Geriatric Psychiatry for Non-Psychiatrists

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Managing Agitated Behaviors in Dementia

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DISCLOSURES

- I have no disclosures regarding any conflicts regarding the content of this presentation

- I will be discussing “off-label” use of pharmacologic agents as to date few medications have been FDA approved to treat agitation in Alzheimer’s disease or other dementias.

Agitation in Alzheimer's Disease

Seen in up to 80-90% of dementia patients

Untreated, often leads to more rapid decline

Leading cause of caregiver burnout

Leading cause of ED visits, hospitalizations, and institutionalization

Neuropsychiatric symptoms of dementia

- Delusions
- Hallucinations
- Depression
- Anxiety
- Euphoria
- Aggression
- Apathy
- Irritability
- Disinhibition
- Wandering or pacing
- Sleep disturbances

Understanding Behaviors

- Often signal an unmet need
- Represent a form of communication
- Typically, are not volitional, but interpreted so
- Often worsen as the day progresses
- Often have a trigger

Once triggers are identified, can be anticipated, eliminated or modified
Behaviors prevented or manageable leading to improved quality of life

Typical Behavioral Triggers

Communication

Communication

Communication

What too often occurs

What we strive for

5-D's

Describe
Decode
Devise
Do
Determine

DICE

Describe
Investigate
Create
Evaluate

If it works – Broadcast it

Use The DICE Approach

Describe

- Caregiver **describes** problematic behavior
  - Context (who, what, when and where)
  - Social and physical environment
  - Patient perspective
  - Degree of distress to patient and caregiver

Investigate

- Provider **investigates** possible causes of problem behavior
  - Patient
    - Medication side effects
    - Pain
    - Functional limitations
    - Medical conditions
    - Psychiatric comorbidity
    - Severity of cognitive impairment, executive dysfunction
    - Poor sleep hygiene
    - Sensory changes
    - Fear, sense of loss of control, boredom
  - Caregiver effects/expectations
  - Social and physical environment
  - Cultural factors

Create

- Provider, caregiver and team **collaborate to create** and implement treatment plan
  - Respond to physical problems
  - Strategize behavioral interventions
    - Providing caregiver education and support
    - Enhancing communication with the patient
    - Creating meaningful activities for the patient
    - Simplifying tasks
    - Ensuring the environment is safe
    - Increasing or decreasing stimulation in the environment

Evaluate

- Provider **evaluates** whether "CREATE" interventions have been implemented by caregiver and are safe and effective

Consideration of Psychotropic Use (Acuity/Safety)

Kales, Gitlin, Lyketsos, JAGS 2014

Study of Use of DICE

Participants (N=136) in both in-person and online DICE trainings experienced significant changes in knowledge, self-efficacy and attitudes from baseline to post-training assessments ($p<.01$)

By using the DICE approach with caregivers of persons with dementia, Wisconsin's DCSs and other dementia professionals are uniquely positioned to help reduce risks associated with BPSD, including the use of psychotropic medications.

Training satisfaction was high, knowledge about BPSD increased, and attitudes improved. The DICE trainings prepared trainees to implement this intervention with 165 family caregivers.

Walaszek et al. Alzheimer's and Dementia. Volume 17, Issue S8 Dementia Care Practice (Descriptive). December 2021

PULSE-D

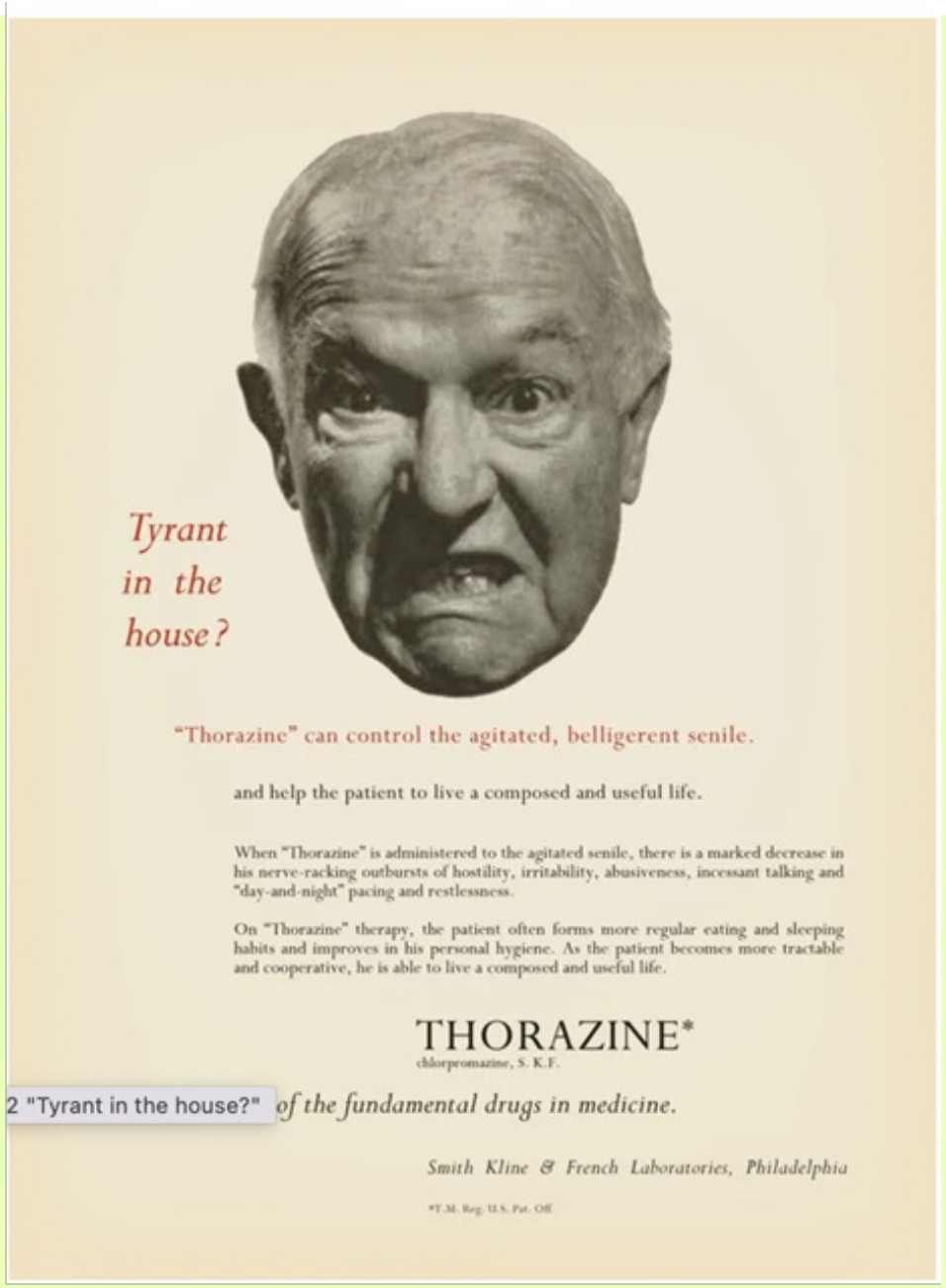
- **P** – Pain/Physical distress
- **U** – UTI, other infection, other acute medical problem
- **L** – Light
- **S** – Sleep + Stress (Caregiver stress in particular)
- **E** – Environment

- **D** – Effects of medications and supplements

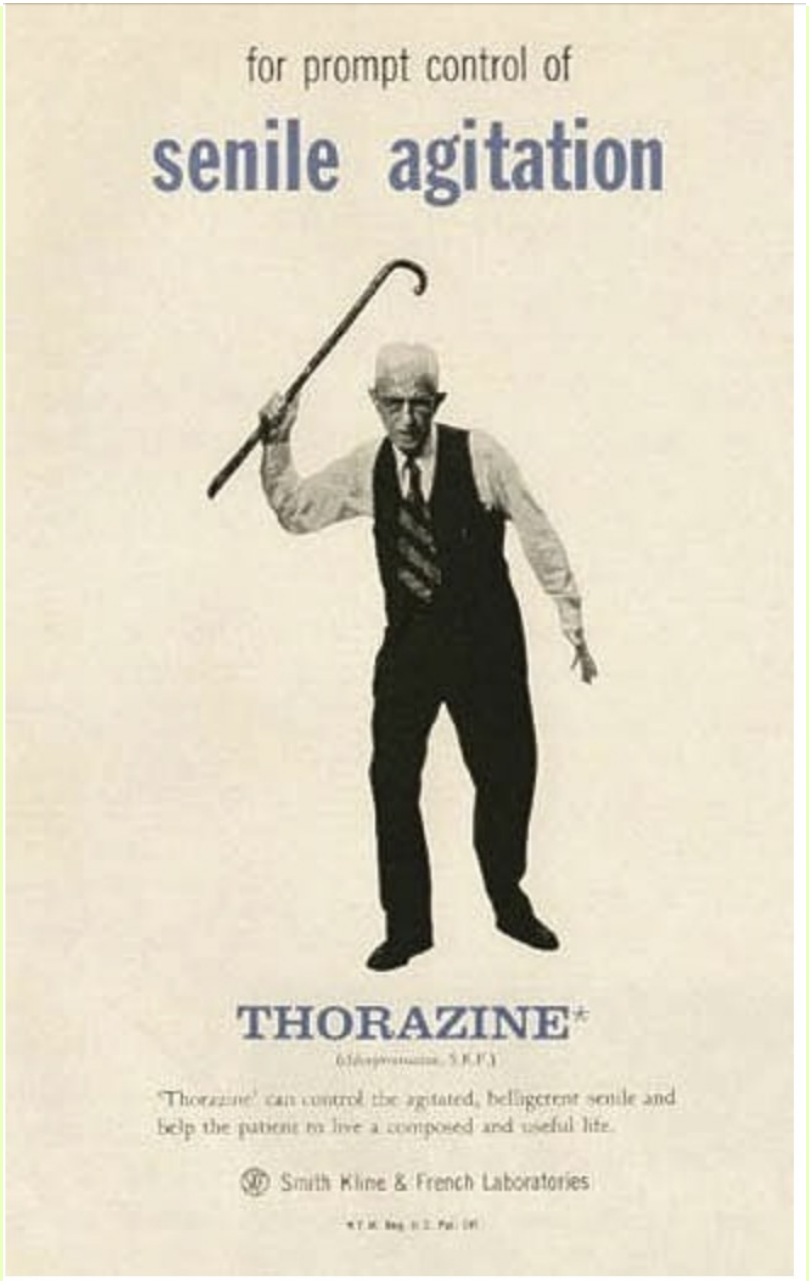
Also, ask about possible lifelong psychiatric disease

When Nonpharmacologic treatments fail,

What do we do next?



2 "Tyrant in the house?"



Algorithm for Treatment of Neuropsychiatric Symptoms of Dementia

- Harvard Algorithm
- International Psychiatric Association
- Geriatric Society of America

All have suggested treatments that have some, often limited, scientific evidence of benefit

Harvard Algorithm

- **Emergent BPSD** (Oral medication not feasible)

- Try intramuscular injection of olanzapine
- No or indadequate response – Try IM injection of haloperidol
- No or inadequate response – Try IM benzos for short-term

Chen A, Copeli F, Metzger E et al. The Psychopharmacology Alzorithm Project at the Harvard SouthShore Program: An update on management of behavioral and psychological symptoms in dementia. Psychiatry Research 295(2021): 11:1-9

Harvard Algorithm

- **Urgent BPSD**

- If not recently on D2 receptor blockade try aripiprazole to max dose of 15 mg
- If no or inadequate response – try risperidone increasing to a max dose of 2 mg
- If no or inadequate response – try prazosin with a maximum dose of 2 mg qAM and 4 mg qPM
- If no or inadequate response – consider ECT

Chen A, Copeli F, Metzger E et al. The Psychopharmacology Alzorithm Project at the Harvard SouthShore Program: An update on management of behavioral and psychological symptoms in dementia. Psychiatry Research 295(2021): 11:1-9

Harvard Algorithm

- **Non-emergent BPSD**

- Decrease anti-cholinergic load and optimize pain control
- If inadequate or no response - consider sleep optimization with trazadone
- If inadequate or no response – initiate donepezil and memantine
- If inadequate response do not d/c donepezil or memantine, try an SSRI either escitalopram or sertraline

Chen A, Copeli F, Metzger E et al. The Psychopharmacology Alzorithm Project at the Harvard SouthShore Program: An update on management of behavioral and psychological symptoms in dementia. Psychiatry Research 295(2021): 11:1-9

Harvard Algorithm

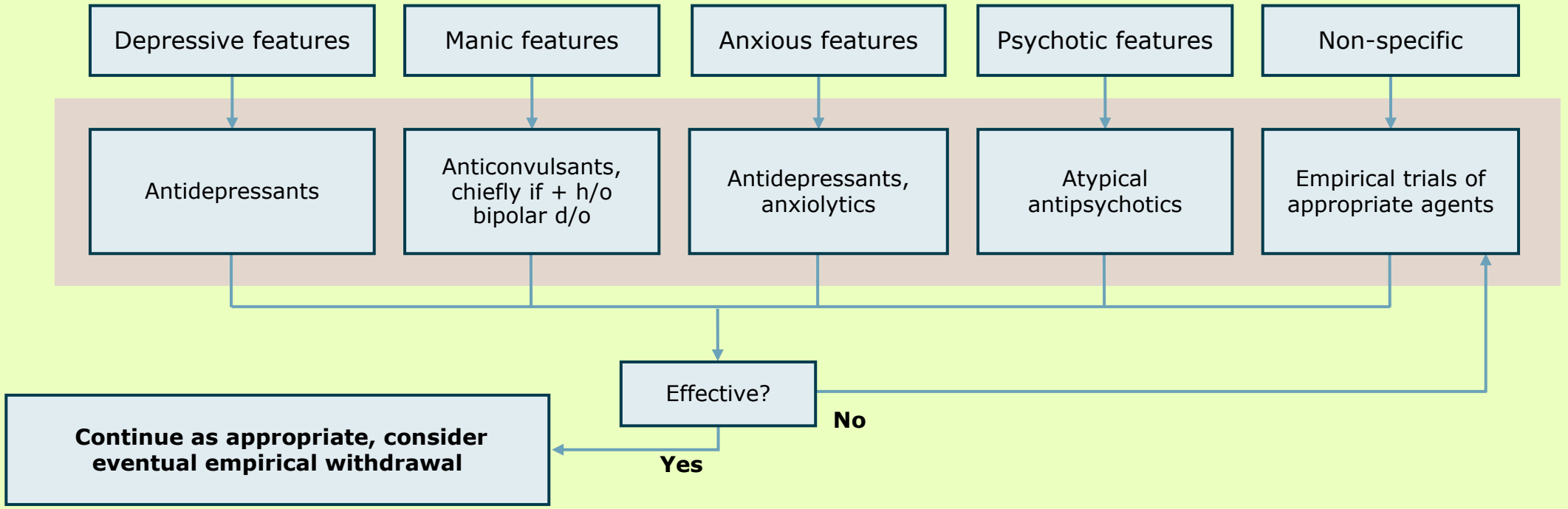
- **Non-emergent BPSD (cont'd)**

- If inadequate or no response – try 2nd generation antipsychotic
- If inadequate or no response – try prazosin (max dose 2mg AM 4mg PM)
- If inadequate or no response – try carbamazepine (max dose of 400 mg)
- If inadequate or no response – try unilateral or bilateral ECT

Chen A, Copeli F, Metzger E et al. The Psychopharmacology Alzorithm Project at the Harvard SouthShore Program: An update on management of behavioral and psychological symptoms in dementia. Psychiatry Research 295(2021): 11:1-9

Psychobehavioral Metaphors

Pharmacological management of agitation in dementia, following unsuccessful non-pharmacological intervention



Tariot et al, 1996

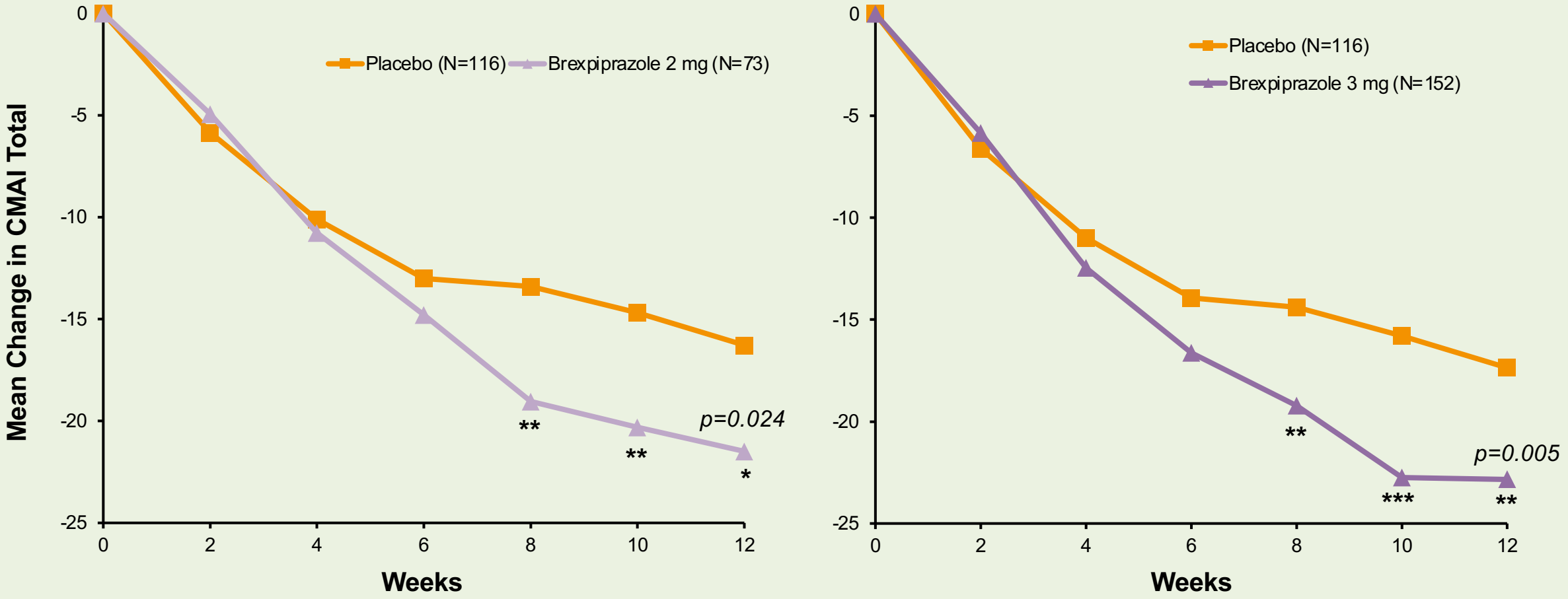
Brexpiprazole

A POTENT ANTAGONIST OF SEROTONIN 2A RECEPTORS, NORADRENERGIC ALPHA 1 B & 2C RECEPTORS

FDA-APPROVED FOR ADJUNCTIVE TREATMENT OF MAJOR DEPRESSION AND FOR TREATMENT OF SCHIZOPHRENIA

Courtesy of Dr. George Grossberg

Primary Endpoint: Change from Baseline in CMAI Total by Dose (MMRM) (Study 331-14-213)

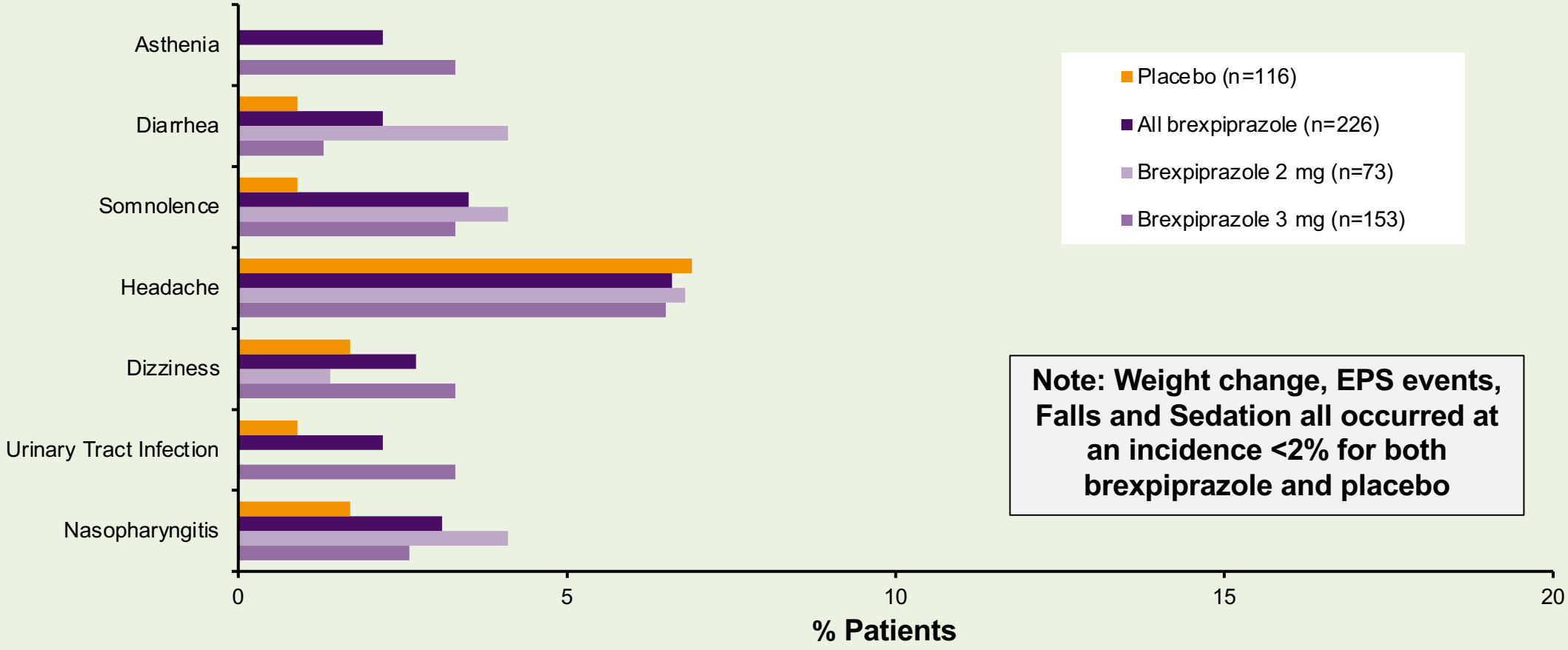


Baseline CMAI Total score: placebo, 79.17, n=116; brexpiprazole 2 mg, 79.07, n=73; brexpiprazole 3 mg, 81.26, n=152

*p<0.05, **p<0.01, ***p<0.001

CMAI=Cohen-Mansfield Agitation Inventory; MMRM=mixed model for repeated measures

Most Common AEs (Study 331-14-213)
(≥2% in the placebo or all brexpiprazole group)



Note: Weight change, EPS events, Falls and Sedation all occurred at an incidence <2% for both brexpiprazole and placebo

Courtesy of Dr. George Grossberg

Dosing

Days 1–7: 0.5 mg
Day 8–14: 1 mg
Day 15: Begin 2 mg dose

Can increase dose to 3 mg

***Important – Not a prn medication**

Special issues

- **Disrupted sleep** – Avoid Benzos, Z-drugs. Alternatively use trazadone, mirtazapine, melatonin, suvorexant, consider light therapy
- **Apathy** – Cholinesterase inhibitors, memantine, methylphenidate, other stimulants, bupropion
- **Psychosis in PD and PDD** – Cholinesterase inhibitors, pimavanserin, quetiapine, clozapine, judicious use of low doses of risperidone
- **FTD** – No specific medications with evidence of benefit, no evidence of benefit for cholinesterase inhibitors, negative study of memantine, SSRI medications may be helpful, prudent use of atypical APs
- **Pseudobulbar affect (PBA)** – Use of combo of dextromethorphan and quinidine

Thank you *Questions?*

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Additional Slides

Due to the limited time of the presentation, I have included some additional slides that describe various non-pharmacologic strategies.

The following slides are for your review

Non-Pharmacological Approaches

- **Evaluate the environment**
  - Changes in setting, caregiver, or roommates
  - "The demented patient's agitation may have more to do with the nursing home roommate than with dopamine or other receptors in the brain"
  - Provide an environment that avoids conflicts (eg, wandering, vocalizing, sexual disinhibition)
  - Make sure it is not too hot/cold/noisy/dark

Adapted from Cohen-Mansfield. *Am J Geriatr Psychiatry*. 2001;9:361-381; Reus VI, et al. *Am J Psychiatry*. 2016;173(5):543-546; Alzheimer's Association position statement on Behavioral and Psychological Symptoms of Dementia, 2014

Non-Pharmacological Approaches

- **Keep consistent routines**
  - Structured activities
  - Regular schedule, avoid boredom or overstimulation
  - Watch out for those holiday decorations!
- **Employ simple behavioral therapy techniques**
  - Distraction/redirection/extinction
  - “She can’t resist if you don’t insist”

Adapted from Cohen-Mansfield. *Am J Geriatr Psychiatry*. 2001;9:361-381; Reus VI, et al. *Am J Psychiatry*. 2016;173(5):543-546; Alzheimer’s Association position statement on Behavioral and Psychological Symptoms of Dementia, 2014

Non-Pharmacological Approaches

- **Train caregivers on communication techniques**
  - Speak slowly and clearly, use normal tone of voice
  - Allow lip-reading
  - Maintain eye contact
  - Allow comfortable space

Adapted from Cohen-Mansfield. *Am J Geriatr Psychiatry*. 2001;9:361-381; Reus VI, et al. *Am J Psychiatry*. 2016;173(5):543-546; Alzheimer's Association position statement on Behavioral and Psychological Symptoms of Dementia, 2014

Non-Pharmacological Approaches

- **Train caregivers on communication techniques**
  - Meet them in whatever time and place they are
  - Don’t over-explain
  - Validate concerns/feelings
  - Reassure them that they are safe and loved
  - Avoid critical remarks

Adapted from Cohen-Mansfield. *Am J Geriatr Psychiatry*. 2001;9:361-381; Reus VI, et al. *Am J Psychiatry*. 2016;173(5):543-546; Alzheimer’s Association position statement on Behavioral and Psychological Symptoms of Dementia, 2014

Non-Pharmacological Approaches

- **Caregiver interventions**
  - Teach that agitation is not volitional
    - "It's the disease talking"
  - Supportive psychotherapy for caregiver
  - Referral to day treatment program
  - Exercise (for the caregiver)
  - Respite care

Adapted from Cohen-Mansfield. *Am J Geriatr Psychiatry*. 2001;9:361-381; Reus VI, et al. *Am J Psychiatry*. 2016;173(5):543-546; Alzheimer's Association position statement on Behavioral and Psychological Symptoms of Dementia, 2014

AdditionalReferences

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