

# Managing Distress and Behaviour Problems in People with Dementia in Care Homes

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# Palliative Care in Dementia



- ▶ 6 out of 7 people with dementia do not survive to the severe dependency
- ▶ Most dementia care in nursing and residential homes should have a palliative philosophy: making life as comfortable and content as it can be in the circumstances
- ▶ The presence of dementia increases mortality 2.5 times
- ▶ 1 year survival in nursing homes is 50%
- ▶ Chances of successful CPR in dementia similar to terminal cancer
- ▶ Success rate approx 2%. But what is success anyway?
- ▶ In this context perhaps some staff time spent on CPR training, prophylactic administration of medication, BP monitoring, would be better directed to other aspects of patient care.

***BMJ. 2006 February 25; 332(7539): 479–482. Cardiopulmonary resuscitation in continuing care settings: time for a rethink?***

# Palliative Care in Dementia



- ▶ Over 5 times difference in number of prophylactic medications prescribed between 1 old age psychiatry ward, and another, and two specialist nursing homes for dementia
- ▶ No evidence for effectiveness of statins in dementia care once dementia established
- ▶ Evidence for antiplatelet, and antihypertensive medication very limited
- ▶ Warfarin: need strong case to continue it

BMJ 2007 335: 235 - Preventive health care in elderly people needs rethinking: Mangin D, Sweeney K, Heath I.

# Management of:



- Hostility
- Psychosis
- Agitation
- Wandering
- Shouting out
- Sleep disturbance
- “Inappropriate” sexual behaviour
- Not eating
- Depression

- ▶ **Frontal lobe impairment** is key to most of the above. By talking about memory clinics, we are giving the impression that that memory is the main problem in dementia. It is not. Dementia is a global brain disorder, and frontal lobe involvement is very frequent. Frontal lobes are the most neglected in training and understanding . Memory impairment easy to understand, frontal impairment difficult.

# Manifestations of frontal damage in dementia include



- ▶ a) Loss of starter motor: why people sit round doing nothing in homes, yet can be occupied when actively engaged and prompted. Why people don't eat, but will eat if someone sits with them and prompts what to do.

# Manifestations of frontal damage in dementia include



- ▶ b) Loss of search engine: cannot answer broad questions but can answer specific questions. Cannot make decisions because cannot search for alternatives. Cannot distract from the immediate so gets stuck with a worry, or preoccupation with a pain. Cannot rationalize pain or worry, or go and find something to do to “take my mind off it”

# Manifestations of frontal damage in dementia include



- ▶ c) Empty head syndrome: no thoughts. Looks depressed to an observer, but responds to interaction. Depressed patients have depressing thoughts and usually blame themselves for feeling as they do. Patients with frontal lobe can't tell you what they are thinking about and can appear quite cheerful during interactions.

# Manifestations of frontal damage in dementia include



- ▶ d) Neglect of personal care: e.g. long toe nails
- ▶
- ▶ e) Loss of inhibitions: hitting out, “abusive comments”, sexual remarks, hostility.
- ▶
- ▶ Frontal lobe problems are often perceived as :  
“manipulative, behavioural, attention seeking, putting themselves to the floor, being difficult. Can create antagonism.

# Management of behaviour disturbances



- ▶ This will be disproportionately about medication. In recent onset situations need to look out for acute confusional state and causes and treat underlying cause. Long list of causes. Usual suspects. Includes side effects from medication.
- ▶ Is the disturbance about the environment: other residents, too much stimulation, too little occupation?

# Management of behaviour disturbances



- ▶ Previous experiences of person can be important: eg early life family hostility, POW.
- ▶ Wrong home: whatever is done does the person need to move to a specialist home?
- ▶ Is the behaviour disturbance really a problem?
- ▶ ABC chart: formal recording of problem behaviour can in itself be therapeutic.

# Medication:



- ▶ Licensed in dementia
- ▶ Donepezil. Rivastigmine. Galantamine . Memantine.
- ▶ Risperidone: for aggression agitation, psychosis.
- ▶ Other medication without robust evidence
- ▶ Other antipsychotics: olanzapine, quetiapine, haloperidol, flupentixol.. etc
- ▶ Antidepressants: Trazodone, mirtazapine, citalopram, sertraline
- ▶ Carbamazepine, sodium valproate, pregabalin
- ▶ Aromatherapy

# Hostility and Aggression



- ▶
- ▶ **Risperidone** 0.5mg bd initially: licensed, good evidence base, available as oral dispersible, and colourless tasteless liquid .
- ▶ Disadvantage: adverse publicity: has a bad name. Outrage at over use of antipsychotics and finding of increase risk of Cerebrovascular event. Risks probably same as all antipsychotics and benzodiazepines.
- ▶ Side effects: sedation, falls.
  
- ▶ **Trazodone**: anecdotal evidence only. Available as liquid. 50mg bd. Can go to 150mg bd
- ▶ Relatively safe.
  
- ▶ **Quetiapine**: 25mg od or bd and increase. Response fairly weak at low doses... but side effects few. Involves joint care arrangement.
  
- ▶ **Citalopram**: limited evidence.

# Hostility and Aggression



- ▶ **Carbamazepine:** limited evidence and side effect problems.
- ▶ **Memantine** currently a red drug. Due to become generic in April 2014.
- ▶ Glutamate antagonist. Potentially useful in behaviour disturbance with dementia

# Hostility and Aggression



- ▶ **Donepezil rivastigmine galantamine:** not licensed for behaviour disturbance specifically however some evidence of effectiveness. Still complicated and expensive but patent ending soon. Then will be simple and inexpensive,. GI side effects in 20% but otherwise worth trying. Donepezil probably easiest to initiate ( 2 stages)
- ▶ Benzodiazepines. Not much evidence for long term effectiveness. In disturbance of acute confusion while underlying cause settling then lorazepam 0.5mg to 1mg bd, tds, may be useful because of quick response.
- ▶ Aromatherapy: some evidence for melissa oil.

# Psychosis



- ▶ Common cause of hostility and distress. Patient feels unjustly picked on, shunned, gossiped about, persecuted, experimented on, in danger. (In psychosis in severe depression patient feels persecution is justified. )
- ▶ “How are you getting on with the staff/ other resident, do they talk about you? What do they say about you? “
- ▶ Can respond really well to low dose antipsychotic eg risperidone 0.5mg bd.

# Agitation



- ▶ Similar response to medication as per hostility. Risperidone 0.5mg bd, or Trazodone 50mg bd initially. More need to consider underlying depression.
- ▶ Also consider donepezil etc especially when off patent.

# Wandering



- ▶ Very difficult : no real evidence of useful response to medication.
- ▶ Is it a problem that would be solved by more secure environment?

# Shouting HELP



- ▶ Very difficult: no evidence of anything helping. Change of environment. Sort out hearing, vision problems, other people around.
- ▶ Try trazodone , try risperidone, try donepezil

# Sleep disturbance



- ▶ No good answers. Is it a problem?
- ▶ Decaffeinated beverages in Care homes routine.

# Inappropriate sexual behaviour



- ▶ Is it inappropriate? Practical management
- ▶ Empirical use of psychotropic medication

# Not eating



- ▶ Is this because of frontal lobe problems: not being able to initiate
- ▶ Prompting, mirroring
- ▶ Is it an end of life issue?
- ▶ Could try Olanzapine 2.5mg once or twice daily
- ▶ Could try antidepressant.

# Depression



- ▶ Little evidence for effectiveness of antidepressants in dementia. Need to distinguish from empty head syndrome of frontal impairment where there is no distress. Also psychosis where depression is secondary and might well respond to antipsychotics.
- ▶ Practical management, managing the environment:
- ▶ Antidepressants still worth trying: citalopram 10mg/ 20mg, mirtazapine 15mg /30mg/45 mg, sertraline 50mg/ 100mg as examples. There are lots, if one dose not work no evidence that trying another will work but can do it anyway.

# Stopping Psychotropics



- ▶ What can be stopped?
- ▶ People accumulate odd 10mg of amitryptiline, or are on an SSRI or other antidepressant and don't seem depressed. Unless there is clear evidence of recurrent depressive disorder it is reasonable to gradually cut these out.
- ▶ Antipsychotics for behaviour disturbance can often be stopped once settled or proved ineffective. One third to a half will need to re start.
- ▶ Benzodiazepines ? Reduce if possible but not if it causes problems.
- ▶ Donepezil etc. Can often be stopped. If doing anything patient will deteriorate within 10 days: re start if a problem.