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How Older-Age Psychiatrists Assess and Support People with Dementia

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Abstract

This article looks at the processing of referrals to old age psychiatry memory services and provide points of learning.

Dementia impairs memory and cognitive abilities. It also affects the personality, causing negative behavioural changes. It is usually of long duration and is often both progressive and irreversible. Dementia is characterised by memory disturbance (amnesia), loss of receptive or expressive language skills (aphasia), impaired ability to carry out motor functions (apraxia), and a failure to recognise objects (agnosia), or a familiar face (prosopagnosia). It also causes disturbances in executive functions (such as planning, organising and sequencing tasks), and an inability to manage abstract thinking. As the dementia progresses, the person will not be able to perform everyday activities or socialise with others.

Key Words: psychiatrists; dementia

Introduction

This article looks at the processing of referrals to old age psychiatry memory services and provide points of learning.

Dementia impairs memory and cognitive abilities. It also affects the personality, causing negative behavioural changes. It is usually of long duration and is often both progressive and irreversible. Dementia is characterised by memory disturbance (amnesia), loss of receptive or expressive language skills (aphasia), impaired ability to carry out motor functions (apraxia), and a failure to recognise objects (agnosia), or a familiar face (prosopagnosia). It also causes disturbances in executive functions (such as planning, organising and sequencing tasks), and an inability to manage abstract thinking. As the dementia progresses, the person will not be able to perform everyday activities or socialise with others.

It is reported that an increasing number of older people in the UK are living with chronic conditions and cognitive impairment (ONS, 2018). Indeed, it is estimated that over 400,000 older people in the UK live-in long-term care homes (LTC) (Laing-Busson, 2018). As the population ages, we are seeing ever increasing rates of dementia within the general population. The London School of Economics and Political Sciences (2019) estimated that in 2020 there would be 907,900 older people living with dementia in the UK; and estimated that the number of older people with dementia in the UK will increase by 80%, from almost 885,000 in 2019 to around 1.6 million in 2040.

Once a referral has been received from the General Practitioner by an Old Age Psychiatrist, the letter is screened for relevant information, such as a history of the problem, background medical conditions and medications, and any results of investigations. Then, the referral in most services is triaged by a single point of entry, or by a specialist memory services team. Once the referral is considered to be appropriate, a discussion takes place as to what is the most appropriate service to meet the patient needs. Some clients who live in care homes in certain areas are assessed by the care home team e.g. South Wales,

while others can be assessed by the community mental health team.

of Constantine VII Porphyrogenitus (913-959 A.D.) [6].
Patients with mild to moderate impairment will usually be seen by the Memory Clinic. In some memory services, the individual will be screened or assessed by a Specialist Memory Nurse, who will give feedback to the Consultant Old Age Psychiatrist, while other patients may be seen directly by the Consultant. If the team feels that further assessment by other members of the team is required, such as a Psychologist or an Occupational Therapist, or that an investigation such as a brain scan is needed, then the team will make the appropriate referral and offer a further appointment. In some areas of the UK e.g. Devon & Bristol, there are One Stop Clinics, where the patient and family are assessed and diagnosed in the same day.

Assessment in old age psychiatry

The thorough assessment of an older person is an essential first step in offering the best management for their mental illness. The assessment aims initially at excluding other conditions, such as delirium or depression, and arriving at the dementia syndrome subtype. It is important as part of the assessment process to exclude treatable causes of dementia, such as physical illness and symptoms (e.g. infection, cardiac failure, anaemia, drug toxicity, malnutrition, pain).

Learning point one

Multidisciplinary Assessment will almost invariably offer more information. Decisions regarding the care of a person living with dementia are made by a team of professionals, who will be offering that individual consistent and effective care. Which health professionals will be involved in the care of your patient?

- Mental health problems are common in older adults, due to an increased likelihood of co-morbid physical illnesses, isolation, and a higher dependence on health and social care services. There is also a higher risk of older people taking their own lives. The mortality rate in people with dementia is 3.3–6.0 times higher than that of the general population (Prince et al, 2012). Suicide is a common cause of death in elderly people, with its prevalence ranging from 18 to 20% (Shah et al, 2016). Death by suicide is infrequent in the advanced stages of cognitive impairment, but some reports have shown a higher risk of suicide during the early stages of cognitive impairment (An et al, 2019) when older people have awareness of their illness and are able to plan suicide. It is important to remember that older people are far less likely to tell a mental health professionals about any 'symptoms' that they are experiencing. They are likely to be reluctant to seek medical treatment for their mental health issue. Instead, the older person living with dementia is more likely to complain of physical illness. What do you think would help patients with dementia to speak more openly to their psychiatrist or another member of their Multidisciplinary Team about their 'symptoms'?
- Please look at the following helpful 'toolkit' that gives more information about dementia:https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

Interviewing relatives and carers

Once the patient and their family / carer give consent to the assessment to establish whether or not the patient has dementia, the process can begin. It is often helpful to interview a carer, or another involved individual. This initial meeting can establish a rapport, which will prove important for providing future help and support. When the carer is interviewed they will be asked about their relationship with the patient, the amount of care that they provide, and what help they think that they can offer the patient. It is important that they have realistic expectations about what care they can offer, and that they do share if they feel that they are under stress, as the caring role can be stressful. It is also helpful if the carer is asked about whether they have observed any changes in the patient's behaviour, such as the amount that they engage in daily living activities.
The mental health professionals will give the carer information about the patient's dementia, and signpost them to services and voluntary organisations where they can receive more support. It is recognised that the family contribute to both a comprehensive assessment of the person's dementia, and subsequently to successful management of the patient's condition.

Taking a patient's history

Normally, the team will try to see the patient on their own first of all, so as to find out more about their perspective of what is going on for them. Therefore, it is important that you feel at ease as much as you can, and that are alert when you are taking the patient's history. As already mentioned, the family and carers will also be interviewed, as their perspectives are important, too.
While taking the patient's history, the team will try to find out about how the individual is currently presenting. What level of daily activities is s/he managing? Do they receive help from a carer, or different carers? Is the patient living in a care-home setting? Does the carer live-in? How many times a day does the carer visit the patient in their own home? Is there any change in the pattern of care? What is the patient's highest level of functioning?

Then, the team will take a detailed psychiatric history that will include the following:

- When did the patient's symptoms start?
- Write down a detailed account of the patient's presenting complaint. Look at the family's history. The team will need to consider any relevant history that runs in families, such as does the person with dementia have a relative who has a psychiatric illness, e.g. dementia or depression. No history is complete without trying to find out about the individual's own personality, so that care can be 'person-centred'.
- The team will then review the life history of the individual. Such a personal history puts the patient and their problems in context. The patient's level of education and occupational history are useful, such as what interests do they currently engage with on a daily basis (i.e. reading, doing crossword puzzles). This will also affect performance on cognitive tests.
- It is important to write down a relevant past psychiatric

history and a medical history, including a list of medications. This will involve reviewing any multiplicity of disorders, or symptoms, multiple medicine use (polypharmacy), ensuring that the patient takes the medication (adherence), and any experienced side-effects or withdrawal effects from the medication, such as falling, drowsiness and confusion that tend to occur in old age.

- A long habit of alcohol dependency may continue and become difficult when medications are added. Some lonely and/or depressed older people may start drinking for the first time in their old age. They may find it helpful to be signposted to support that Alcoholics Anonymous can offer. Please see this link: https://aa.org/

Part of the purpose of taking a patient's history is to identify any gaps in their social network, and any social stressors that may impact on their quality of life. As loneliness is common in older people, it is important to find out what interests they have, and about their social network. It may be that the person with dementia can be encouraged to take up a new hobby or interest, such as singing in a choir, or joining a gardening group for older people.

- It is important to note that no history is complete without trying to find out about the person with dementia's personality. Knowing the individual, rather than just listening to what their relative or friend has to say about them and their condition, helps to create a care plan that will best meet their needs.

Learning point two

- How do you involve the person with dementia's network in their care plan?
- If what the person with dementia says, differs significantly from what their relative says about their condition and behaviour, what do you do?
- How do you manage the issue of alcohol dependency, if the person with dementia is not well enough to attend Alcoholics Anonymous? Do you have a local contact in Alcoholics Anonymous, who could arrange for two members of their AA group to go together to visit the person with dementia and their carer in a care-home, or in a community setting?

Conducting a Mental State Examination

Appearance and behaviour: We check if the individual is fully alert, animated and articulate, or placid and lacking in spontaneity. We try to find out any sensory impairment issues, such as any impairment of vision, hearing, or mobility. We also try to find out any obvious signs of neglect or risks to the patients, such as self-harming behaviour, or safeguarding issues.

Speech: We look for evidence that the history is spontaneous, consistent and insightful, or hesitant, circumstantial, and unfocused. We ensure that questions are understood and answered adequately in a relevant and informative way. If not, we check if the individual is hard of hearing/deaf, dysphasic, cognitively impaired, confused or disaffected.

Mood: Anxiety symptoms are common in older people. It is important that we pay attention to masked depression i.e. when the individual presents with physical symptoms, rather than mood symptoms. It is vital that we ask about suicide ideation, as it is relatively common in later life.

Abnormal beliefs: Paranoid ideation or suspiciousness may compound deafness, be a phase of dementia, colour severe depression, or be a symptom of schizophrenia.

Abnormal perceptions: Auditory hallucinations are common in paraphrenia. Visual hallucinations especially towards evening are not uncommon in dementia.

Cognition: A full cognitive examination is essential. Cognitive assessments cover a very broad range of activities. So, it is not surprising that there is no single examination which covers all situations. Remember that difficulties in memory, concentration and attention do not necessarily lead to a diagnosis of dementia. Also, when assessing cognition, be sensitive to the cultural and educational background of the individual.

Insight: People with early dementia may admit that their memory is faulty, but later revert to defensive denial. Depressed older people tend to emphasise their infirmity and incompetence. Anxiety may be attributed to physical illness or environmental hazards (such as walking on stairs; or the risk of being mugging).

Physical examination and investigations: The assessment is incomplete without a physical examination. Vision, hearing, speech and mobility should be noted. Particular attention is paid to the patient's general state of nutrition, health, signs of injury or self-neglect, and disability that limits function or causes distress, thus affecting mood or cognition.

Investigations: These include weight, temperature, pulse and respiration rate, urine testing, blood tests for haematology, B12, folate, syphilis serology (if relevant) and chemical profile (glucose (or HbA1c), full blood count, eGFR, urea & electrolytes, liver function tests and thyroid function tests) and both ECG and chest X-ray when relevant. The aim is to exclude and treat any condition that could be contributing to the cognitive impairment.

Brain imaging is required where there is cognitive impairment or a rapid or unusual form of dementia, and to exclude space occupying lesions, including haematoma, hydrocephalus and cerebral infarction. Computerised tomography (CT) and magnetic resonance imaging (MRI) scans can be used to identify intracranial lesions, such as tumours, abscesses, haematomas, haemorrhages, infarcts and normal pressure hydrocephalus. Single photon emission computerised tomography (SPECT) can study brain activity and give a measure of the regional cerebral blood flow. This can be useful for Lewy Bodies Dementia or help differentiate the subtype of dementia when in doubt. Positron emission tomography (PET) measures blood flow, regional metabolism and receptor populations. Currently, PET is mainly available for research purposes.

Rating scales/instruments are often used in old age psychiatry. A variety of tools can be found on the following web-page: https://www.alz.org/getmedia/9687d51e-641a-43a1-a96b-b29eb00e72bb/cognitive-assessment-toolkit

Diagnosis and Treatment

Once a diagnosis has been made, the psychiatrist will have a discussion with the individual and family members / carers, who are involved in the care of the patient. The psychiatrist will explain the diagnosis, the prognosis, and possible management options that are available, including having input from the multidisciplinary team members, such as a Memory Nurse, Community Psychiatric Nurse, Occupational Therapist for

functional assessment, or a Psychologist for detailed neuropsychological testing. If there is a need for social services input to provide a package of care, then a referral will be made. The individual and the family will be provided by leaflets about the medications and services available, as well as support that is available from charities, such as the Alzheimer's Society or Age Concern. The patient and their family will also be informed about any current research that is going on that may benefit the patient. In some cases, further assessment is required by other professionals, such as a Neurologist, if there is concern that this may be a neurological disorder. Legal matters, such as driving, Lasting Power of Attorney or Court of Protection Order are discussed as part of the management. Risks will be identified, and an agreed plan will be written to minimise these risks, and it will also outline ways of reducing the burden that is placed on the family and carers. Finally, realistic expectations from all those involved, and service limitations should be addressed, during the assessment and management process.

Diagnosis: Psychiatrists use the internationally recognised criteria when making diagnoses, such as the International Classification of Disease version 10 (ICD-10), or the American Diagnostic and Statistical Manual (DSM-V), or other internationally agreed classifications.

Prescribing: The general rule to 'start low, go slow' applies to the prescription of psychotropic medications to older people. Treatment regimens should be kept as simple as possible. It is important to try to avoid augmentation or treating side effects with additional medications. Older people have a high prevalence of chronic and multiple illnesses and are likely to be prescribed multiple medications. Potentially inappropriate prescribing (PIP) is reported to be highly prevalent in this age group and has been associated with adverse drug events (ADEs) leading to admission to hospital and death (Aziz et al, 2018). Be patient as older people might take much longer to respond to these medications. An electronic assistive technology, such as a medication dispenser, can help people to remember to take medicines, while a calendar clock can help the person to keep track of time.

Learning point three

- How do you 'start low and go slow' when prescribing psychotropic medications to older people?
- If a person with dementia's behaviour is challenging on a ward, and medication is not helping, what else can you do to improve the situation?
- If the person with dementia refuses to take medication, what would you suggest happens?

What are the treatments for dementia?

There is at present no cure for dementia. However, there are medicines and other treatments that can help with dementia symptoms. More than one symptom can occur at the same time, and the clinician needs to decide which symptoms need to be tackled first and by what approach. The management of dementia should be person-centred care that utilizes a problem-oriented approach i.e. that is tailored to the needs of that particular individual, with planned input from the multidisciplinary team. This care package should consider legal and ethical responsibilities, such as the various UK Laws, Advance Directive, and both DVLA rules about driving (https://www.gov.uk/dementia-and-driving) and Lasting Power of Attorney. One of the roles of the Old Age Psychiatrist is to advise that failure to notify the DVLA about the dementia, as a medical condition that could affect driving, may lead to a £1,000 fine and that the individual will be prosecuted if they are involved in an accident as a result. Once the individual notifies the DVLA, the Psychiatrist will receive a form to complete and send back to the DVLA. It is only the DVLA that will decide about the driving and the License. For management of people with dementia requires different tasks to be undertaken, and hence effective team working, and good communication skills are needed.

A. Medicines to treat dementia

Most of the medications available are used to treat Alzheimer's disease, as this is the most common form of dementia. These medications can help to temporarily reduce symptoms or slow down the progression of the disease. The main medicines are as follows:

Acetylcholinesterase inhibitors

These medicines prevent an enzyme from breaking down a substance called acetylcholine in the brain, which helps nerve cells communicate with each other. Donepezil, Rivastigmine and Galantamine are used to treat the symptoms of mild to moderate Alzheimer's disease. Donepezil is also used to treat more severe Alzheimer's disease. There is evidence that these medicines can also help treat dementia with Lewy bodies, as well as people who have a mixed dementia diagnosis of Alzheimer's disease with vascular dementia. There is little difference between these medicines in their effectiveness. However, Rivastigmine may be preferred if hallucinations are one of the main symptoms. Side effects can include nausea and loss of appetite. The nausea usually improves after two weeks of taking the medication.

Memantine is another medicine used for moderate or severe Alzheimer's disease, and is suitable for those who can't take acetylcholinesterase inhibitors. It works by blocking the effects of an excessive amount of a chemical in the brain called glutamate. Side- effects can include headaches, dizziness and constipation, but these are usually only temporary side-effects.

B. Medicines to treat related conditions

Where functional mental health problems exist (e.g. depression, anxiety, insomnia or psychosis), these should be treated. There are some conditions that present vascular risk factors (such as heart problems, diabetes, hypertension, stroke, high cholesterol and depression) that can affect symptoms of dementia, particularly vascular dementia. It is important that these conditions are diagnosed and treated.

C. Medicines to treat challenging behaviour

A person with a behavioural disturbance should not be viewed as 'difficult', but as a person who is unwell and requires help. According to the Alzheimer's Society, in the later stages of dementia, a significant number of people will develop what is known as 'behavioural and psychological symptoms of dementia or BPSD'. These behaviours are the result of a complex interaction between the illness, the environment, physical health,

medication and interactions with others. These symptoms can often remit spontaneously, but they can also be persistent and severe. The presenting neuropsychiatric symptoms include restlessness, wandering, agitation, aggression, sleep disturbance, sexual disinhibition and shouting are collectively referred to as 'behavioural and psychological symptoms of dementia (BPSD)'. The variety of symptoms means that each one needs to be treated specifically. More than one symptom can occur at the same time, and the clinician needs to decide which symptoms need to be tackled first, and by what approach.

Medicines are only to be given if the person affected is extremely distressed or aggressive as a result of experiencing hallucinations. The decision to prescribe a medicine should be taken by a dementia specialist. The only medicine licensed for this situation is risperidone, an antipsychotic that is commonly used in the treatment of schizophrenia. It should be used at the lowest dose and for the shortest time possible, as it has serious side-effects. Antidepressants may sometimes be given if depression is suspected as an underlying cause of anxiety.

D. Alternative remedies

Some people with dementia and their carers use complementary remedies, such as gingko biloba, curcumin or coconut oil. However, there is not enough evidence to say whether such remedies are effective. If you're thinking about taking such a product or a supplement, it is important to consult a doctor first, as some remedies may interact with prescribed medicines.

E. Treatments that don't involve medicines

Medicines for dementia symptoms are important. However, they are only one part of the care for a person with dementia. Other treatments, activities and support are just as important in helping people to live well with dementia. Their carer may also benefit from joining in these activities.

Cognitive stimulation therapy (CST) is a brief treatment for people with dementia. UK Government NICE guidance (2006) on the management of dementia recommend the use of group Cognitive Stimulation for people with mild to moderate dementia, irrespective of drug treatments received. It involves taking part in a group activity, where exercises are undertaken that improve memory, language and problem-solving abilities. Studies have mainly been conducted with people with Alzheimer's disease or mixed dementia, but CST would be relevant to all. People with dementia who took part in the therapy group reported improved quality of life, improvement in memory, thinking skills and quality of life (Comas-Herrera and Knapp, 2018).

Cognitive rehabilitation (Kudlicka et al, 2019) is an approach, based on a problem-solving framework to enable people with dementia to engage in, or manage everyday activities, function optimally, and maintain as much of their independence as possible. It involves working with an Occupational Therapist and a relative or friend to re-learn how to do an everyday task, such as learning to use a mobile phone. In the early stages of dementia, it can help the person with dementia to cope better with the condition.

Reminiscence and life story work: Reminiscence work involves talking about things and events from your past. It usually involves using poetry or props such as photos, favourite possessions or music. On the other hand, life story work involves a compilation of photos, notes and keepsakes from your childhood to the present day. It can be either a physical book or a digital version. These approaches can improve mood and well-being and can help you and those around you to focus on your skills and achievements, rather than on your dementia.

You'll find more details about these treatments in the Alzheimer's Society's 'The Dementia Guide: Living well after diagnosis'. Please see this link: https://www.alzheimers.org.uk/publications-about-dementia/the-dementia-guide

Letter back to the GP

Once an agreed care plan that meets that individual's needs is completed, the psychiatrist will write to the GP giving the details of assessment and outcomes, and ongoing management that is required from both primary care and secondary care.

Any follow up arrangements organized by the psychiatric team will be followed up by a letter to the GP. A copy is sent to the patient and/or their carer with their consent.

The patient is monitored by primary care and secondary care, who will provide further advice or amendments to the patient's care plan if necessary. It is important to remember that GPs provide the major medical support for most people with dementia.

Once a person-centered Care Plan has been created by the Care Team for the patient living with dementia, the Old Age Psychiatrist will refer that patient back to their GP. The psychiatrist will write to the patient's GP giving details of their assessment and the predicted outcome, as well as detailing an online management programme that is to be provided by both primary care, and secondary care.

Any follow up arrangements organized by the psychiatric team will be followed up by a letter to the GP. A copy of this letter is sent to the patient and/or their carer with the patient's consent (if they are able to provide informed consent).

Conclusion

The patient is monitored by primary care and secondary care teams, who will be available to offer further advice or make amendments to the care plan if necessary. While GPs provide the majority of the medical support for most people living with dementia, it is not usually appropriate for one person to carry out all of the caring tasks. Therefore, management of dementia requires the ability to think widely and sometimes 'outside of the box'. Most importantly, assessment and management must be centered on respect for the individual, and emphasize a structured, person-centered approach.

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