

Welcome to the seventh edition of the PgRC Bulletin for Durham Region! We hope that this serves to keep you informed and aware of issues relevant to our practice as psychogeriatric resource professionals. We invite your sharing and submissions.

#### DEMENTIA NETWORK FOR DURHAM REGION

Three workgroups are actively meeting and exploring projects: 1) Access, 2) Public Awareness and 3) Advocacy. If you have an interest in any of these areas and wish to become involved **please** contact Christine, ext. 6527 (advocacy), Jan, ext. 6530 (public awareness), Joan, ext. 6533 or Loretta ext. 6528 (access)



#### Alzheimer Strategy Update

##### **Strategy #1: Staff Education and Training.** *Events in Central East:*

1. U-First! for PRPs trained prior to April 2003. Resource material will be ready in 2004. Format is 10 hrs over 3 sessions. This will be offered through our local P.I.E.C.E.S. learning network as soon as we can get dates organized. Contact your PRC.
2. Next LTC facility P.I.E.C.E.S.: Feb/Mar. 2004 in Newmarket. See P.I.E.C.E.S. website [www.pieces.cabhru.com](http://www.pieces.cabhru.com) for more information.
3. Community P.I.E.C.E.S. (16 hrs): for community health professionals in Durham Region. Currently in planning stages, contact Loretta (x6528).

#### INNOVATIONS – Recent conferences

##### **PSYCHOGERIATRIC UPDATE 2003, November 28, 2003, Baycrest Hospital: *Advances in the Treatment of Late-Life Depression* Alastair Flint MB, FRCP(C)**

Dr. Flint outlined that there are three types of treatment for depression. They include: psychotherapy, antidepressant medication and electroconvulsive therapy (ECT).

The first goal of treatment is to decrease symptoms of depression. Other goals include: reducing risk of relapse, improve quality of life of the individual, improve medical health status, decrease mortality (decrease suicide), prevent inappropriate institutionalization and ultimately decrease health care costs.

As expected, there are many obstacles to treatment. Dr. Flint described the paradox in the older client. There are more drugs being prescribed for seniors but there is less of a chance that the drugs are being prescribed to the right people!!! Other obstacles include: a failure to diagnose properly, inadequate treatment trial, non-compliance of treatment plan, side effects of drugs are too onerous, inter-current medical illnesses, psychiatric co-morbidity, self medication (especially alcohol) and psycho-social obstacles.

There is a relationship between anxiety and late life depression. It appears that anxiety is the red flag. When anxiety is noted in a client then there is a greater likelihood of detection of late life depression. Dr. Flint quoted J. Fawcett from JAMA 1972: "The presence of a reason for depression is not a good reason to ignore its presence."

There are quite a few SSRI drugs used to treat late life depression. These include citalopram (Celexa), and sertraline (Zoloft). It is suggested that response to treatment be evaluated after 6 weeks. Dr. Flint stated that the strongest

indicator of non-compliance to taking drugs is based on how many drugs that an individual client is taking. When prescribing antidepressants, one should emphasize that depression is more like a chronic disease than an infection for which you would take time limited antibiotics! Physicians have noticed that there is greater compliance for taking drugs if additional educational messages are included with the prescription. Let patients know that they should take medication every day. The benefits of the medication are not apparent for at least two to four weeks. One should continue to take medication even when feeling better. Side effects of medication are the most noticeable in the early stages of treatment. Finally, **DO NOT STOP MEDICATION** without checking with the physician!!!

What strategies could be used for treatment resistant depression? Dr Flint suggests optimizing existing treatment. Augment the antidepressant. Try combining the antidepressants. Substitute another antidepressant. Try ECT. Age is not a contraindication of ECT rather it is an indication.

Treating late life depression can be a challenge. The risk factors for recurrent depression include; prior episodes of depression, coexistent psychiatric disorder, chronic medical illness, slow or incomplete recovery from an index episode, a family history of affective disorder and finally if the onset of depression is after sixty years of age. (In fact, depression is 60% more likely to reoccur if the age of onset is greater than sixty years of age.). The chance of recurrence is reduced if the treatment plan includes Interpersonal Therapy (IPT) with the administration of drugs (Reynolds et. al. 1999).

Dr Flint gave recommendations on when to refer an individual to a psychiatrist: 1) when there is diagnostic uncertainty, 2) uncertainty about the treatment selection, 3) severe illness, ADL impairment or distress, 4) delusions or hallucinations, 5) a need for an evaluation for electroconvulsive therapy, 6) failure to respond to an adequate trial of treatment, 7) side effects or the drug interactions limit treatment. 7) poor adherence to the treatment plan, 8) a relapse or recurrence despite adequate treatment.

Dr. Flint concludes that there are three truisms for the effective treatment of late-life depression:

- Patience and perseverance
- Long term view
- Commitment to follow-up

Submitted by: Joan Honsberger, PRC

### TIPS QUESTIONS

Note: *TIPS* questions are from the P.I.E.C.E.S. website [www.pieces.cabhru.com](http://www.pieces.cabhru.com). We encourage you to explore this resource. It is a great way to brush up on your P.I.E.C.E.S. thinking! *TIPS* information should be used similar to the way you would use information from a textbook. *TIPS* is not intended to serve as an individual consultation service. P.I.E.C.E.S. participants should use this information in context, and always work closely with the family physician involved in the care of the resident or client and with other Partners in Care to find solutions to individual resident/client issues.

Question:

How do you know when to stop an antidepressant when you don't know the degree of depression or the history of the resident and the resident cannot give a history?

Response:

You have highlighted one of the greatest problems and challenges in our health care system today. When an individual moves from one sector to the other, we are often faced with "bodies without backgrounds"

I would do everything I can to get the old records and collateral history from family to try to clarify the reason for the initiation of the antidepressant, the severity of the illness that the antidepressant was used for, and the response. Also, recurrence of any depressive symptoms would be important.

I would also suggest a Cornell for baseline as well as SIGECAPS to get a picture and clear idea of the degree of depression presenting at this time.

In general if he or she has had two or more episodes of depression, the rule of thumb at this point in time is to leave them on the

antidepressant as there is up to 60-90% chance of relapse of major mood disorders for those who have had two or more episodes. J. Kenneth Le Clair, MD, FRCPC

Question:

As for clarification regarding “what antipsychotic is best for reduction of noisy behaviours?” I would like to specify what has been prescribed unsuccessfully for two residents. Both have yelling and crying behaviours. If you talk to either one of them when they are going through their spells, they may or may not stop momentarily. Once you walk away, they start over again. Usually this occurs when family members are not present, and behaviours are related to “missing them”. For resident ‘A’ we have her on Seroquel 150 mg daily, oxazepam 15 mg daily, and Risperdal 1 mg daily. In addition she gets Haldol 1 mg prn. Resident ‘B’ gets Zyprexa 10 mg, trazodone 25 mg, lorazepam 1 mg and Paxil 20 mg. On a prn basis she also gets Ativan and Haldol. We are not great fans of Haldol as it only puts residents in a stupor. The psychiatric consultant has tried different dosages and combinations, but the noisy behaviours continue to disrupt the unit. Any suggestions??

Response:

Noisy behaviour is clearly one of the most challenging behaviours. Often psychotropics may not have a major impact unless a clearly identified disorder is established, i.e., panic disorder, depression, reaction to delusions. Medication use should always be considered a “clinical trial” and done in conjunction with other strategies.

You have clearly identified one of the triggers as missing family. Behaviours should always be considered a symptom due to a resident’s disorder or a way of expressing “need”.

Assessment – I have found it always useful to use the **P.I.E.C.E.S. 6-question template** to review the possible triggers – e.g., pain, drugs, seizures – also remembering severity, frequency and context. It is also very important to do the ABC’s and DOS and have a clear consensus of your goals from everyone’s perspective.

In terms of psychotropics: 1) if you have a definable illness an antidepressant may be warranted e.g., depression, panic disorder; 2) for yelling, secondary to fear associated with delusions, consider an atypical antipsychotic.

In circumstances where a definable co-existing illness in dementia is not present, strategies that help include environmental changes, matching the emotional needs with the environment both social and physical. Rule out physical causes (medication in this situation) because they are often adjuncts and sometimes can make things worse. J. Kenneth Le Clair, MD, FRCPC

Upcoming educational events:

Thursday, January 22, 2004, Alzheimer Society of Durham Region presents Dr. R. Keren: “*How Dementias Distinguish Themselves*”, at WMHC, registration required, call 905-576-2567.

March 1-2, 2004, *Ontario Elder Abuse Conference*, Delta Chelsea Hotel, Toronto, and Wednesday, March 3, 2004, *Provincial Stakeholder Networking Day: Focus on Diversity*, Queen’s Park Conference Facilities, Toronto, contact Meeting Management Services, Inc, 905-335-7993, email [Marianne@mmsonline.ca](mailto:Marianne@mmsonline.ca)  
OR visit the ONPEA website at [www.onpea.org](http://www.onpea.org)

Thursday, April 1 or Friday, April 2, 2004, 17<sup>th</sup> Annual Alzheimer Symposium “*Exploring Dementia Care*”, Metro Toronto Convention Centre, contact Marta Murawiecka at 416-597-3422, ex. 3693 or [www.alzheimertoronto.org](http://www.alzheimertoronto.org)

