DEMENTIA NEWSLETTER *for* PHYSICIANS

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A Publication of the Dementia Network of Ottawa

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Non-pharmacological Approaches to Behaviour Symptoms in Dementia

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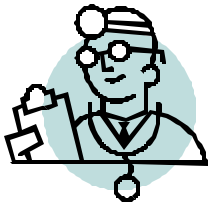

Behavioural symptoms occur in up to 90% of patients with dementia. A structured approach can lessen physician and staff anxiety in assessing and trying to determine appropriate treatment.

1. **Who is agitated?** Lack of knowledge or understanding can make behavioural problems frightening to deal with. Sometimes successful resolution of a behavioural problem starts with teaching and possibly treating the caregiver.
2. **What is the behaviour?** Define and track target symptoms: This not only allows for tracking responses to treatment, but can also help staff and family members place some emotional distance between themselves and the behaviour, turning it into an object of inquiry rather than a personal attack. Tools such as the Cohen-Mansfield Agitation Inventory or the Neuropsychiatric Inventory (NPI) can help.
3. **What is going-on "inside"?** Establish or revisit medical diagnoses: Try to identify any medical condition that may be responsible in causing or bringing out the behaviour, especially delirium. Any sudden change in behaviour compared to the patient's normal state should be considered a delirium so as not to miss this highly fatal problem. Possible causes include: infection, dehydration, metabolic abnormalities, medication side-effects, and pain (including that caused by constipation).
4. **What is going-on "outside"?** Assess and reverse aggravating factors: Cohen-Mansfield (Am J Geriatr Psychiatry 2001; 9: 361-81) identifies 3 theoretical models that provide a framework to formulating a treatment plan.

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If you would like to receive this newsletter electronically, send your email address to hferraton@alzheimerott.org

Non –pharmacological Approaches to Behaviour Symptoms in Dementia

(continued from page 1)

A. Unmet needs: such as sensory deprivation, boredom, and loneliness. Provision of stimulating activities and social interaction can help. Evaluate for hearing and visual deficits and try to correct these. Assessing quality of care (use of restraints, light levels, toileting and communication) is essential and can be addressed by ongoing staff training.

B. Learning/behavioural: This assumes a problem is a learned behaviour that is triggered or reinforced by others, such as increased attention when unwanted behaviour occurs. Tracking behaviour over the course of at least a week can sometimes identify patterns that can help point to a cause. Treatment is aimed at withholding the punitive trigger or reinforcer, or encouraging the expression of a desirable behaviour that will hopefully replace the problem.

C. Environmental Vulnerability/Reduced Stress-threshold: A dementia causes the patient to have a progressively lower threshold of tolerance to environmental changes, to the point that even normal levels of stimulation can be unbearable. Distracting the patient and provision of a calm surrounding, camouflaged exits, neutral colours, removal of TVs, radios or phones can help. An understanding of the progressive loss of skills and abilities (which in Alzheimer Disease is the reverse of child development) can allow assignment of an equivalent age and provide a teaching tool for staff and family members. For example, the patient who has lost the ability to put clothes on unaided is operating at a similar functional level as a 5 year old and cannot be expected to be able to entertain him or herself alone.

5. **What does the family know?** Identify relevant pychosocial factors. Emotionally laden memories are better preserved, even in dementias, than other types of memory. Some reactions may be understood by a careful psychosocial history. Family members may have insight into the patient's life that will help caregivers in dealing with situations that may trigger painful memories.

In general, it is preferable to manage these problems in the setting the patient lives in, especially if the patient lives in a nursing home, rather than admit them to an inpatient unit. This allows caregivers to learn how to approach and deal with problems so that they can more effectively help other patients with similar problems in the future. Some possible treatment modalities have been alluded to above, however, there are too many to discuss in this brief overview. The references below, which are easily found, provide a starting point.

References:

1. Allen-Burge R et al. Effective Behavioural Interventions for Decreasing Dementia-Related Challenging Behaviour in Nursing Homes. Int J Geriatr Psychiatry 1999; 14: 213-32
2. Cohen-Mansfield, J. Nonpharmacologic Interventions for Inappropriate Behaviours in Dementia. A Review, Summary, and Critique. Am J Geriatr Psychiatry 2001; 9: 361-81
3. Finkel, SI (Project Editor) BPSD IPA Educational Pack 2002 (can be obtained free of charge at www.ipa-online.org
4. Raskind, MA. Evaluation and Management of Aggressive Behavior in the Elderly Demented Patient. J Clin Psychiatry 1999; 60 [suppl 15] : 45-9
5. Tariot, PN. Treatment of Agitation in Dementia. J Clin Psychiatry 1999; 60 [suppl 8] : 11-20

Who Should be Assessed For Cognitive Problems?

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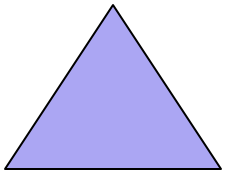
Certainly anyone with memory complaints or anyone whose family is concerned should have comprehensive cognitive assessment. However, think of urinary tract infection in the elderly; UTI may present with specific urinary complaints but may also present non-specifically with falls, dwindles, immobility, anorexia, fatigue etc. Similarly, you should assess cognition in elderly patients who present nonspecifically: falls, failure to thrive, not doing well and especially with any recent unexplained change in function or behaviour. Think ABC and have a "high index of suspicion" for cognitive impairment. It is easy to be fooled by good conversational skills and good "social graces".

A=ADL's

Finances
Shopping
Driving
Cooking
Travel
Laundry

B=Behaviour

Anger
Irritability
Apathy
Depression
Agitation



C=Cognition

If Someone is Asymptomatic (no ABC complaints) When Should You Screen for Dementia?

In 1999, the Canadian Consensus Guidelines stated "there is insufficient evidence to recommend for or against screening for cognitive impairment in the absence of symptoms of dementia."

In 2001, the American Academy of Neurology stated "General cognitive screening instruments (eg MMSE) should be considered for the detection of dementia when used in patient populations with an elevated prevalence of cognitive impairment due to age or presence of memory dysfunction."

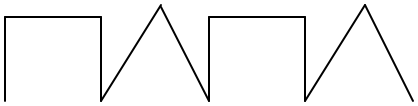
Screen High Risk Asymptomatic Elderly

- Age over 80 (prevalence of dementia > 25%) by age alone
- Age over 65 and other clinical factors
- Post CVA, delirium / depression / first onset over age 65
- Warning signs / behavioural flags
- "Vascular" risk factors (hypertension, CVA, TIA, CAD, DM, hyperlipidemia, atrial fibrillation)
- Family history positive

How Should You Screen?

You can do a full MMSE and further tests of executive function / visuospatial / language

- Clock drawing
- Naming 4-legged animals anywhere in the world (N is >12) in one minute
- Ramparts (continue the line)



- Trails B test

If this takes 20 minutes minimum, you can document start and stop times in your chart and bill K032 (specific neurocognitive assessment — $52.50)

OR

You could do a Dementia Quick Screen (2-3 minutes)

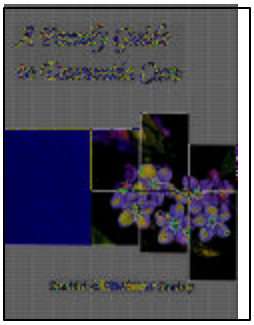
- Year
- Clock drawing
- 3 item recall
- Name 4 legged animals in one minute

If any items incorrect, do full cognitive assessment.

Have a look at: www.dementiaeducation.ca

This site has been developed as part of the Physician Education Initiative of Ontario's Strategy for Alzheimer Disease and Related Dementias. This multi-faceted education program was developed to inform and promote practice change in regards to Alzheimer Disease and related dementias. Registered users of the site will have access to clinical tools, educational materials and teaching resources. The website hosts casebased interactive learning modules, clinical practice guidelines, various educational resources and information on community resources. Take a look…be informed!

A Helpful Resource for Your Patients



This revised comprehensive 12 chapter guide provides information on commonly asked questions about the Alzheimer journey from beginning to end. Topics include: The Disease, Drugs and Research, Understanding the System, Daily Life, Paperwork and Planning, When Living at Home is not Possible.

For more information call:
The Alzheimer Society of Ottawa at 523-4004

Top Three Reasons to Refer Your Patients to First Link

First Link / Premier lien

1. Caregiver support
2. Dementia education
3. Info about community services

Local physicians have referred more than 200 patients to First Link, a support and education initiative for individuals and families with dementia. First Link is an Alzheimer Society of Ottawa program implemented in collaboration with the Dementia Network of Ottawa. When you refer a patient to First Link, they receive: a personal phone call from the Alzheimer Society, an information package about Alzheimer Disease and dementia, guidance and information about community resources and care issues.

Dr. Ian Richardson, an Ottawa family physician reports: "Patients who have made the First Link connection are generally more knowledgeable about the disease and the help available, and more secure in having someone specific to call on when they need to".

For more information:
www.alzheimerottawa.org/first_link
or phone 523-4004
for your First Link referral kit

THANK YOU

The Dementia Network of Ottawa would like to thank Novartis, Janssen-Ortho, and Pfizer for sponsoring this edition of the Dementia Newsletter for Physicians.

NOVARTIS
JANSSEN-ORTHO Inc.
Pfizer

NEWS! NEWS! NEWS!

THE DEMENTIA EDUCATION PROGRAM FOR FAMILY PHYSICIANS now meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for Mainpro–C credits. Should participants choose not to participate in a reflection exercise, they may still claim Mainpro-MI credits (1 credit per hour).

FOR MORE INFORMATION ABOUT THIS PROGRAM PLEASE CONTACT THE ALZHEIMER SOCIETY at 523-4004

The Dementia Network of Ottawa
Réseau de la démence d'Ottawa

DEMENTIA NETWORK OF OTTAWA
DEMENTIA NEWSLETTER *for* PHYSICIANS

EVALUATION SURVEY

The Dementia Newsletter *for* Physicians was first published in the winter of 2001. It is now published 3 times a year and this edition is the ninth one that has been distributed. Articles are written by health care professionals for physicians in order to:

- share information about clinical care, education and research
- support the Family Physician through provision of up-to-date information on assessment, treatment and management strategies

We are asking for your help in order to evaluate this newsletter by answering the questions below.

1. **Do you read this newsletter?**
   ____never
   ____skim
   ____only articles that catch my attention
   ____all of it
   ____all of it and save for future reference

2. **How useful is it to you?**
   ____poor
   ____fair
   ____good
   ____very good
   ____excellent

3. **Do you have suggestions for improvement? (topics)**
   _____
   _____
   _____

4. Significant expense can be saved by sending an electronic version. If this is suitable for you, please provide your email. _____

5. The Dementia Network of Ottawa provides a small group academic detailing program for physicians. Approximately 200 family physicians have taken this program and rate it very highly. The format is usually a 30 to 60 minute breakfast lunch and learn session at your office (food provided) with a review of a binder of modules focusing on practical approaches to assessment, diagnosis and treatment of dementias and driving assessment. Physician educators are Drs. Byszewski, Carrier, Dalziel, Guzman, Loy-English, Mendis and Power. If you are interested in arranging a session, please fill in the following information:
   Name: _____ Phone #: _____
   or contact_____

Please fax back this form to: Alzheimer Society of Ottawa
Fax #: 523-8522

Thank-you for taking the time to complete this evaluation survey.