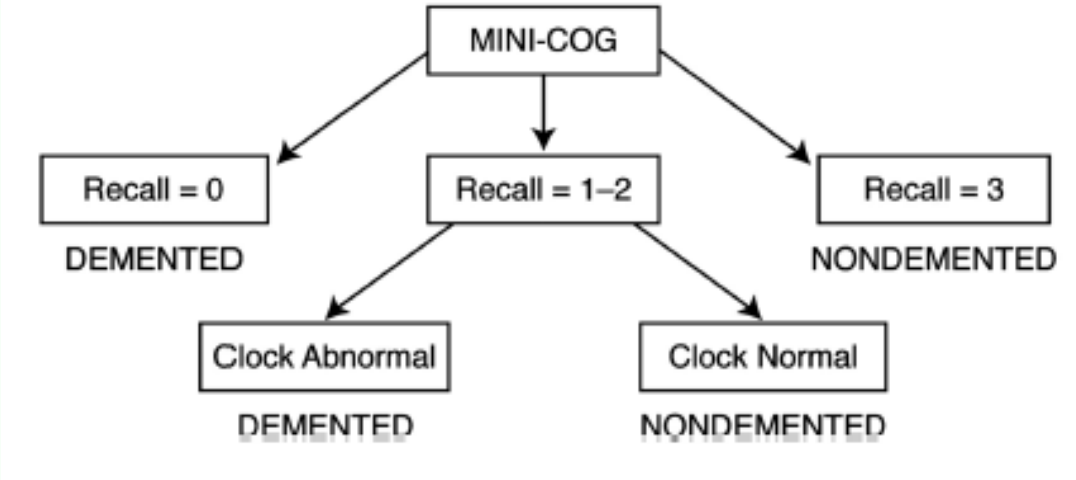
(F

3) SAY: "What were the three words I asked you to remember?"

_____ _____ _____ (Score 1 point for each) 3-Item Recall Score ☐

Score the clock (see other side for instructions): Normal clock 2 points Clock Score ☐
Abnormal clock 0 points

Total Score = 3-item recall plus clock score ☐ ***0, 1, or 2 possible impairment; 3, 4, or 5 suggests no impairment***



Borson 2000, Galvin 2012

MMSE

-more frequently used than Mini-cog

-good for assessing degree of dementia

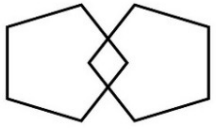
-not too useful for detecting MCI

MINI MENTAL STATE EXAMINATION (MMSE)

Name:

DOB:

Hospital Number:

One point for each answer	DATE:		
ORIENTATION Year Season Month Date Time	...../ 5	...../ 5	...../ 5
Country Town District Hospital Ward/Floor	...../ 5	...../ 5	...../ 5
REGISTRATION Examiner names three objects (e.g. apple, table, penny) and asks the patient to repeat (1 point for each correct. THEN the patient learns the 3 names repeating until correct).	...../ 3	...../ 3	...../ 3
ATTENTION AND CALCULATION Subtract 7 from 100, then repeat from result. Continue five times: 100, 93, 86, 79, 65. (Alternative: spell "WORLD" backwards: DLROW).	...../ 5	...../ 5	...../ 5
RECALL Ask for the names of the three objects learned earlier.	...../ 3	...../ 3	...../ 3
LANGUAGE Name two objects (e.g. pen, watch).	...../ 2	...../ 2	...../ 2
Repeat "No ifs, ands, or buts".	...../ 1	...../ 1	...../ 1
Give a three-stage command. Score 1 for each stage. (e.g. "Place index finger of right hand on your nose and then on your left ear").	...../ 3	...../ 3	...../ 3
Ask the patient to read and obey a written command on a piece of paper. The written instruction is: "Close your eyes".	...../ 1	...../ 1	...../ 1
Ask the patient to write a sentence. Score 1 if it is sensible and has a subject and a verb.	...../ 1	...../ 1	...../ 1
COPYING: Ask the patient to copy a pair of intersecting pentagons 	...../ 1	...../ 1	...../ 1
TOTAL:	...../ 30	...../ 30	...../ 30

MMSE scoring
24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment

OME Oxford Medical Education

Folstein 1975

SLUMS

(St. Louis University Mental Status Exam)

-useful in detecting MCI

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu.

Name _____ Age _____

Is patient alert? _____ Level of education _____

Department of Veterans Affairs

__/1 (1) 1. What day of the week is it?

__/1 (1) 2. What is the year?

__/1 (1) 3. What state are we in?

4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car

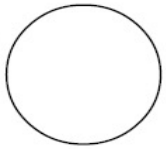
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
(1) How much did you spend?
__/3 (2) How much do you have left?

6. Please name as many animals as you can in one minute.
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 7. What were the five objects I asked you to remember? 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
__/2 (0) 87 (1) 649 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(2) Hour markers okay
__/4 (2) Time correct

__/2 (1) 10. Please place an X in the triangle.

(1) Which of the above figures is largest?

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

(2) What was the female's name? (2) What work did she do?
__/8 (2) When did she go back to work? (2) What state did she live in?

_____ TOTAL SCORE

Department of Veterans Affairs

SAINT LOUIS UNIVERSITY

Scoring		
High School Education		Less than High School Education
27-30	Normal	25-30
21-26	MNCD*	20-24
1-20	Dementia	1-19

* Mild Neurocognitive Disorder

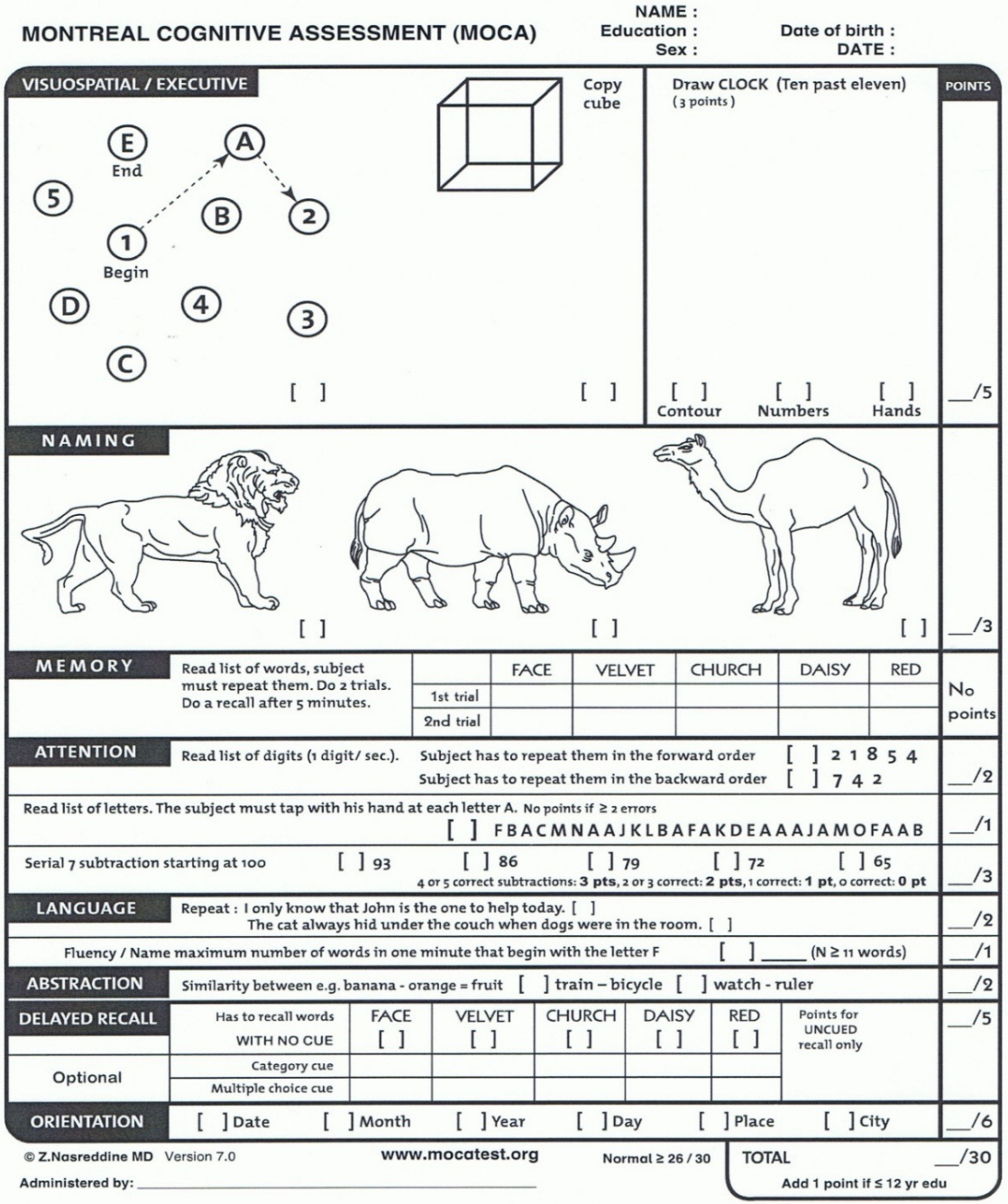
SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. J am Geriatri Psych (in press).

MOCA

-useful in detecting MCI

-takes longer than other tests

-recurrent certification fee



MONTREAL COGNITIVE ASSESSMENT (MOCA)

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

VISUOSPATIAL / EXECUTIVE — POINTS

Copy cube

[ ] [ ]

Draw CLOCK (Ten past eleven) (3 points)

[ ] Contour [ ] Numbers [ ] Hands __/5

NAMING

[ ] [ ] [ ] __/3

MEMORY — Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION — Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** __/3

LANGUAGE — Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ] __/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words) __/1

ABSTRACTION — Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z.Nasreddine MD Version 7.0 www.mocatest.org

Normal ≥ 26 / 30

TOTAL __/30

Add 1 point if ≤ 12 yr edu

Administered by: _____

Nesreddine 2005

Addressing Memory Decline

Irreversible risk factors:

family history, increased age, lower education levels

Reversible risk factors:

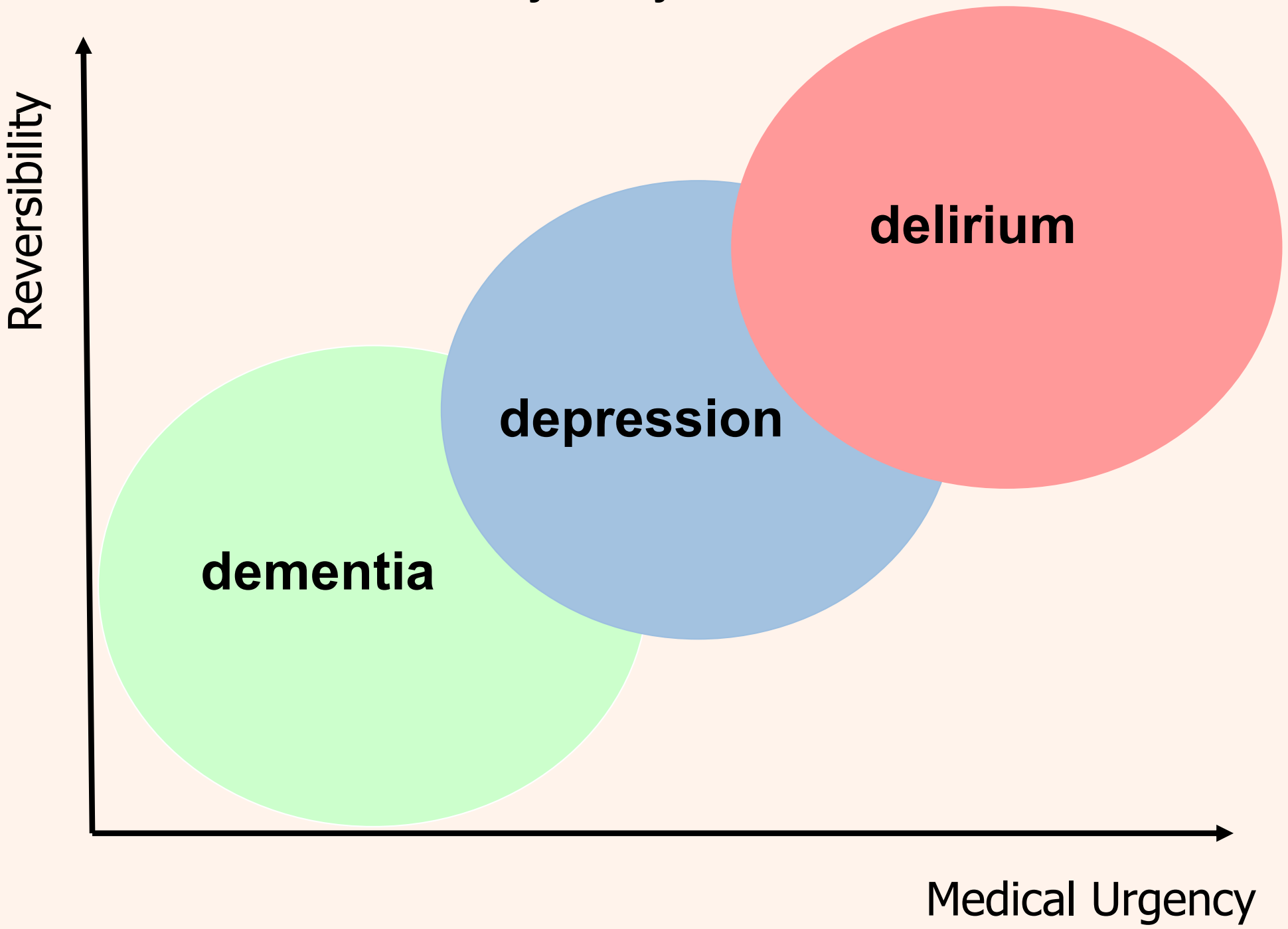
-treat underlying depression aggressively

-good control of blood pressure, cholesterol, fasting glucose/diabetes

-lifestyle: physical exercise, psychosocial routines, diet

-dementia medications (slow decline by 6-12 months), smaller effect

The Three D's of Geriatric Psychiatry



	Delirium	Depression	Dementia
Onset	Acute	Variable	Insidious
Duration	Days	Variable	Months to years
Course	Fluctuates	Possible diurnal variation (worse in morning)	Slowly progressive (though may be step-wise)
Consciousness	Impaired and fluctuating	Unimpaired	Clear at onset
Attention and memo	Inattentive Poor memory	Poor concentration, sometimes complaining of poor memory	Poor memory but without inattention
Affect	Variable	Depression, loss of interest and pleasure in usual activities	Variable

Tang 2018

Geriatric Mental Health in the Time of COVID-19

3 D's in Geriatric Psychiatry:
Delirium, Depression, Dementia

Dementia-Related Behavior and Treatment

- **national/local crisis**
- types of behavior
- non-medication approaches
- role of medications

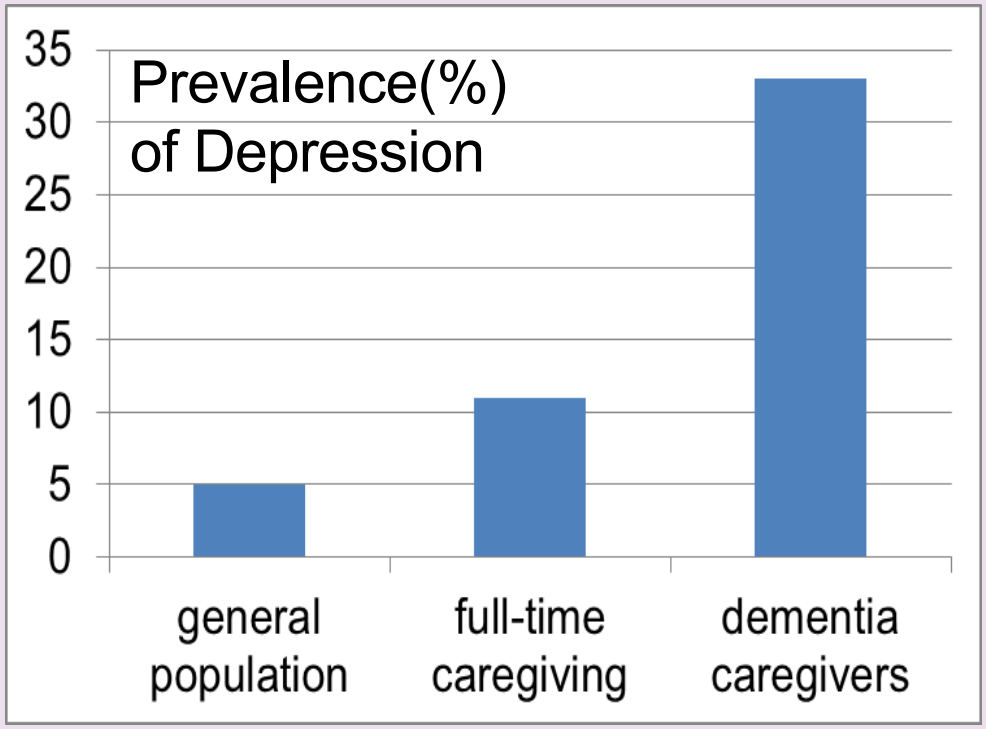
Behavioral and Psychological Symptoms of Dementia (BPSD)

Present in 60-98% with dementia

Premature institutionalization

Predicts higher mortality

Suffering for patients
and caregiver



Adelman 2014; Covinsky 2003, NSDUH 2007

Baby boomer cohort in US (1946-1964):
"**Crisis in geriatric mental health**" starting around 2011

Jeste 1999, Stoudemire, 1996; Streim, 1996, 2005

Hawaii: microcosm of the geriatric mental health crisis facing the US

Hawaii (2019):

population: 1.4 million

Ages >=65: 19% (14.5% in US)

#1 life expectancy: 81 yrs (79 in US)

Rankings [edit]

Rank	Rank (50 states & DC)	State	Life Expectancy, All (in years)
01	01	Hawaii	81.3
02	02	Minnesota	81.1
03	–	Puerto Rico	80.9
04	03	Connecticut	80.8
04	03	California	80.8
06	05	Massachusetts	80.5
06	05	New York	80.5
06	05	Vermont	80.5
09	08	New Hampshire	80.3
09	08	New Jersey	80.3

US Census Bureau 2020, wikipedia

Outpatient:

Few psychiatric providers, even fewer for seniors

PCPs increasingly relied upon

Inpatient:

dedicated geriatric psychiatry beds: **zero**

seniors dispersed in adult psychiatric or general medical units

Hawaii: microcosm of the geriatric mental health crisis facing the US

Emergency services:

Increased number/percentage of elderly to Queens psychiatric ER

Increasingly brought by police,
12% of seniors in 2007
to 24.5% in 2011

Oldest patients (ages >=80) needing a psychiatric admission with the highest length of stay (LOS) in the ER (median 8 hr)

Lu 2017

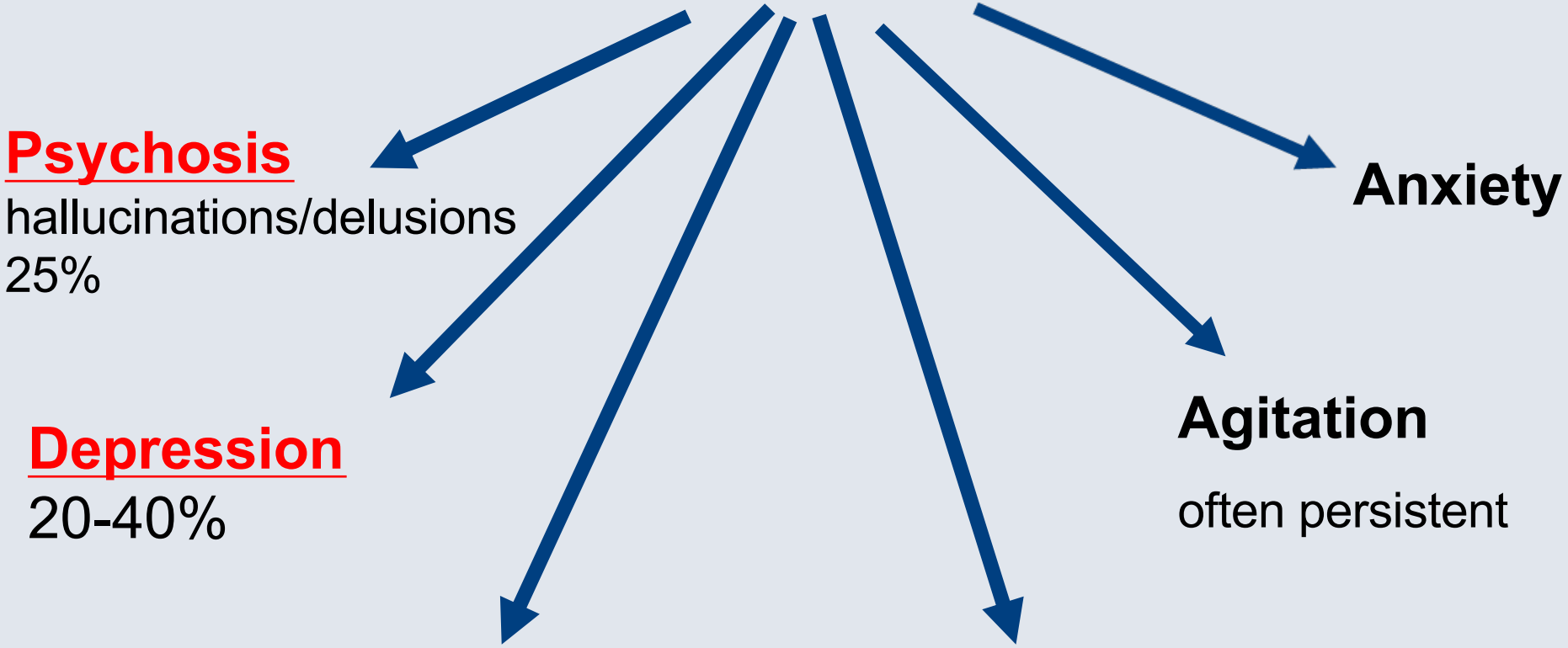
Geriatric Mental Health in the Time of COVID-19

3 D's in Geriatric Psychiatry:
Delirium, Depression, Dementia

Dementia-Related Behavior and Treatment

- national/local crisis
- **types of behavior**
- non-medication approaches
- role of medications

Types of Behaviors in Dementia



Psychosis
hallucinations/delusions
25%

Depression
20-40%

Apathy
indifference

Altered circadian rhythms
disrupted sleep patterns

Agitation
often persistent

Anxiety

Psychosis in Dementia

Psychosis = reality testing impaired

Misidentification of caregivers/surroundings

Paranoid delusions: lost items, accusations, poison

Visual hallucinations: stalkers, stranger in the house

Increases with dementia progression (~25%)

Leads to physical aggression, institutionalization, and higher risk of death

Leonard 2006, Lopez 2013, Steinberg 2006

Depression in Dementia

15 - 40% in Alzheimer's (especially in early stages)

25 - 40% in Vascular dementia

40%+ in Lewy Body or Parkinson's Disease dementia

Irritability, self-pity, rejection sensitivity, loss of interest, isolation, poor effort to engage, poor eye contact

Leads to physical aggression, higher risk of death, and faster memory decline

Alexopoulos 1988, Asmer 2018, 2002; Kumar 2013, Leonard 2006

Depression in Dementia

20% in Alzheimer's

20% - 40% in Vascular dementia

>50% in Parkinson's Disease dementia

Irritability, self-pity, rejection sensitivity, loss of interest, isolation, poor effort to engage, poor eye contact

Leads to physical aggression, higher risk of death, and faster memory decline

Alexopoulos 1988, 2002; Kumar 2013, Leonard 2006

Agitation/Disinhibition in Dementia

Impulsive and inappropriate behaviors

Examples: verbal/physical aggression (often self-directed), inappropriate sexual behavior, intrusive wandering, impulse buying

Apathy in Dementia

Indifference, lack of motivation, no poor mood/irritability

Up to 70% in dementia, especially later stages

Antidepressant in apathy w/o depression may worsen apathy

Landes 2001

Anxiety in Dementia

repeatedly asking questions on a forthcoming event
fear of being left alone
pacing/fidgeting

Circadian Rhythm Disturbances in Dementia

increased sleep latency (more time to fall asleep)
Increased awakenings throughout the night
Sundowning (late day confusion/aggression)

Geriatric Mental Health in the Time of COVID-19

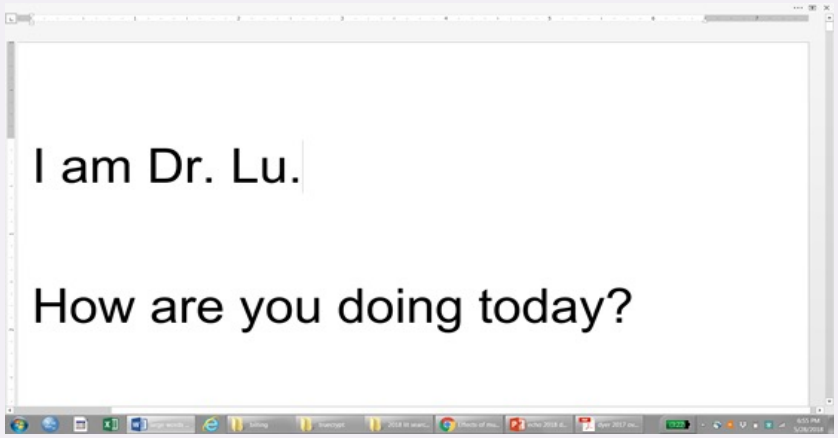
3 D's in Geriatric Psychiatry:
Delirium, Depression, Dementia

Dementia-Related Behavior and Treatment

- national/local crisis
- types of behavior
- **non-medication approaches**
- role of medications

Non-Medication Approaches for Dementia Behavior

Identify and address triggers/unmet needs



Basic care:
Encourage self-care/orientation
Speak calmly/gentle touch
Use gestures/written words
Approach patient from front

Safety: grab bars
conceal exits/lethal means

Routines/Recreations:
More individualized tasks

Ballard 2009, Beier 2007, Cook 2012, Gerdner 1993, Kong 2009, Rowe 1999

Non-Medication Approaches for Dementia Behavior

Sensory stimulation:
plants, animals,
massage, aromatherapy
Music (familiar!)

Even more important
With COVID restrictions

Courtesy of Manoa Cottages

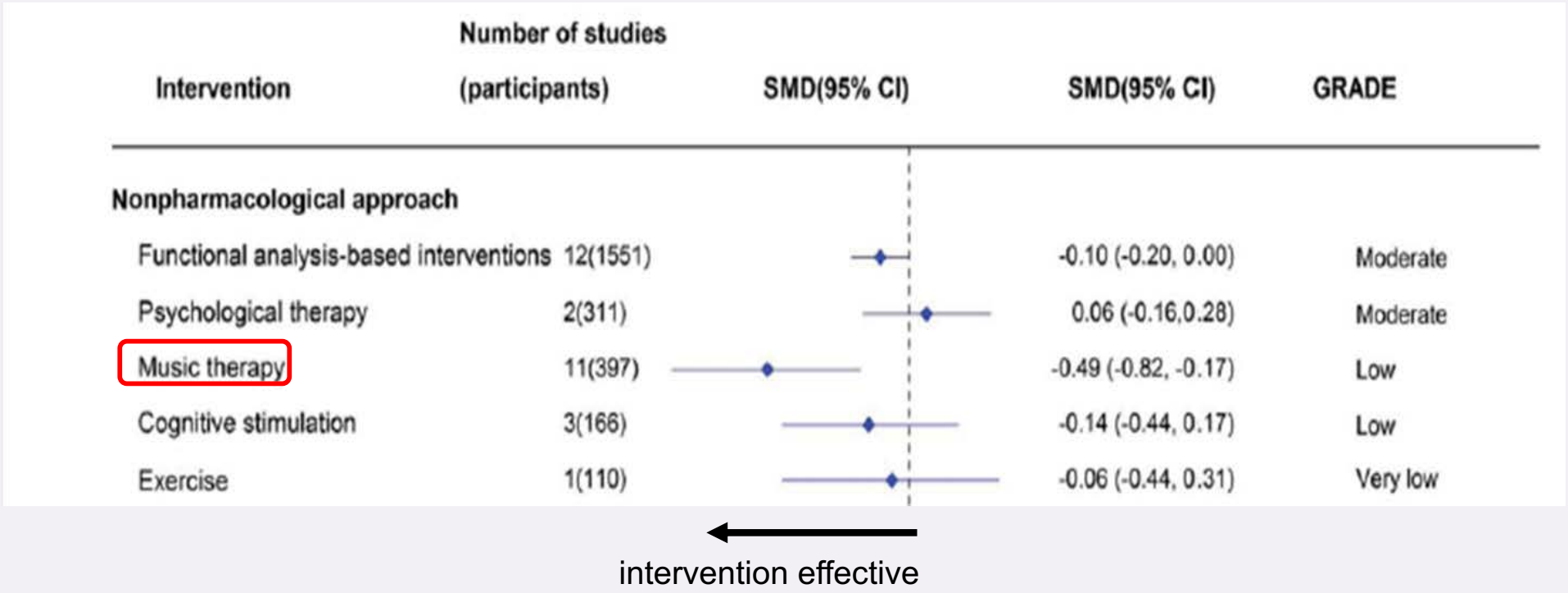
Ballard 2009, Beier 2007,
Dyer 2017, Gerdner 1993,
Kong 2009, Rowe 1999, Ueda 2013

Evidence for non-med interventions so far…

NO ADVERSE EFFECTS

No clear evidence in reducing agitation or aggression in nursing homes. Exception is that music may be effective.

Jutkowitz 2016



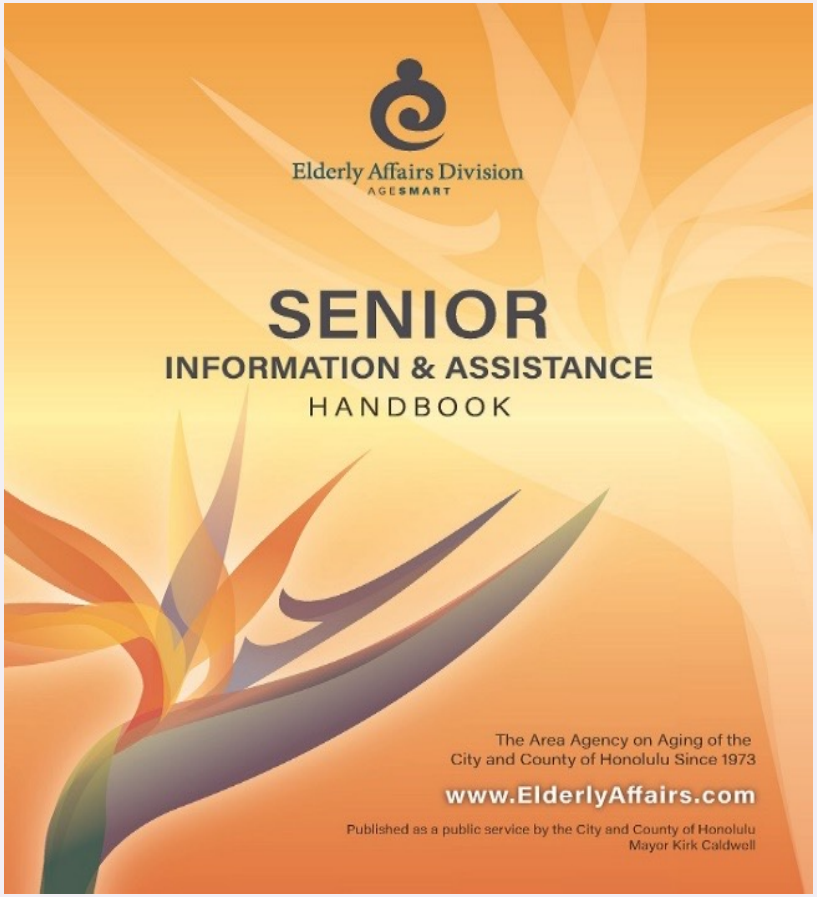
Dyer 2017

Non-Medication Approaches for Dementia Behavior

<u>Paranoia/Hallucinations</u>
Avoid confrontation
Reassurance/validate followed by distraction
Safety (hide harmful objects)

<u>Sleep</u>
wake up on time/avoid long naps
keep occupied/awake in the day
light early evening activities
hallway/bathroom lights

<u>Activities</u>
physical and mental, individualized
community resource/day programs



808-768-7700

Geriatric Mental Health in the Time of COVID-19

3 D's in Geriatric Psychiatry:
Delirium, Depression, Dementia

Dementia-Related Behavior and Treatment

- national/local crisis
- types of behavior
- non-medication approaches
- **role of medications**

Medical Causes of Behavior in Dementia

Delirum

- New medical illness
- New medications

Depression: associated with physical aggression

Constipation: associated with physical aggression

Leonard 2006

Pain

When Medications Appropriate?

Indications: Poor Quality of Life, Safety Concerns

distressing psychosis/anxiety, severe depression

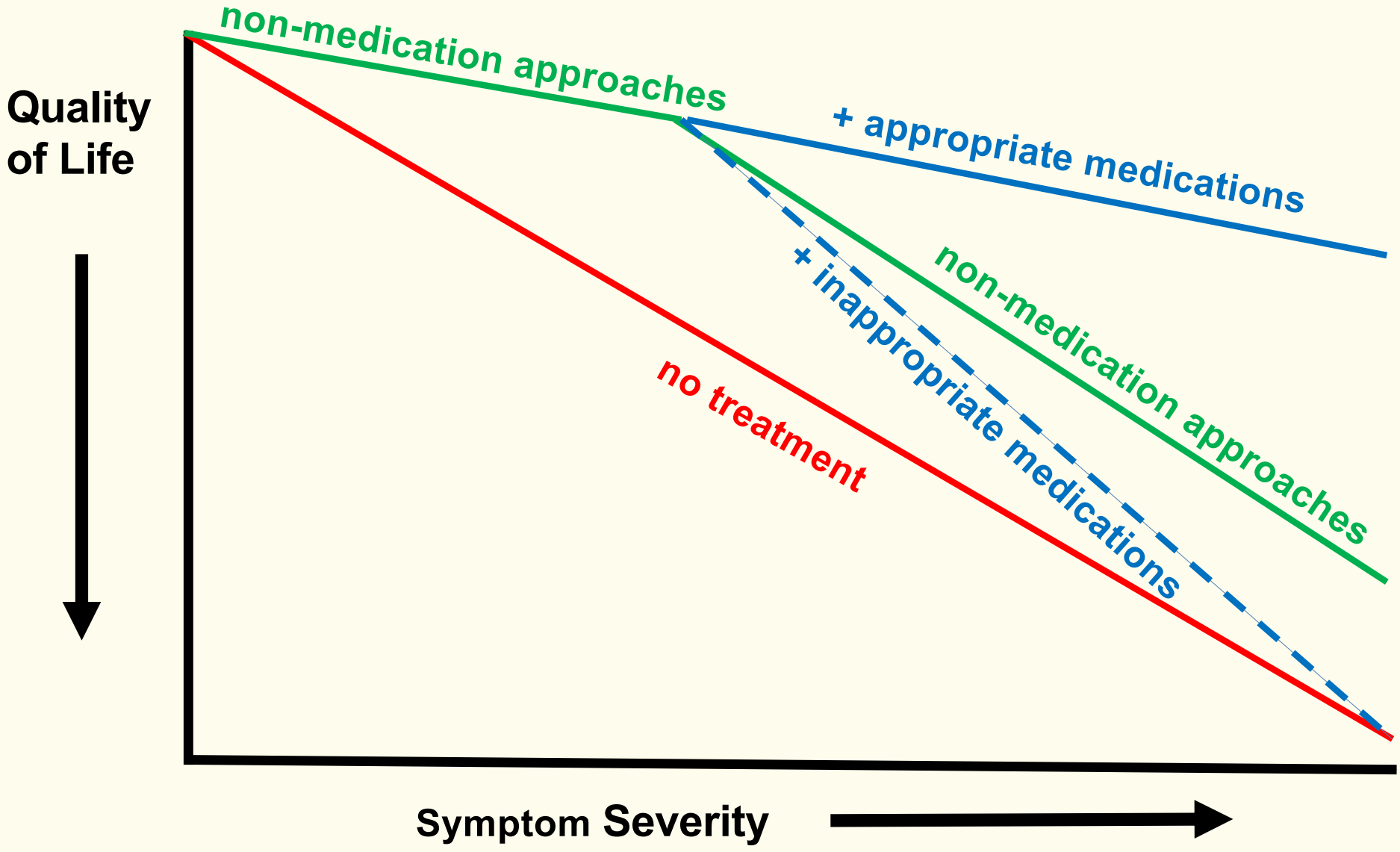
elopement, physical aggression

to avoid institutionalization, emergency services

Goals of Medications Treatment

What is the highest quality of life possible, using medications with the highest benefit to risk ratio?

Maintaining Quality of Life in Dementia



1. There is no cure for dementia, but it is possible to try to slow down the progression or to lessen behavioral symptoms of this illness.

TRUE

2. Once a person with dementia is placed in a facility with caregivers experienced in dementia care, they should be able to manage all types of dementia-related behavior, including physical aggression, without any need for medications.

FALSE

3. If an older person with dementia gradually becomes more irritable, increasingly refusing food and care, it could be a sign of depression.

TRUE

4. If someone can still recall details and birthdates of family members from long ago, this person is unlikely to have dementia, even if the person is easily confused in new situations and unable to remember new information.

FALSE

5. A person with dementia angrily accuses a family member for stealing, despite repeated denials by the family. The next best thing is to ask the doctor to side with the family to tell the person that the allegation was untrue.

FALSE

Preparing for a doctor's visit

Bring complete medication/supplement list

Describe one or two typical examples
of difficult behavior, with details

Describe what interventions tried (and how effective?)

Describe how the behavior led to serious safety
risks and caregiver burnout

Medications for Dementia-related Behavior

No “FDA-approved” medication for dementia behavior

Ensure family members/medical surrogates informed and agreeable

In general:

Antidepressants (citalopram, escitalopram):

improve depression/agitation/psychosis, less side effects

Antipsychotics (example: risperidone, olanzapine, quetiapine)

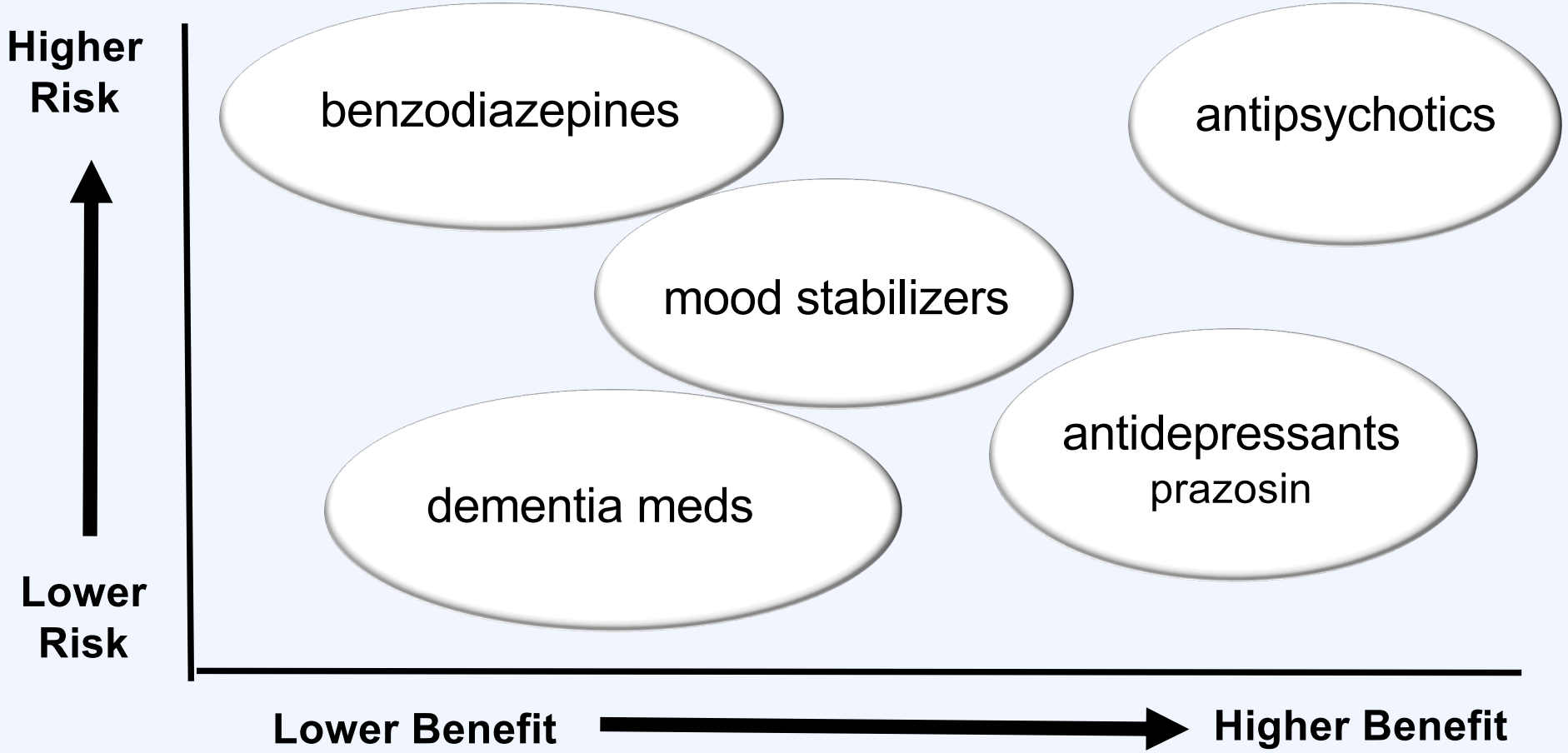
can also help, more sedation/serious side effects

Dementia medications (slow down decline by ~6 months):

smaller improvement in behavior

Medications for Dementia-related Behavior

Use meds with higher benefit/risk ratio



Weighing the benefit and risk of medications

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

See full prescribing information for complete boxed warning.

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. RISPERDAL® is not approved for use in patients with dementia-related psychosis. (5.1)

Example: risperidone (Risperdal) in dementia

Potential Benefit:

30-70% chance of reducing physical aggression

Katz 1999

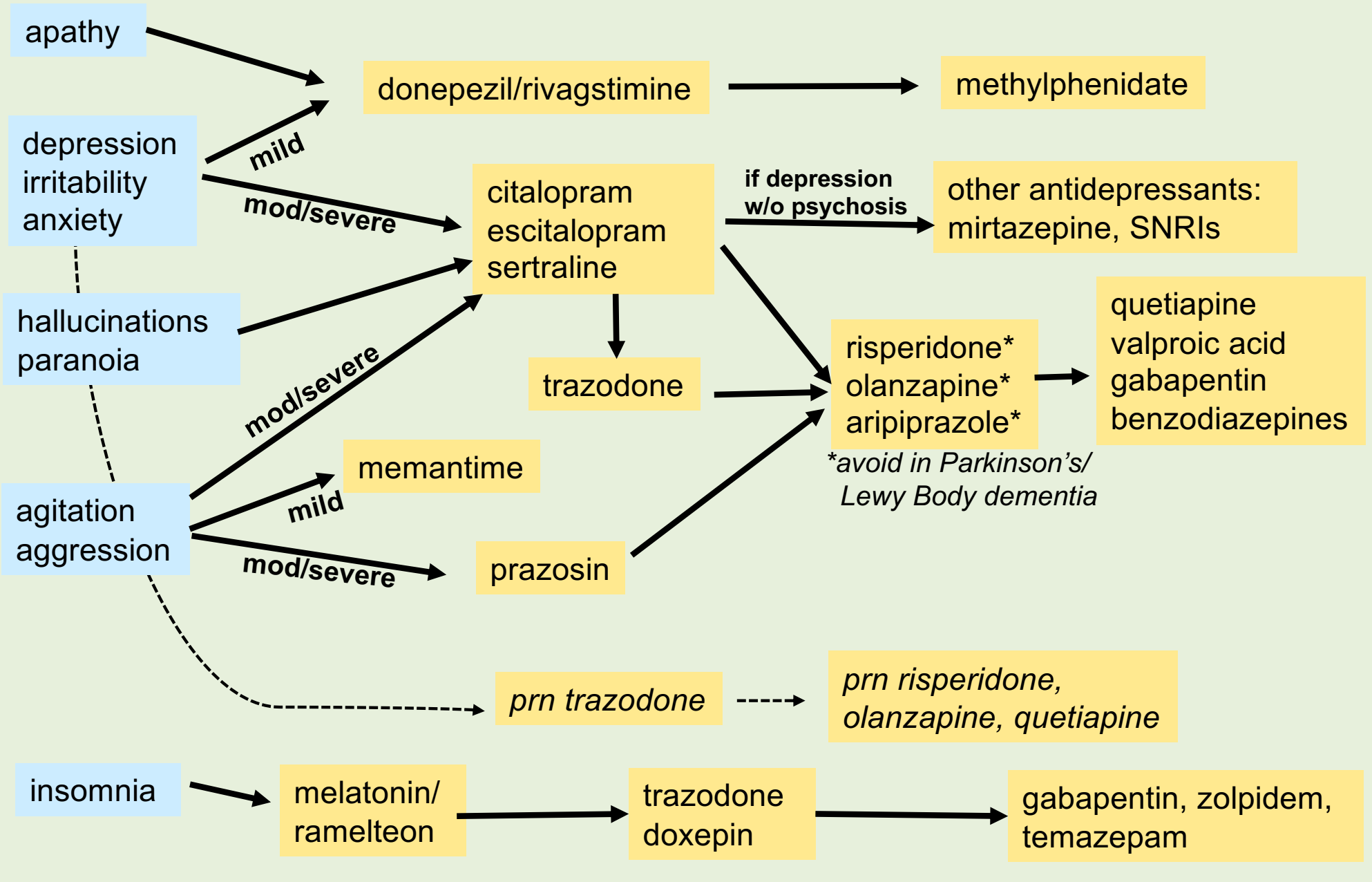
Potential Risk:

risk of death increased from 3% to 4%

Haupt 2006

If doing well, can consider decreasing/stopping every 6 months. (hallucinations often resolve within a few months)

Honolulu Medication Algorithm for Behavioral Symptoms in Dementia



updated (June 2020) per evidenced-based benefit to risk ratio, Lu 2016

What to expect during medication trial?

Effective?

-start with low dose, to ensure tolerability

-may need up to 2-6 weeks for sustained improvement

-if behavior persist during this time,

-not necessarily due to “medications not working”

-not necessarily due to “medication side effects”

Side Effects?

Clear changes from baseline:

sedation, falls, insomnia, confusion, constipation, agitation, disinhibition, decreased appetite

Responsible Medication Use = Better long-term outcomes

When used for disruptive behaviors (psychosis, aggression, agitation), antipsychotics use in dementia not associated with greater nursing home admission rate or risk of death

Lopez 2013

Rather, it is the debilitating levels of depression, psychosis, aggression that accelerate cognitive/physical decline, poorer quality life, and premature institutionalization

"judicious use of pharmacological interventions, including antipsychotics, is appropriate, necessary, and ethically justified…"

Desai 2012

Questions?