New Directions in the Treatment of Behavioral and Psychological Symptoms of Dementia

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SPEAKER DISCLOSURES

- Dr. Daniel Heiser has no relevant financial relationships
- Dr. Shackson has no relevant financial relationships
- Anita Reid has no relevant financial relationships

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LEARNER OBJECTIVES

- Define the primary differences between neuropsychiatric vs. psychiatric patients
- Identify key components of differential diagnosis
- Discuss the legacy/history of treating behavioral and psychological symptoms of dementia (BPSD)
- Present a new paradigm in pharmacologic treatment approaches

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TOPIC 1: NEUROPSYCHIATRIC VS. PSYCHIATRIC DIAGNOSES

- Over 50% of LTC patients have a diagnosed neurocognitive disorder, with up to 80% of LTC patients when including missed or improper diagnoses
- Approximately 95% of these patients have no history of serious mental illness (SMI) before their admission to an LTC facility
- Their psychiatric status exhibited by their BPSD (behavioral and psychological symptoms of Dementia) is often misunderstood as a psychiatric disorder
- For these residents, this is an expression of the primary **neurological** disorder - not a primary psychiatric disorder

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TOPIC 1: NEUROPSYCHIATRIC VS. PSYCHIATRIC DIAGNOSES

- 98% of Dementia patients residing in LTC Facilities will develop at least one DSM-5 Axis I Psychiatric condition (MDS Data)
- 70% of these patients will exhibit severe symptoms
- Severe = CMS qualified diagnosis for acute inpatient psychiatric hospital admission
- Greater than 50% of these severe patients will have multiple episodes

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TOPIC 1: NEUROPSYCHIATRIC VS. PSYCHIATRIC DIAGNOSES

Clinical Review of Case Study:

- 75-Year-old female resident admitted with Vascular Dementia 3 months prior. Starts to decline and exhibits distressing auditory and visual hallucinations in her room. Clinical review shows no premorbid history of psychiatric stays or medication. Delirium workup is negative.

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BEHAVIORAL AND NEUROLOGIC SYMPTOMS OF DEMENTIA (BPSD)

Non-cognitive manifestations of Dementia

- Agitation
- Aberrant motor behavior
- Anxiety
- Elation
- Irritability
- Depression
- Apathy
- Disinhibition
- Psychosis
  - Delusions
  - Hallucinations
- Sleep and appetite changes

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LTC/AL DEMENTIA DIAGNOSES

- Alzheimer's
- Macrovascular
- Microvascular
- Parkinson's Disease Dementia
- Lewy Body
- Fronto-Temporal Dementias
- LATE
- Huntington's Disease Dementia
- Traumatic Brain Injury

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COMORBID SECONDARY DIAGNOSES

- Pseudobulbar Affect
- Partial Complex Seizures
- Obstructive Sleep Apnea
- Primary REM Disorder
- Sundowning (Cerebral Adrenergic Overload)

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TOPIC 2: IDENTIFY KEY COMPONENTS OF DIFFERENTIAL DIAGNOSIS

1. **Medical history will be a major factor**
2. **Social history will also be a major factor**
3. **Geriatric patients do not develop these illnesses de novo**

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DSM-5 CRITERIA FOR SCHIZOPHRENIA

- Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be delusions, hallucinations, or disorganized speech:
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence)
  - Grossly disorganized or catatonic behavior
  - Negative symptoms (i.e., diminished emotional expression or avolition)
- Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet the above criteria (i.e., active phase symptoms) and may include periods of prodromal or residual symptoms.
- During these prodromal or residual periods, the signs of the disturbance may be manifested only by negative symptoms or by two or more symptoms listed above present in an attenuated form.
- No other physiologic causation was identified.

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DSM-5 CRITERIA FOR SCHIZOPHRENIA

- For a significant portion of time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is a failure to achieve expected level of interpersonal, academic, or occupational functioning).
- Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated)

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PREVALENCE RATES & TYPICAL AGE OF ONSET

- Schizophrenia affects approximately 24 million people or 1 in 300 people(0.32%) worldwide. This rate is 1 in 222 people (0.45%) among adults (2). It is not as common as many other mental disorders. Onset is most often during late adolescence and the twenties, and onset tends to happen earlier among men than among women.
- Schizophrenia is frequently associated with significant distress and impairment in personal, family, social, educational, occupational, and other important areas of life.
- People with schizophrenia are 2 to 3 times more likely to die early than the general population (3). This is often due to physical illnesses, such as cardiovascular, metabolic, and infectious diseases.

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SCHIZOAFFECTIVE DISORDER DSM-5 DIAGNOSTIC CRITERIA

- An uninterrupted period of illness during which, at some time, there is either a major depressive episode., a manic episode, or a mixed episode concurrent with symptoms that meet Criterion A for schizophrenia.
- During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.
- Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.
- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

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PREVALENCE RATES & TYPICAL AGE OF ONSET

- About 1 in 300 (0.3%) people develop schizoaffective disorder at some point in their lives. While this mental health disorder is fortunately somewhat uncommon, it can be quite severe for those who have it, affecting most areas of their life.
- The typical schizoaffective disorder diagnosis age tends to be between 16 and 30.
- Unfortunately, many people with schizoaffective disorder may be misdiagnosed with either schizophrenia or bipolar disorder. This is thought to be due to the fact that schizoaffective disorder includes symptoms of both conditions, and modern psychologists could have a bias toward diagnosing the less serious condition. While the typical age of onset maybe 16-30 years old, people may be misdiagnosed at first or may develop schizoaffective disorder later in life.

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TOPIC 3: PROPER INDICATION FOR ANTIPSYCHOTIC USAGE

1. **Antipsychotic usage for true psychiatric residents**
2. **Antipsychotic usage for neuropsychiatric residents and safe alternatives**
3. **Supporting facility staff approaches to best care practices**

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BEHAVIORAL AND NEUROLOGIC SYMPTOMS OF DEMENTIA (BPSD)

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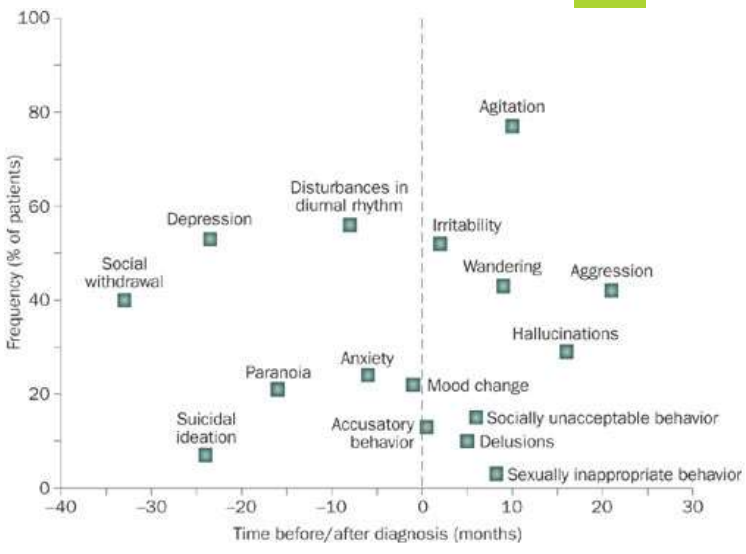
PEAK FREQUENCY OF BEHAVIORAL SYMPTOMS AS ALZHEIMER'S DISEASE PROGRESSES



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HISTORICAL BACKGROUND: TREATMENT OF BPSD

- **Psychiatry as primary treatment**
- **Index case from Dr. Alzheimer presented with psychiatric symptoms**
- **Knowledge of symptoms and medications**
- **Lack of understanding or research**
- **Bias against psychiatric patients and symptoms**
- **Lack of specific treatment much less a cure**
- **Leading to institutionalization of dementia patients**

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JAMDA PUBLISHED ARTICLE

Antipsychotic Drug Reduction through the Implementation of a Neurologically Oriented, Interdisciplinary Psycho-Diagnostic and Antipsychotic Stewardship Program

Steven L. Posar, MD - Anita Reid, MSN, APRN, FNP, GNP - Daniel M. Heiser, PsyD - Jose Pinon, MD - Janean Kinzie, MSW

Abstract: Antipsychotic utilization in skilled nursing facilities (SNFs) is a major focus of regulatory compliance and a key theme in resident care. This created opportunities for innovations in clinical care of behavioral and psychological symptoms of dementia (BPSD). In a shared initiative with one of our SNF operators, the authors implemented a joint clinician/facility program focused on rigorous clinical diagnosis and “best practices” in clinical care, specifically aimed at assessing and reducing antipsychotic use where appropriate.

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NEUROLOGIC BPSD MITIGATION

- Acetylcholinesterase Inhibitors
- NMDA Blocker-Memantine
- SSRI
- Dextromethorphan/Quinidine
- Antiepileptics
- Alpha and Beta-adrenergic Blockers

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EFFECTIVE PSYCHIATRIC TREATMENTS FOR MAJOR NEUROLOGIC COGNITIVE DISORDERS

- Dependent on effective primary care and neurologic treatments
- Thoughtful neurologic diagnosis and treatment is critical
- Primary care and psychiatric treatment must consider the primary neurological diagnosis
- Polypharmacy often contains medications that can exacerbate BPSD or counteract neurologic medications

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EFFECTIVE PSYCHIATRIC TREATMENTS FOR MAJOR NEUROLOGIC COGNITIVE DISORDERS

- Some psychiatric treatments can worsen overall condition both by class of medications and/or individual medications
- Some psychiatric treatments can negatively impact the patient's overall neurologic status-such medications include benzodiazepines, antipsychotics, and anticholinergics
- Effective treatments require the focus to be on evidence-based safer medications

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EFFECTIVE PSYCHIATRIC TREATMENTS FOR MAJOR NEUROLOGIC COGNITIVE DISORDERS

- Depression, Anxiety, and Mood-Stabilization-Sertraline, Escitalopram
- Insomnia - Trazodone, Mirtazapine
- Anxiety – Lorazepam, Clonazepam
- Psychosis – Risperidone, Olanzapine, Pimavanserin
- Bipolar – Valproic Acid, Carbamazepine, Oxcarbazepine, Lamotrigine

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KEY TAKEAWAYS

- Properly identifying and diagnosing neurological disorders is vital
- Evidence of primary psychiatric diagnoses will typically be seen in social and medical history
- There is no such thing as de novo geriatric onset Schizophrenia, Schizoaffective, Bipolar
- Treating BPSD is much more effective when treating the neurological disorder first, then the psychiatric
- Frequent re-assessment and treatment adjustments are required
- Diagnoses and treatments can evolve with neurologic disease progression

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