

ABCD -The role of psychogeriatrics in **A**ssessment and **B**etter **C**are for **D**ementia

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AAIC Satellite Symposium 2019



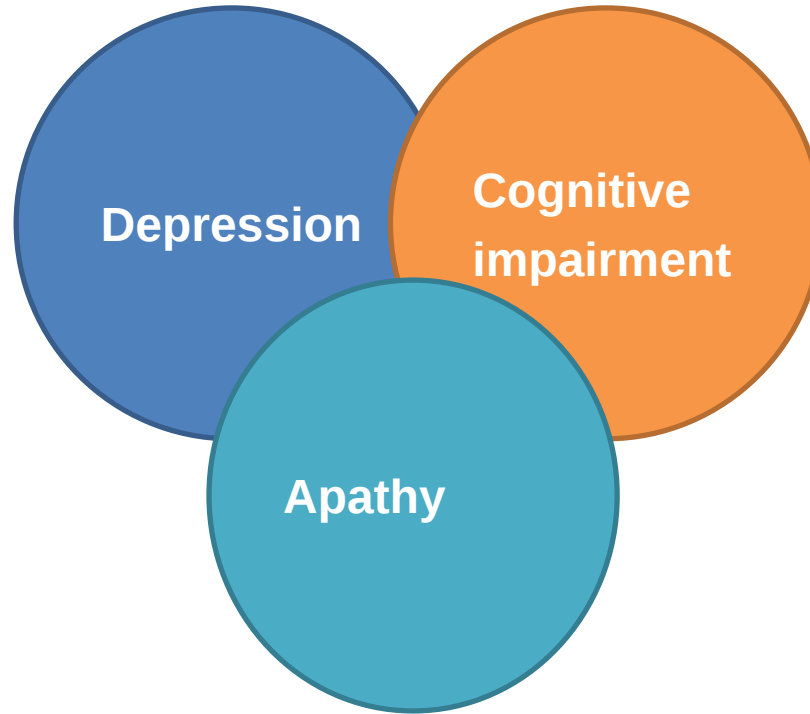
Roles of psychogeriatrics in dementia

- **Multidisciplinary – Nurse, Psychologist, SW, OT, OAP**
- **Diagnosis, differential diagnosis**
- **Behaviours & Psychological Symptoms associated with dementia**
- **Psychotropic prescribing and deprescribing**
- **Non-pharmacological management**

Differential diagnosis

- Depression vs dementia ('pseudodementia')
- Apathy vs depression

Depression, apathy & cognition



Symptoms common to both

- **Hamilton Depression Rating Scale-21 in dementia**
 - total possible score of 64
 - Sleep disturbance, agitation, retardation, loss of interest, loss of weight/ appetite, loss of libido, loss of energy, lack of insight, paranoid delusions, hallucinations → ≤ 34

Clinical features more indicative of depression

- Content of depressive thoughts
 - eg guilt, nihilism
- Pervasive depression, lack of reactivity
- Suicidal
- Past history of depression
- ? Family history

TRAP – 20%+ of people with dementia will have comorbid depression

Bedside Dx: depⁿ v dementia¹

Depression

- Onset recent, course > rapid
- **Family always aware**
- PPH, FH of dep >likely
- **> cognitive Sx, > specific**
- Pt highlights failures
- **Affect pervasive**
- Behaviour incongruent with cognitive Sx eg social skills ↓
- **O/E – “don’t know” answers, memory loss, past = recent; memory gaps often**

Dementia

- Longer duration, >gradual
- **Family often not aware**
- FH of dementia may exist
- **Pt. complains less**
- Pt. highlights success
- **Affect labile, shallow**
- Behaviour compatible with cogⁿ Sx
- **O/E recent memory<<past, memory gaps unusual**

Pseudodementia

- **Defⁿ: Dx confirmed if cognition recovers when psychiatric condition resolves**
- **Psychiatric conditions → Pseudodementia¹**
 - Depression
 - Schizophrenia, paraphrenia
 - Mania and bipolar disorder
 - Hysteria
 - Malingering, Ganser syndrome

¹Kiloh LG, Acta Psych Scandanavica 1961

Depression + '*reversible dementia*'

- Pseudo-pseudodementia – Pts Dx with pseudodementia → dementia at follow-up¹
- **Alexopoulos (1993)** followed up 23 in-pts with depression and criteria for dementia vs 34 with depression and no dementia¹
 - Age $\approx 74 \pm 6.7$; follow-up ≈ 33 months
 - HRSD on admission 36.6 vs 27.3 **
 - MMSE on admission 18.6 vs 27.3 ***
 - MMSE at discharge 26.4 vs 27.6 ($p < 0.09$)
 - Dementia follow-up 43% vs 12% **; OR 4.69

¹Shraberg D, Am J Psychiatry 1978;135:601-2;

²Alexopoulos GS et al Am J Psychiatry 1993; 150: 1693-9

Follow-up studies of **depressive** pseudodementia pts ¹

Study	n	Age at baseline Mean (SD)	Follow-Up (yrs)	Proportion with frank dementia at follow up
Tsiouris et al. (1997)	4	44.0 (4.2)	0.5-3	0 (0%)
Sachdev et al. (1990)	8	57.8 (6.1)	7-9	0 (0%)
Allen et al (1982)	3	60.7 (4.0)	<1	0 (0%)
Reynolds III et al. (1987)	8	71.8 (7.7)	0-2	0 (0%)
Pearlson et al. (1989)	15	71.9 (1.5)	2-0	1 (7%)
Raninesi et al. (2013)	20	72.7 (5.3)	0-2	0 (0%)
Alexopoulos et al. (1993)	23	73.7 (6.8)	2-7	10 (44%)
Bulbena & Berrios (1986)	10	75.4 (6.9)	1-3-3-9	3 (30%)
McNeil (1999)	13	76.2 (7.1)	3-0	0 (0%)
Kral & Emery (1989)	44	76.5 (N/R)	4-0-18-0	39 (89%)
Sáez-Fonseca et al. (2007)	21	77.6 (N/R)	5-0-7-0	15 (71%)
Rabins et al. (1984)	18	N/R	2-0	2 (11%)
Copeland et al. (1992)	4	N/R	3-0	2 (50%)
Wells (1979)	6	N/R	<1-0	0 (0%)
Redding (1985)	31	N/R	2.5	16 (52%)

¹ Connors MH, Qinto L, Brodaty H, Psychological Medicine, 2018; 48(11):1749-1758



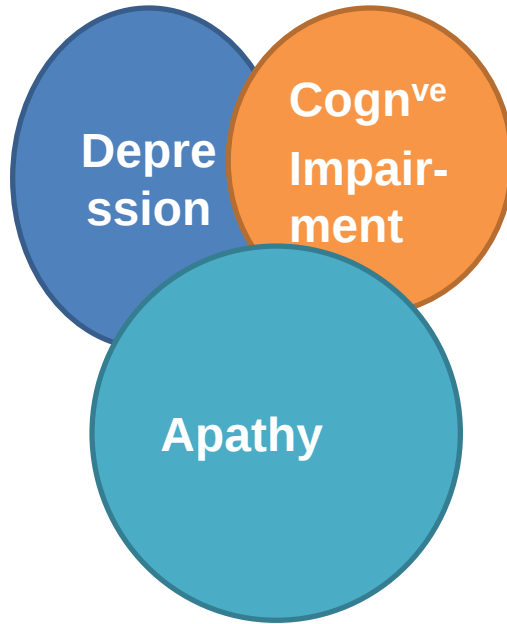
Follow-up studies of pts with depressive pseudodementia x age

- 66 pts <73yo: only one (1.6%) → dementia
- 111 pts >73: 67 (60.4%) → dementia
- 28 pts age not reported 4/28 (14.3%) → dementia

Pseudodementia ≠ diagnosis; it's a clinical Px

- **Age and past psychiatric history important**
- **Misdiagnosing a person with pseudodementia as true dementia when underlying condition is treatable is the tragedy that Kiloh highlighted**
- **Late onset depression and other psychiatric conditions may be harbinger of organic brain Δ**
- **Dementia & psychiatric disorders may co-exist**

Depression & apathy & cognition



- Apathy > associated with right frontal subcortical circuits
- Depression with left
- After stroke as > CVD
 - overlap between apathy & depression increases
 - overlap between apathy & cognition increases

Withall A, Brodaty H... Sachdev P *Int Psychoger*, 2011;23:264-273,

Distinct from depression

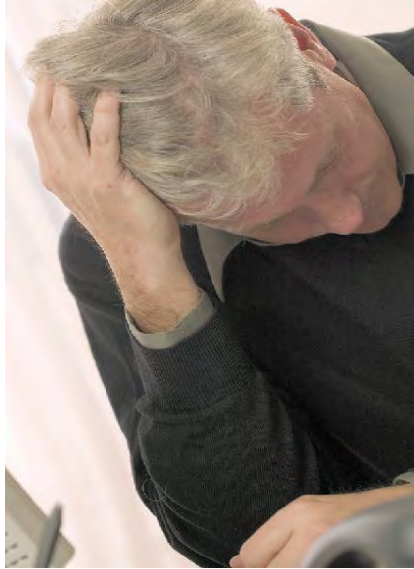
- Related but distinct from depression & dysphoria¹
- Symptoms overlap
- Association between apathy & cognitive impairment (esp. executive function) stronger in apathy than depression²
 - eg MCI + apathy more likely to progress to dementia

¹Marin et al *J Nerv Ment Dis* 1994;182:235-239

²Brown & Pluck *Trends Neurosci* 2000;23:412-417



Symptoms in common



- **Lack interest**
- **Lack initiative**
- **Lack motivation**
- **Decreased libido**
- **Decreased concentration**
- **Less energy**

Apathy

vs

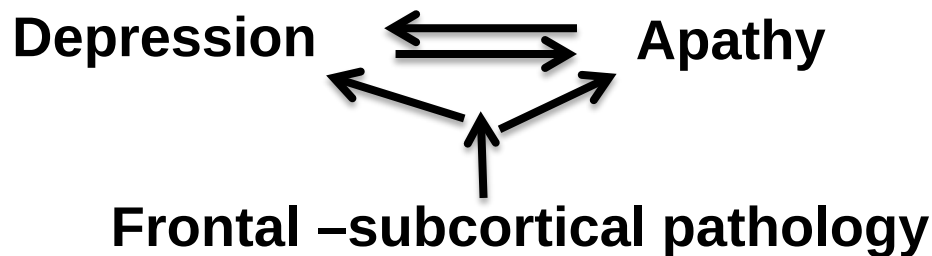
Depression

- Lack emotion
- Don't care
- Not suicidal
- Not usually anxious
- Vegetative Sx absent usually except lose interest in food/ sex
- No sadness 'transmits'
- A'D Rx: Poor response

- Sad, tearful
- No point to life
- May be suicidal/ 'rather be dead'
- May be anxious
- Vegetative symptoms
 - Sleep, appetite
 - weight, libido
- Clinician 'feels' sadness
- Rx: Moderate response

Pseudodepression

- Apathy often misdiagnosed as depression
- Apathy is common in depression
- Both are common in dementia
- Apathy is unresponsive to antidepressants¹
- Apathy may respond to ChEIs¹ esp with memantine², stimulants^{3,4,5}, TMS²
- Apathy and depression may be comorbid



¹ Berman, Brodaty et al
Am J Ger Psychiatry
2012; 20:104–122

² Burns K et al, in preparation

³ Rosenberg P et al,
J Clin Psych 2013

⁴ Lancot K et al, *Int Psychoger*,
2014; 26:239-246

⁵ Scherer RW et al, *Trials* 2018

Apathy: Non-pharmacological interventions

- Non-pharmacological interventions have potential to reduce apathy in dementia ¹⁻⁴
- Therapeutic activities: esp individually tailored¹
- Exercise; staff education; small vs large RACF⁵

¹Brodaty H & Burns K, *Am J Geriatric Psychiatry*: 2012; 20(7):549–564

²Theleritis C et al *J Geriatric Psychiatry & Neurology*. 2017;30(1):26-49

³Olley R et al. *Australian Health Review*. 2018;42(4):361-9

⁴Goris ED et al. *J Adv Nursing*. 2016;72(11):2612-28

⁵Burns K et al, in preparation

Therapeutic activities

Heterogenous group

- Cognitive stimulation
- Creative activities
- Cooking
- Recreation
- Montessori methods
- Occupational therapy
- Psychotherapeutic
- Behavioural treatments
- Attention-focusing
- Activities matched to skill levels



Diagnostic criteria



International
Psychogeriatric
Association

- **Agitation (IPA)**
- **Psychosis (IPA)**
- **Apathy (European psychogeriatric group)**

Agitation in cognitive disorders¹

- Criteria for cognitive impairment or dementia syndrome
- ≥ 1 of following behaviours
 - (a) Excessive motor activity (eg pacing)
 - (b) Verbal aggression (eg yelling)
 - (c) Physical aggression (e.g. grabbing, shoving)
- Associated with observed or inferred evidence of emotional distress
- Persistent or frequently recurrent for ≥ 2 weeks

Cummings J et al. *Int Psychogeriatr*. 2015 Jan; 27(1):7-17

Agitation in cognitive disorders

- Represents a change from patient's usual behaviour
- Behaviours severe enough to → excess disability beyond that due to cognitive impairment and ≥ 1 of:
 - (a) Significant impairment in relationships
 - (b) Significant impairment in social functioning
 - (c) Significant impairment in ADLs
- Agitation not attributable solely to another psychiatric disorder, suboptimal care, medical condition or physiological effects of a substance

IPA *Proposed* Criteria

Psychosis in Major and Minor Cognitive Disorder

A. *Characteristic Symptoms:* ≥ 1 of following symptoms:

- 1. Visual or auditory hallucinations**
- 2. Delusions**

B. *Primary Diagnosis*

**Criteria for major or minor neurocognitive disorder met
Aetiologic diagnosis specified (eg AD, LBD, TBI)**

C. *Chronology of onset of psychosis vs. onset of major or mild neurocognitive disorder*

**Evidence from history that symptoms in Criterion A have not
been present continuously since prior to onset of Criterion B**

Psychosis in Major and Minor Cognitive Disorder

D. *Duration*

Symptom(s) in Criterion A present, at least intermittently, for 1 month or longer

E. *Severity*

Symptoms severe enough to cause disruption in patients' and/or others' functioning or pose threat to safety of self or others

Psychosis in Major and Minor Cognitive Disorder

F. Exclusionary Criteria

- 1. Patients who meet criteria for Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Mood Disorder with Psychotic Features, or Depression with Psychotic Features**
- 2. Psychosis occurs exclusively during course of a delirium**
- 3. When the psychosis is solely attributable to another general-medical condition (eg hypothyroidism) or direct physiological effects of a substance (eg drug of abuse, medication)**
- 4. Symptoms are culturally appropriate (eg ancestor visions)**
- 5. Hallucinations more readily attributable to conditions known to cause hallucinations eg epilepsy, migraine, sensory disorder**

Psychosis in Major and Minor Cognitive Disorder

G. Associated features: (Specify if associated)

With *Agitation*: when there is evidence, from history or examination, of prominent agitation with or without physical or verbal aggression

With *Depression*: when prominent depressive symptoms are present, (Mood Disorder with Psychotic Features is an exclusion)

Diagnostic criteria for apathy in brain disorders¹

A+B+C+D criteria need to be met:

Criterion A

- **A quantitative reduction of goal-directed activity either in behavioural, cognitive, emotional or social dimensions in comparison to the patient's previous level of functioning**
- **Changes may be reported by patient or others**

¹ Robert P et al, European Psychiatry, 2018;54:71-76

Apathy: Criterion B1 = Behaviour & Cogⁿ

- **Loss of, or diminished, goal-directed behaviour or cognitive activity as evidenced by > 1 of:**
 - Lower level of general level of activity
 - Less persistence of activity:
 - Less interest in external issue:
 - Less interest in doing new things
 - Less interested in own health and wellbeing or personal image (general appearance, grooming, clothes, etc.)

Apathy: Criterion B2 = EMOTION

- Less spontaneous emotion
- Less emotional reaction
- Less concern about impact of actions or feelings on others
- Less empathy
- Less verbal or physical reaction that reveal emotions

Apathy B3: Social Interaction

- **Less initiative in proposing social or leisure**
- **Participates less or less comfortable or more indifferent to social or leisure activities suggested by others**
- **Less interest in family members**
- **Less likely to initiate a conversation, or withdraws soon.**
- **Prefer to stays at home more frequently or longer than usual**
- **Less interest in getting out to meet people**

Apathy: Definitional criteria

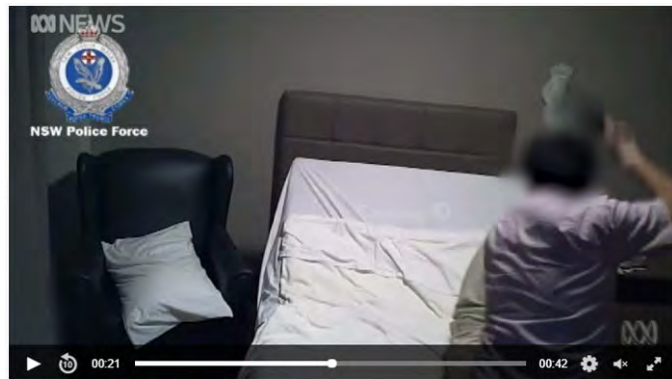
- **CRITERION B** presence of ≥ 2 of 3 dimensions (B1, B2, B3) for ≥ 4 weeks and present most of the time
- **CRITERION C** Symptoms (A - B) cause clinically significant impairment in personal, social, occupational or other important areas of functioning.
- **CRITERION D** Symptoms (A - B) are not exclusively explained or due to physical disabilities (eg blindness, loss of hearing), motor disabilities, diminished level of consciousness, direct physiological effects of substance or major changes in the patient's environment

APATHY DIAGNOSIS: Positive if criteria A, B, C and D are present

Psychotropics and dementia “Chemical Restraints”



4



VIDEO: CCTV from aged care home (ABC News)



Royal Commission into Aged Care Quality and Safety



Hearings



Residential Aged Care Facilities (Long-term Care) & psychotropics

- 1-in-3 RACF residents has a treatable serious psychiatric disorder (excluding dementia)**
- 1-in-5 has ≥ 2 treatable serious psychiatric disorders¹**
- $>1/2$ are on ≥ 1 psychotropic; 15-30% on multiple²**
- 20%+ are on antipsychotics; 20%+ on benzos³**
- Antipsychotics prescribed for >2 yrs despite rec^s to review and guidelines for maximum 3 months⁴**

¹Commission on Long-Term Care report to US Congress, 2013 (cited in Desai and Grossberg, 2017); ²Steiz et al, 2010; ³Westbury J, MJA, 2018; ⁴Harrison submitted

RedUSe: Reducing psychotropics in RACFs¹

4 complementary interventions in 150 RACFs:

- psychotropic medication audits by a local champion nurse**
- RACF staff education sessions**
- interdisciplinary prescribing reviews for each RACF resident**
- academic detailing for prescribers**
- Antipsychotics ↓13%; Benzos ↓21%**

Westbury J et al MJA 2018; 208: 398-403

Halting Antipsychotics in Long-Term Care (HALT)



- A single arm 12-month longitudinal study in 24 aged care facilities in urban & semi-rural NSW
- Resident participants assessed $\approx$ 1-4 wks prior to deprescribing & at 0, 3, 6 and 12 months
- GPs (academic detailing) & Train-the-trainer model $\rightarrow$ nurse champions $\rightarrow$ train care staff
- 136 pts started deprescribing $\rightarrow$ 93 follow-up @ 12 m

¹Brodaty H, Aerts L et al, JAMDA, 2018; ²Aerts et al, IJGP in press

HALT Conclusions



- ***Deprescribing* APs in 86%; sustained in 75%¹**
 - Without re-emergence of behaviours
 - Without substitution regular medication & with minimal prn benzodiazepine use
- ***Represcribing* drivers: Nurses (63%), family (40%), GPs (24%), specialists (13%), hospital staff (11%)²**
- **Is there subgroup (20-25%) who benefit from Rx?**
- **Questions remain about identifying who benefits from continuing antipsychotics**

¹Brodaty H, Aerts L et al, JAMDA, 2018; ²Aerts et al, IJGP in press

Non-pharmacological interventions

- Behavioural
- Person centred care ^{1,2}
- Novel strategies eg Humour Therapy ³⁻⁵
→ Agitation ↓ (Depression ↓, QOL ↑)

¹ Chenoweth L et al. *Lancet Neurology* 2009; 8:317-325

² Chenoweth L et al *Int Psychogeriatr.* 2014; 26(7):1147-1160

³ Low LF et al. *BMJ Open* 2013;

⁴ Brodaty H et al. *Am J Ger Psych* 2014;

⁵ Low LF et al. *JAMDA* 2014

Psychogeriatrics → ABCD

- **Assessment – diagnosis and differential diagnosis**
- **Better Care**
 - Best use of psychotropics
 - Non-pharmacological
 - Management of behaviours and psychological symptoms
- **Working as a multidisciplinary team**

Thank you



- Centre for Healthy Brain Ageing (CHeBA) at UNSW
- Dementia Centre for Research Collaboration (DCRC) at UNSW

www.dementiaresearch.org.au

www.cheba.unsw.edu.au

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