



## Winter 2014 E-News Letter

### From the President

Dear TGS Members:

Happy New Year 2014! I wish all of us a warm and heartfelt New Year.

Our Texas Geriatrics Society is continuously growing. We have new members each year that promise to bring the fresh ideas to the organization. We are expanding to include more members from interdisciplinary professionals. I believe it is essential for us to know our new members. In this year's first E news, I would like to highlight our newest TGS Board of Director: Dr. Abimbola Farinde, Pharm D.



Yanping Ye, MD, CMD



Abimbola Farinde

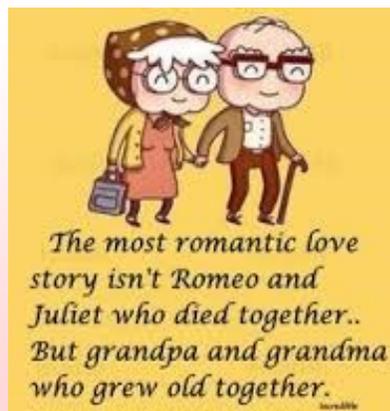
Dr. Farinde is a clinical pharmacist specialist in psychopharmacology and geriatric pharmacy. She earned Doctor of Pharmacy degree from Texas Southern University, and went on to complete her post-graduate training as a generalist with an emphasis in primary care in Temple, Texas, and then a psychopharmacology residency specialist training in Dallas, Texas. Her research interests focus on the development of neurological and psychiatric disorders in the elderly population, and examining the facets of the cognitive processes in this population. She also has an interest in the development of novel drug formulations. She then transitioned into taking on a managerial/supervisory within a supported living facility that provided healthcare services to individuals

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### Special points of interest:

- **Overview: Geriatric Pharmacotherapy**
- **2014 Dues!**
- **Save the Date!**
- **State of Mental Healthcare in Nursing homes**

Happy Valentine's Day!



*(Continued from page 1)*

with mental impairments and developmental delays. Dr. Farinde has published articles in both scientific and healthcare related journals and serves as an associate editor and reviewer for several peer-reviewed journals. She is a member of the American Association of Pharmaceutical Scientists, American Society of Clinical Psychopharmacology, British Association of Psychopharmacology, and Commission for Certification in Geriatric Pharmacy.

In her spare time, Dr. Farinde enjoys running, horseback riding, and watching classic movies. Dr. Farinde welcomes the opportunity to serve on as a Board Director of the Texas Geriatrics Society. She looks forward to the opportunity to promote continuous growth and the advancement of the organization.

Dr. Farinde brings a great deal of her experience and professionalism to our board. We welcome you!

## 2014 DUES

It is that time of year to renew your 2014 dues (if you have not done so!).

Please go to our website and click on the Membership tab and pay online!

[www.texasgeriatrics.org](http://www.texasgeriatrics.org)

### TGS Only

Physicians: \$75.00

Health Care Profs.: \$37.50

Retired: \$30.00

### Joint Membership with TMDA

Physicians: \$135.00

Health Care Profs: \$67.50

### New Member Discount!

Do you know of someone who has **NEVER** been a member of TGS or TMDA? Encourage them to join this year for 1/2 price! TGS and TMDA are offering 1/2 price memberships to any physician or health care professional who has NEVER been a member before. See our website for more information!

## *Brief Overview of Geriatric Pharmacotherapy Considerations*

Abimbola Farinde, PharmD., MS

Geriatric psychopharmacology can prove to be quite challenging because one must consider the co-occurring physical or medical issues before the decision is made to prescribe psychoactive medications to this population. Geriatric patients experience a decline in renal and hepatic functioning with age and can also be more prone or sensitive to side effect development. In general, the use of antidepressant (SSRIs, mirtazapine, trazodone) and electroconvulsive therapy have been shown to be effective in elderly patients, especially with the treatment of depression disorder (Schatzberg, Cole, & DeBattista, 2010). On the other hand, tricyclic antidepressants should be avoided due to their anticholinergic effects, benzodiazepines can cause cognitive impairments, and antipsychotics use especially in elderly patients with dementia has been associated with an increased risk of mortality as a result of infections, pneumonia, or cardiovascular complications (Hersen, Turner, & Beidel, 2007).

Similar to the other special population (e.g., pregnant women and pediatric population) the use of psychopharmacologic agents in the geriatric population must be given careful consideration before it is initiated. The geriatric population can present with many problems when it comes to psychopharmacologic medications because there may be the decreased ability to metabolize some of these drugs, the presence of low serum protein levels that can lead to relatively higher levels of the free drug, and they also may have an increased sensitivity of the side effects that can be associated with these medications such as central nervous side effects of delirium tremor, or tardive dyskinesia (Schatzberg, Cole, & DeBattista, 2010). The misuse of these medications in the geriatric population can develop from administration due to the fact that the individual may have a compromise cardiovascular system, renal, or liver function and appropriate dose modifications are not made based on these conditions (Hersen, Turner, & Beidel, 2007). Whether it is the use of antidepressants, hypnotics, mood stabilizers, antipsychotics, or medications that are used to manage symptoms of dementia, a clinician must be aware of the full functional capacity of a geriatric client before initiating any and all medications. Just like the pediatric population few trials are conducted in the geriatric population because most clinical trials are controlled and recruit healthy individuals with normal organ functioning who are fully developed which can pose a problem as there can be impairments or dysfunctions present in a geriatric participant.

While, the treatment of the geriatric population can prove to be challenging, this has the potential to improve quality of life and performance of activities of daily living. It is always the goal of doing what is in the best interest of the patient and to achieve optimal therapeutic benefits in the end.

### References

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*THE STATE OF MENTAL HEALTHCARE IN NURSING HOMES*

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A Review by Dr. Leo J. Borrell

Studies over the past twenty years have recognized the pervasiveness of mental illness among residents of nursing homes. Dementia, behavioral and psychological symptoms of dementia (BPSD), and depression characterize the resident population. Seitz and colleagues<sup>1</sup> reported on the prevalence of major psychiatric disorder in long-term care derived from a number of carefully screened epidemiological studies. **Dementia in nursing home residents was 58% whereas the prevalence of BPSD was 78%.** Major depressive disorder had a median prevalence of 10%, and the median prevalence was 29% for depressive symptoms. Minimum data set results reveal that 46.5% have dementia, 47% have depression, 30% show behavioral symptoms, 3% have mental retardation, and 20% have other psychiatric disorders. Nursing home residents are becoming bewilderingly more complex than in the past and more difficult to address<sup>2</sup>. It is incumbent to comprehensively assess our readiness to meet this substantial challenge.

To what extent has the field of geriatric psychology improved since the introduction of the US Omnibus and Reconciliation Act of 1987 (OBRA 87)? We are more vigilant and appropriately cautious about the use both of physical restraints and of psychotropic medications, we still have quite a way to go. Diagnostic clarification and psychopharmacology is the dominant intervention offered by psychiatrists. This narrow emphasis is not serving the nursing home population adequately. **The available antidementia compounds, cholinesterase inhibitors and memantine, do have demonstrable, but limited impact on relieving BPSD.**

Geriatric psychiatrists will be offering inadequate clinical value in the nursing home if the psychotropic medications currently available are not safe and are not sufficiently effective. Ninety-seven percent of residents were experiencing at least one symptom. Agitated behaviors were especially persistent and apathy tended to increase over time, although there was a decrease in affective symptoms. Early identification of depression is of great importance to the well-being of nursing home residents. Mitchell et al<sup>3</sup>. from the United Kingdom report on a meta-analysis of the diagnostic accuracy of different versions of the Geriatric Depression Scale<sup>3</sup>. Screening programs in nursing homes must be adequately resourced so that their clinical utility can be properly evaluated and demonstrated<sup>4</sup>.

Stevenson and colleagues<sup>5</sup> noted that 26% of residents were prescribed an antipsychotic medication. Of particular concern was the finding that 40% of those receiving an antipsychotic had no documented appropriate indication for such use. Among the 13% of residents who received a benzodiazepine, 42% had no appropriate indication identified.

In this situation, the specific contributors to the display of mental illness in the nursing home are: the physical environment, the processes of care, and the behavior of people (care providers and other residents). Literature on environmental design concluded that there is sufficient evidence accumulated to come to a consensus on guiding principles for the design of long-term care environments for people with dementia that maximize function and mental well-being. The use of single rooms, unobtrusive safety measures, varied ambience, and controlled levels of stimulation are all supported by the literature as useful interventions. There is less agreement on the usefulness of other interventions (e.g., enhanced signage, homelikeness, provision for engagement in activities of dialing living, small size, and access to outside space).

Over the past two decades, research has examined nonpharmacologic interventions that benefit nursing home

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residents with dementia. A recent review of psychosocial interventions in dementia care specific to nursing homes concluded that **the most effective interventions utilized behavior management techniques, cognitive stimulation, or physical activity interventions. Evidence also supports psychotherapies such as reminiscence and cognitive behavior therapies for residents with symptoms of depression and other related symptoms<sup>6</sup>.**

The mental health of nursing home residents can be enhanced in an environment offering high-quality medical care guided by some basic principles of ensuring well-being<sup>7</sup>. Various models of psychogeriatric services in nursing homes reported on nine controlled trials and concluded that liaison-style services that employed educational approaches, treatment guidelines, and ongoing involvement of mental health staff are more effective than a purely case-based consultation model<sup>8</sup>. Snowdon<sup>9</sup> recently described a variety of models of mental health service provision including solo practitioners. The value of consultation via interactive videoconferencing, particularly for nursing homes located in remote areas and for nations that limit funding for residential care, was also highlighted. Recommendations are provided that include adequate screening for mental illness, designation of staff members who take responsibility for identification, and, if necessary, referral to a mental health specialist. **Active involvement of the primary care physician and effective liaison between the facility and mental health teams is a required essential feature. A**

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## Save the Date 2014!

Mark your calendar for the following events!

We hope to see you there!

- ⇒ AMDA Conference 2014: Creating Harmony in Long Term Care.  
February 27 thru March 2, in Nashville, TN, Gaylord Hotel.  
[www.ltcmedicine.com](http://www.ltcmedicine.com)
- ⇒ TexMed 2014: Redefining the Culture of Medicine.  
May 2-3 at the Ft Worth Convention Center.  
TGS will host a 1/2 day geriatric session! [www.texmed.org](http://www.texmed.org)
- ⇒ American Geriatrics Annual Conference.  
May 15-17 in Orlando, FL at Walt Disney World Swan and Dolphin.  
[www.americangeriatrics.org](http://www.americangeriatrics.org)
- ⇒ TGS/TMDA Annual Conference: Partnering in Care.  
August 8-10 at the Omni La Colonnade in San Antonio.  
More details coming soon!

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**number of reports have highlighted the benefits of having nurse specialists provide significant front-line consultation and care**<sup>10,11</sup>. Moyle et al. have recently reviewed the literature on this topic and made a series of useful recommendations<sup>12</sup>. They are as follows:

**Nursing homes should have an established staff development program** related to resident mental healthcare needs.

**Prior training in mental healthcare should be a key selection factor** when hiring new staff.

**A process of staff evaluation should be in place** and homes should facilitate staff attendance at education and training sessions.

**A reward system should be in place for staff** who undertake educational programs. It is also particularly important to support unregulated staff to achieve competency in the mental healthcare needs of older individuals.

**Curriculum designers must take into account the special** needs and schedules of LTC staff.

### **Psychiatric and Psychotherapy Economic Considerations**

A study by O'Brien and Caro<sup>1</sup> compared management levels and the annual costs of caring for nursing home residents with and without AD or other dementia. In this study of 49,724 nursing home residents, 26.4% had a documented diagnosis of dementia. Each of these patients required, on average, an additional 229 hours of care annually compared with residents without dementia, resulting in a mean additional cost of \$3,865 per patient with dementia per year in 1997 dollars. In 2005 dollars, this would translated to approximately \$4,700 per patient per year.<sup>2</sup>

Problem behaviors add costs to long-term care. Physical agitation, care refusal, and requests for attention were among the most frequently observed problem behaviors in a study of AD patients in long-term care settings.<sup>3</sup> Management strategies for these behaviors typically took one or more nursing staff an **estimated 5 to 20 minutes to put into practice, at a cost of \$1.35 to \$4.09 per episode (2000 dollars; \$1.53 to \$4.62 inflated to 2005 dollars)**. Behavioral problems have been specifically measured in some studies with donepezil<sup>4-6</sup> and rivastigmine.<sup>7</sup> These studies show that treatment has a positive impact on measures of behavior. Because behavior problems are costly, cholinesterase inhibitors may reduce the cost of handling problem behaviors in long-term care. In fact, discontinuing cholinesterase inhibitor treatment is associated with a significant increase in daily labor costs. Nursing home residents who discontinued the medication incurred a mean daily labor cost of \$55.16 compared with \$49.60 at baseline. Patients who continued donepezil incurred a mean of \$6.90 less per day than patients who discontinued.<sup>8</sup>

A 2004 article on the use and cost benefits of cholinesterase inhibitors in long-term care reviewed both cost-saving and cost-effectiveness data.<sup>9</sup> The authors concluded that given the cost of drug therapy, the difficulty in correlating cognition and behavioral scoring tools with disease severity, and the applicability of community costs prior to nursing home care, the results of the current data are equivocal at best. However, there is the real consideration of resident quality of life, maintained independence, and nursing home caregiver burden; which all need to be studied in some manner.

### **Severe Psychiatric Disorders, Cognitive Impairment, and Mental Healthcare Costs**

A 2005 study states the costs for treatment of psychiatric illness is at over 47 billion dollars per year. The factors that contribute to the high cost of mental healthcare are:

*(Continued on page 7)*

(Continued from page 6)

Increased use of mental healthcare services (including inpatient, outpatient, and medication treatments)

Combination of treating psychiatric and substance abuse disorders

Increased use of emergency room services

Higher occurrences of medication nonadherence

The 2005 study did not address cognitive impairment as an additional factor for increased mental healthcare costs. A valid assessment of cognitive impairment is the *Mattis Dementia Rating Scale- Second Edition* and the *Clinical Dementia Rating* is used to assess stages of dementia in seniors with cognitive impairment.

The source study published in February 2011 specifically researched the impact of cognitive impairment on costs and concluded that seniors with cognitive impairment who also have a diagnosis of a severe psychiatric disorder are a significant factor for rising mental healthcare costs. A 6-month study on mental healthcare costs comparing young schizophrenic patients to the cognitively impaired elderly suggests that costs for the young patient group was **significantly higher at \$23,824 than the elderly group at \$8,145 due to more intensive, inpatient, specialized treatment for severe psychiatric problems such as schizophrenia and bipolar disorder**. However, one limitation of the study is lack of access to the cost of medications during treatment which is believed to be a considerable factor in mental healthcare costs.

The degree to which specific therapies for those with cognitive impairment may reduce costs requires more detailed research. Past research have shown that the cognitively impaired patient did benefit from mental healthcare and found that costs can be mitigated if the individual receives tailored intensive mental health treatment. **While intensive treatment is more costly short-term, the improvement of the patients suggests a reduction in long-term mental healthcare therefore reducing overall costs.**

### **Evidence-based Reduction of Need for Psychiatric Hospitalization due to Psychotherapy**

Recent research has demonstrated that the intensity of a mental healthcare intervention program significantly reduces the chance of psychiatric hospitalization, **intensity should determine the extent of psychosocial intervention (e.g., psychotherapy), and intensity of therapy should not be left completely in the hands of medical care professionals (Spijker, et al. 2011)**. The best patient predictors for psychiatric hospitalization are noted as **severity of dementia and behavioral problems**. Interestingly, the research did see evidence that caregiver depression and the caregiver's sense of competence in caring for the patient are equal and additional predictors for psychiatric hospitalization. **Furthermore, the intensity of the psychotherapy intervention should be standardized and not be dependent upon the judgment of health professionals. This research supports that standardized-intensive psychotherapy for both the patient and the family is essential and distinguishes effective programs from ineffective ones with no difference being noted between children or spouses of patients as caregivers. Both groups benefit from therapy and help to reduce the need for patient psychiatric hospitalization. (Spijker, et al. 2011)**

### **Depression**

Depression affects 20% to 32% of persons with dementia and the prevalence is higher in patients with vascular dementia than in patients with Alzheimer's disease (AD). Assessing depression in dementia patients pos-

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es several challenges. Depressive symptoms can be the initial manifestations of dementia and may fluctuate over time. Compared with older patients with intact cognition, patients with dementia are more likely to report a diminished ability to concentrate or indecisiveness during a major depressive episode. On the other hand, patients with dementia are less likely to report insomnia/hypersomnia, feelings of worthlessness and guilt, or thoughts of death/suicide.

Further confounders of assessment include symptoms of apathy and anxiety. These symptoms frequently coexist with depression but are also independent behavioral dimensions.

### Depression Screening

How often within the past two weeks have any of the following problems bothered you? (scale: 0=not at all, 1=several days, 2=more than 1 week, 3=almost two weeks)

⇒	Had little interest or pleasure in doing things	0	1	2	3
⇒	Felt down, hopeless, or depressed	0	1	2	3
⇒	Had trouble falling or staying asleep or slept too much	0	1	2	3
⇒	Felt tired or had little energy	0	1	2	3
⇒	Little appetite or overate	0	1	2	3
⇒	Felt bad about self, felt like a failure, or felt like you let self or family down	0	1	2	3
⇒	Had trouble focusing (trouble reading newspaper or watching television)	0	1	2	3
⇒	Others noticed you moved or spoke slower than usual or were more fidgety/restless than usual	0	1	2	3
⇒	Felt that you or loved ones would be better off if you were dead	0	1	2	3
⇒	Had thoughts of hurting self in some way	0	1	2	3

If you checked off any problems, how have these problems affected your daily life (work, taking care of self/home, or relationships with others)?

Not difficult at all    Somewhat difficult    Very difficult    Extremely difficult

### Treatment of Depression

A variety of approaches can be used to treat depression in patients with dementia. These include electroconvulsive therapy (ECT), pharmacotherapy, and psychosocial modalities.

*Psychosocial modalities.* Nonpharmacological interventions include supportive-therapy techniques, such as reminding the patient of earlier accomplishments, focusing on positive aspects of life, instilling hope, and promoting enjoyable recreational activities. Of 11 randomized controlled studies of psychosocial treatments of depression in older adults with dementia, 7 showed significant improvement in the treatment group com-

(Continued on page 9)

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pared with the control group. In 6 of these studies, improvements were maintained beyond the active treatment.

The psychosocial treatments studied were diverse. They included interventions based on behavioral approaches that focus on training caregivers to problem-solve and communicate effectively. Structured programs were used to increase social engagement, and interventions were employed to modify sensory or environmental stimulation. Group reminiscence therapy also improved cognitive and affective function in a recent randomized controlled trial undertaken by Wang.

Typical psychological interventions were based on the traditional one-on-one psychotherapy model<sup>2</sup>. Researchers propose that intervention be based on an integrative-behavioral model of depression utilizing a collaborative relationship between mental health professionals and the members of the activities staff (research assistants and other outside consultants for implementation may also be useful)<sup>2</sup>. Chose participants who are: not terminally ill, not already in psychotherapy, not under hospice care, who are medically stable, have a Mini-Mental State Examination score of > than 13, and/or have a Geriatric Depression Scale score of 11 or greater<sup>2</sup>. You may find that consenting participants may not actually benefit from the intervention due to depression rating scores being too low or their cognitive impairment is too severe. The phases of the intervention are: baseline assessment (may last 2 – 4 weeks), active treatment (6 weeks), treatment maintenance (4 weeks), and follow up is at week 24<sup>2</sup>.

Researchers Meeks, Looney, Van Haitsma and Teri<sup>2</sup> developed an intervention manual with changes made to allow a more realistic allotment of session time between the NH staff and mental health professionals who became responsible for scheduling treatment sessions. The manual also contains a list of “Pleasant events” and were recorded on a “Pleasant events” scale which is reviewed each session<sup>2</sup>. During nursing home staff meetings, it was noticed that the majority of the meeting involved discussing barriers to pleasant events with little time needed reviewing behavioral problem issues<sup>2</sup>.

The researchers found the nursing home staff members (3 were in social services and 4 were in the activities department) eager to follow the “Treatment Session Content” (see table below), but staff were restricted due to lack of time and resources<sup>2</sup>. The collaboration between staff and therapist necessitated the therapist demonstrating empathy for the staff and assisting in problem-solving around the barriers. Nursing home staff did recognize the value of the manual’s ability to help structure tasks and visualize client progress<sup>2</sup>. Participation in the activities increased when obstacles decreased (ineffective communication resulting in residents not ready for activities, lack of supplies, and staff using ineffective methods such as nagging to prompt residents to participate)<sup>2</sup>. Although the nursing home staff were aware of these barriers, the empathic support of the therapist was needed to overcome these obstacles<sup>2</sup>.

Depression symptoms were monitored during the treatment sessions and the results showed a clinically significant reduction in symptoms with a 75% recovery rate at follow-up (vs. 50% for control group)<sup>2</sup>. The treatment group did receive more attention for the therapist than the control group and this cannot be ruled out as a confounding variable making it indistinguishable to determine if increased attention or increased activities caused the decrease in depression symptoms<sup>2</sup>.

The treatment session in the below table represents an approach to depression intervention in long-term care that does not solely rely on education, training, or the use of external mental health professionals<sup>3</sup>. It does require the collaboration between nursing home staff and trained mental health professionals and has the potential to increase staff satisfaction, be widely used, and improve the quality of life for residents<sup>2</sup>.

*(Continued on page 10)*

## Treatment Session Content<sup>2</sup>

### Session

### Content

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1st	<b>Introduction to Behavioral Therapy for Depression:</b> Introductions, review research procedures. Explain relationship between pleasant events and mood, relevance for depression. Assess pleasant events. Plan three events that are easily accomplished. Identify relevant family members to be involved, if appropriate. ASF present with therapist and resident.
2 <sup>nd</sup>	<b>Scheduling Pleasant Events and Encouraging Family Involvement:</b> Focus is planning further pleasant events. Last week's events are reviewed. Therapist reinforces resident for accomplishments and effort. If family member is present, discuss how he or she can be involved in further implementing pleasant events. Plan events for coming week.
3rd	<b>Confronting Obstacles:</b> The focus is on obstacles to achieving desired events. The A-B-C behavioral method is used to understand obstacles and, if necessary, develop a behavior plan to overcome them. Therapist reinforces resident (and family member if present) for effort. Last week's events are reviewed and new events planned for the next week.
4th	<b>Increasing Pleasant Events:</b> The goal of this session is to continue to increase pleasant events that are feasible for staff and residents, and include family members when possible. Obstacles are confronted and problem-solving focuses on changing them. A goal of 6-8 pleasant events is optimal, but individual differences are taken into consideration.
5th	<b>Assessing Progress/Choice Point:</b> ASF is included in this session. Goal is reevaluation and checking; resident and therapist review progress with staff (and family if present). If the resident is involved in five new events weekly, then future sessions will focus on increasing and/or maintaining activity level. If the resident is still struggling to find feasible events, the focus on the next few sessions is eliminating barriers.
6th-9th	<b>Maintaining Gains, Problem Solving:</b> Goals depend on decisions during Session 5. Problem solving continues as necessary. During these weeks, the activities staff develops an ongoing plan that will be integrated into the resident's care plan. The staff members and resident learn about the possibility of relapse and other factors that could make activity level decline in the future, and develop plans for coping with such setbacks. Staff members may participate, and even take the lead, in some sessions, supported by the therapist.
10 <sup>th</sup>	<b>Summing Up:</b> ASF is present for this session. Progress is reviewed. Plans for the

*(Continued from page 10)*

future are discussed and summarized, including how staff will help resident continue activity levels and how staff, resident, and family will cope with changes in future. Resident, staff, and family are reinforced for effort and progress.

Note: ASF=activity staff facilitator: A-B-C=antecedent-behavior-consequence.’’<sup>2</sup>

(See also: Broekman BFP, Niti M, Nyunt MSZ, Ko SM, Kumar R, & Ng TP. Validation of a brief seven-item response bias-free geriatric depression scale. *Am J Geriatr Psychiatry* 2011; 19[6]:589-596).

## **Anxiety**

Community prevalence of anxiety in patients with dementia is nearly 20%. Generalized anxiety disorder (GAD), one of the most frequently diagnosed anxiety disorders in later life, occurs in 5% of patients with AD. Estimates of clinically significant anxiety are as high as 70% depending on the clinical sample (higher for vascular and frontotemporal dementias) and screening modality (lower in studies that employed structured clinical interviews).

As with depression, the assessment of anxiety disorders in individuals with dementia is challenging. First, geriatric patients tend to underreport psychological problems and overemphasize somatic complaints. Another issue is the high comorbidity of anxiety with major depression in AD (more than 75%): this statistic raises the question of whether AD is independent from, or an epiphenomenon of, depression.

### Treatment of anxiety

Although pharmacological interventions are most frequently employed, no randomized clinical trials have evaluated the use of medication for treating anxiety disorders in persons with dementia. Thus, all recommendations for drug therapy must be cautiously interpreted.

## **Psychosis**

Psychotic symptoms of delusions and hallucinations have been shown to be present in 18% and 14%, respectively, of patients with dementia in a community-based cohort, and it is higher in LTC patients. Considerably higher estimates are often quoted in clinical samples, especially in patients with Lewy body dementia.

## **Agitation/Aggression**

Among individuals with dementia in the community, 27% exhibit agitation/aggression. The prevalence increases as dementia progresses (13% in mild dementia; 24% in moderate dementia; and 29% in severe dementia).

### Treatment of Agitation/Aggression

#### *Therapy for agitation/aggression*

The effectiveness and safety concerns of medication use, especially antipsychotics, argue for greater emphasis on nonpharmacological interventions in treating behavioral disturbances.

#### *Behavioral approaches*

A systematic "ABC" approach to implementing a behavioral plan helps individualize treatment and monitor improvement.

Antidepressants (SSRIs and bupropion) have not been well studied for symptoms other than depression, although their relative safety profile may warrant a therapeutic trial, especially for nonpsychotic patients

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with mild agitation. Results from a small, randomized, clinical trial with trazodone showed promising results for decreasing problematic behaviors in patients with frontotemporal dementia.

There is also evidence of modest, but statistically significant, efficacy of cholinesterase inhibitors. There is limited evidence of efficacy for anticonvulsants, lithium (Drug information on lithium), and alpha-blockers. All these agents can cause significant adverse effects and thus are not recommended, except for patients who have not responded to other treatments.

## Conclusion

Psychiatric comorbidity in persons with dementia reflects phenomenology and diagnostic treatment challenges that are distinct from those in elderly, cognitively intact individuals with psychiatric illness. To date, large systematic reviews of available pharmacological treatments highlight their lack of efficacy and increased adverse effects.

Given the rising incidence of dementia, the ubiquitous nature of associated neuropsychiatric disturbances, limits of current pharmacological treatments, and modest effect of pharmacological and nonpharmacological interventions, the clinical judgment of the psychiatrist and psychotherapist are the best that can be done.



### Articles:

#### A Review by Dr. Leo J. Borrell

(Source: Reichman WE, & Conn DK: Nursing Home Psychiatry: Is it Time for A Reappraisal? *Am J Geriatr Psychiatry* 2010;18(12):1049-1053)

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### **Psychiatric and Psychotherapy Economic Considerations**

- Source: Bright-Long, L. Alzheimer's treatment in nursing homes: Room for improvement. *JAMDA* 2005;09.
  - See also: Vernooij-Dassen M, et al. Focus on mental health issues in long-term care homes. Psychosocial interventions for dementia patients in long-term care. *International Psychogeriatrics* (2010), 22:1121-1128 *Cambridge Journals*
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### **Severe Psychiatric Disorders, Cognitive Impairment, and Mental Healthcare Costs**

- (Source: Macklin RS, Delucchi KL, Bennett RW, & Arian PA. The Effect of Cognitive Impairment on Mental Healthcare Costs for Individuals with Severe Psychiatric Illness. *Am J Geriatr Psychiatry*. 2011; 19[2] :176-184)

### **Evidence-based Reduction of Need for Psychiatric Hospitalization due to Psychotherapy**

- (Summarized by Dr. Borrell. Source: Spijker A, Wollersheim H, Teerenstra S et al. Systematic care for caregivers of patients with dementia: A multicenter, cluster-randomized, controlled trial. *Am J Geriatr Psychiatry* 2011 ;19(6):21-3 1)

### **Depression, Treatment of Depression, Anxiety, Psychosis, Agitation/Aggression**

1. (Source: King-Kallimanis MS, Gum AM, & Kohn R. Comorbidity of depressive and anxiety disorders for older Americans in the National Comorbidity Survey-Replication. *Am J Geriatr Psychiatry* 2009; 17(9):782-792.)
2. (Source: Meeks S, Looney SW, Van Haitsma K, & Teri L. BE-ACTIV: A staff-assisted behavioral intervention for depression in nursing homes. *The Gerontologist* 2008;48(1):105-1 14.)

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## 2014 Save the Date!

TexMed: May 2-3, 2014/Ft. Worth, Texas

AGS: May 15-17, 2014/Orlando, FL

TGS/TMDA: August 8-10, 2014/San Antonio

If anyone is interested in contributing an article to our e-news letter, please email me (Maggie@texasgeriatrics.org).

Our next issue will be in Spring 2014.

Thanks

Maggie Hayden  
Executive Director, TGS

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