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Senior PsychCare
4314 Yoakum Blvd
Houston, Texas 77006
713.850.0049 ph
713.850.0036 fax

Senior *A Better Quality of Life Through Integrated Mental Health Care* Minutes

SENIOR PSYCHCARE
IN AFFILIATION WITH
SENIOR PSYCHOLOGICAL CARE

Quality Mental Health Care for Geriatric Patients in Nursing

Today, Americans are living longer. Unfortunately, these extra years are not always quality ones. For physicians who recognize that a geriatric patient may have a co-morbid psychological disorder along with medical physical or cognitive problems, there are services offered to help improve their patients' quality of life and medical treatment. What behaviors most frequently form the basis for referrals for psychiatric evaluations in nursing home residents? These behaviors very commonly are interpersonal problems with other residents, staff and visiting family members. There is also non-compliance with daily routine and care, including refusal to shower or follow other hygienic requirements. A general apathy such as disinterest in social interaction, non-participation in activities and lack of productive activity is all too common. Depressed residents often retreat to their room or bed and do nothing but watch television. It is simple to recognize that even though these residents are not necessarily causing problems, this type of behavior is evident of other subtle problems with serious implications to their mental and physical health. **The optimum program teams are comprised of a licensed psychiatrist and a support group of therapists.**

In many residents, there is a incidence of co-morbid psychological disorders. These disorders can be precipitated by a reaction to the onset of debilitating physical problems, the anxiety and depression that often accompanies the onset of dementia or the difficulty adjusting for a generation of independent adults for whom losing their independence is devastating. Stress or trauma in these patients can sometimes cause a relapse of a prior condition. There is little argument about the deleterious effects of these problems on a patient's attitude, outlook, treatment compliance and even immune system. It is imperative that caregivers recognize the psychological factors affecting our patients and make an effort to best

assure that their emotional and physical needs are addressed. The first step should be proactive. The attending physician should request a brief psychiatric evaluation conducted upon admission to the nursing home. It does not have to be extensive, just a brief assessment of the patient's mental status: a short questionnaire addressing depressive symptoms and a clinical interview by a psychiatrist to detect possible psychological or cognitive problems. Not only does this

provide early detection, it becomes a baseline of information that can be referenced in the future. This can help to recognize subtle yet significant declines in a patient's mental changes in language or cognition, fairly rapid loss of ability to concentrate or remember (markedly more pronounced than the course of most common dementias), severe delusions not typical of the individual and evidence of delirium. Immediate medical evaluation, usually including urinalysis or blood work, most patients are found to have many of the common infections frequently encountered in the elderly. The next step following this initial screening is to begin documenting ongoing observation of the patient. Small changes can signal the onset of medical conditions or indicate increasing psychological distress.

In addition to gathering patient information, having a role in the treatment team gratifies the staff providing a more effective working environment.



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Equally important is the availability of the ongoing data collection to inform the primary care physician when positive changes occur during medical treatment. This includes adjustment of medications, particularly when so many of the psychotropic medications having anti-cholinergic effects result in dampening cognitive functions. Given the natural decline in the ability of the elderly to concentrate, access short/long term memory and to perform cognitive tasks necessary to daily life diligence is critical. Loss of memory and the ability to concentrate are the most distressing aspects for patients. It is very important to remember to prescribe the minimum necessary doses of anti-cholinergic drugs to patients with dementia.

In closing, increased initial data collection, documentation, ongoing observation and assessment, enhanced communication among treatment professionals, can all result in less frustration in our respective jobs working with geriatric patients. More importantly, we can optimize the effective level of care for our patients and, consequently, their quality of life.

Psychiatric Treatment Options of Seniors:

A Summary of Evidence

Alzheimer's is an incurable but treatable disease. The use of medications is increasing, but clinicians and healthcare organizations must realize that supportive care must extend beyond prescriptions. Support includes providing caregivers with practical advice on a variety of issues such as where to obtain financial planning and how to access respite care. Caregiver education and emotional support are essential interventions. Some agents enhance cognition and may afford neuro-protection as well as dementia. Treatment goals help caregivers and patients set realistic expectations. Treatments that enhance cognition and improve behavior lead to symptomatic improvement. After initial improvement most patients eventually continue to decline though the rate varies depending on patient. One can expect the progression of the disease to be slowed but should not anticipate arrest. Stabilization or a temporary delay in progression is the most notable outcome of treatment.

Cognition Enhancers

The brain of a patient suffering from Alzheimer's disease exhibits damaged neurons and reduced levels of the neurotransmitter acetylcholine (ACH) as well as the enzyme that synthesizes ACH. This is an essential finding in the cholinergic hypothesis which states that cognitive function may be preserved if levels of ACH are maintained

though increasing the level of Ach is not yet possible. The main cognitive medications and cholinesterase inhibitors, such as Galantamine, are the most thoroughly studied medications used to treat the disease. Tacrine is an older less selective agent in that class, but is now rarely used. Stabilization from treatment with cholinesterase inhibitors may persist for up to a year.

Donepezil was first marketed in January 1997 and is the preeminent drug in its class. During a half-year trial, more than 4 of 5 patients receiving treatment showed improvement or no decline in cognitive function. Treatment with Donepezil produced improvements in secondary outcomes such as on the Mini-Practice Improvements usually noticed even sooner, in about 6 weeks, after the start of the treatment. Side effects from the treatment were usually transient and generally mild, and cholinergic adverse events (mostly diarrhea, nausea and vomiting) were more frequent in the group that received the higher dose. Rivastigmine is the second selective cholinesterase inhibitor. Its duration lasts about 10 hours and is administered twice daily; unlike Donepezil, which is only administered once. The side effects from this treatment are similar to Donepezil, although a conservative dose titration schedule is recommended to avoid significant gastrointestinal intolerance.

Galantamine is an ACH esterase inhibitor that has been approved for use and has also shown improved cognitive function.



Early initiation of treatment is beneficial and it has been shown to modulate nicotinic cholinergic activity. How this relates to the efficacy of the drug is unknown. The use of cholinesterase inhibitors can provide a significant improvement in cognitive and functional performance of Alzheimer's disease patients.

The drugs are well tolerated; and though the target is a secondary degenerative effect of the disease, they are one of the few pharmacologic tools for delaying the cognitive decline of patients with Alzheimer's disease.

Antioxidants

Other therapeutic strategies have been another approach to treatment of Alzheimer's disease through reduction of oxidative stress within the brain. Agents in various antioxidant neuroprotective strategies for the treatment of Alzheimer's disease have included alpha-tocopherol (Vitamin E); selegiline, a selective monoamine oxidase inhibitor: ascorbic acid, coenzyme Q, ginkgo biloba and estrogen.

Vitamin E and selegiline are currently used by many clinicians and are based partly on the results from a large clinical trial involving two of them.

Q: How do you respond to patients and families who don't feel they see a change since the initiation of treatment?

A: Even if the patient does not improve after nine-twelve months, that fact is significant. Since the disease is progressive, that delay in progression is considered a meaningful and positive outcome.

Q: How long should the medication treatment trial last? How do you decide to continue medication?

A: If the medication is well tolerated and the disease has stabilized after six months, the patient should continue the therapy. If there was no evidence of benefit, the therapy should be discontinued. If the patient's disease became worse after the treatment was terminated, then the therapy should be re-initiated.

Q: Some managed care organizations use a Mini Mental Status Examination (MMSE) for approval of the pharmacy benefit. Sometimes a medical director requires evidence that the patient had an exam score between 5 and 20 to obtain approval for drug benefits for that patient. Is this reasonable?

A: Although the MMSE is an inappropriate standard for approval because scores vary by education, eligibility should be determined by a clinical diagnosis of probable Alzheimer's disease. The whole current approach to treatment for Alzheimer's disease is actually counter-intuitive within the context of therapy for most chronic diseases. Imagine a patient with arthritis who, three or five years after treatment initiation experiences disease progression and worsening symptoms. Do you withdraw the non-steroidal anti-inflammatory drug and deny treatment because the disease has progressed? Similarly, the cholinesterase inhibitors don't effect the progression of Alzheimer's disease as far as know, but they may improve cognition at all stages of the disease. A drug holiday after a certain period of time has elapsed is an imperfect idea. Patients sometimes return to their pre-holiday status when treatment is resumed. The FDA indicates the use of cholinesterase inhibitors for the treatment of mild-to-moderate Alzheimer's disease, although physicians in practice can use medicines for any indication. Donepezil clearly benefits with other forms of dementia not just those with Alzheimer's.

Q: Is there FDA approval on the use of anti-dementia drugs in the managed care environment? What about those not approved by the FDA for the treatment of dementia such as ginkgo biloba and other agents that demonstrate some efficacy but not enough for FDA approval?

A: The American Psychiatric Association treatment committee recommended the use of Vitamin E; then went against the use of selegiline, primarily because of safety issues.

Q: Can anti-psychotic drugs delay the progression of Alzheimer Disease?

A: Patients may actually deteriorate cognitively and functionally with the use of some conventional neuroleptics. With olanzapine, a suggestion of cognitive improvement in some patients who were using the drug to functional improvements are observed in depressed in depressed patients with Alzheimer's who receive treatment with anti-depressants.

Q: Is there a real difference between the effect of olanzapine and that of risperidone in terms of extra pyramidal and other symptoms?

A: Yes, research shows when greater than risperidone 2 mg/day is given. The patient deteriorates because of the occurrence of frequent side effects like extra pyramidal symptoms, somnolence and mild peripheral edema.

References available upon request

Disclaimer: The information presented in this newsletter is intended for educational purposes only. It is not a substitute for practical medical advice on any specific situation.

Corporate Offices:

Houston: 4314 Yoakum, Houston, Texas 77006

District Manager: Jason Lacy

Regional Manager: Beryl Shorter

Ph: 713-850-0049 **Fax:** 713-850-0036

San Antonio: 1380 Pantheon Way Ste. 240, San Antonio, Texas 78232

District Manager: Lee Jones

Regional Manager: Charles Henderson

Ph: 210-366-8035 **Fax:** 210-496-1901

Dallas:

District Manager: Spencer Dunn

Regional Manager: Soni Rao

Toll Free: (800) 806-0465 **Toll Free Fax:** (800) 318-0120

For additional information please visit our website:

www.seniorpsychiatry.com