When the Benefits Outweigh the Risks: Helping those living with Serious Mental Illness now also living in Long Term Care

Maureen C. Nash, MD, MS, FAPA, FACP

webinar

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Maureen Nash, MD, MS, FAPA, FACP, FRCPC

Fellow of the American Psychiatric Association
Fellow of the American College of Physicians
Fellow Royal College of Physicians of Canada
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Psychiatry & Neurology

Medical Director, Providence Elderplace Oregon
A Program of All-Inclusive Care for the Elderly
Affiliate Asst Professor Psychiatry, OHSU
American Psychiatric Association Council on Geriatrics

Disclosures

No Financial Conflict of Interest
Off-label use of medications may be discussed*

***Off-label: using a medication to treat someone with a diagnosis for which the pharmaceutical company did not seek or achieve an "indication."**

"Off-label" does NOT mean or imply illegal, ill-advised, or non-evidence based. A "label" is unrelated to the presence or absence of evidence.

Jim goes to the SNF

- Hospital DC to SNF
- SNF-ist discontinues chlorpromazine 400mg daily despite protests of Jim
- "Thorazine is an old medicine and no one should be on it."
- How I met Jim
- What happened for him

What I hope you take away from this talk:

- I can't teach you how to mini-psychiatrists in 1 talk but I hope I can impart some knowledge you may not have had access to elsewhere
- Knowledge of where to find reliable answers
- Framework for understanding Serious Mental Illness
- Approaching those with mental illness first psychiatrically and secondly age-wise
- Highlights of physical health challenges in those with serious mental illness

Neurocognitive Domains DSM V

Cognitive changes in normal aging

- **Memory**
  - Long term knowledge remains stable
  - Recent memory and formation of memories is vulnerable in aging
- **Attention**
  - Simple or focused such as ability to watch a TV show is usually preserved
  - Divided attention often presents difficulties, i.e. watching TV and talking on the phone

Cognitive changes in normal aging

- **Language**
  - Vocabulary is preserved
  - Word retrieval or the process of getting words out takes longer and is more challenging but the information is not lost.

Cognitive changes in normal aging continued

- **Reasoning and problem solving**
  - Traditional ways of problem solving preserved
  - Problems not previously encountered may take longer to work out
- **Speed of Processing**
  - Declines with normal aging

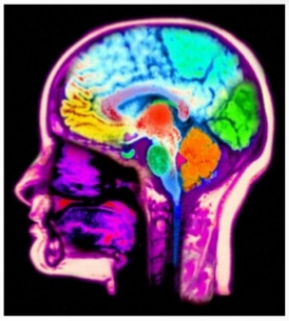
Other factors affecting cognitive aging

- Medications
- Hearing loss, vision loss
- Pain, Heart Failure, Kidney Failure, COPD and other health conditions
- Changes in mood or anxiety decreasing one's motivation

Chronic Mental Illness (aka Severe and Persistent Mental Illness) or Serious Mental Illness

- Major Depressive Disorder (MDD)
- Bipolar Disorder (BD)
- Schizophrenia
- Schizoaffective Disorder (when someone has both Schizophrenia and either MDD or BD at the same time)

BIPOLAR DISORDER & COGNITIVE IMPAIRMENTS



- VERBAL MEMORY
- PSYCHOMOTOR SPEED
- EXECUTIVE FUNCTIONING
- VISUAL MEMORY
- ATTENTION

fppt.com Eleonora Lombardi PsyD

Increased risk of nursing facility admission among middle aged and older adults with schizophrenia

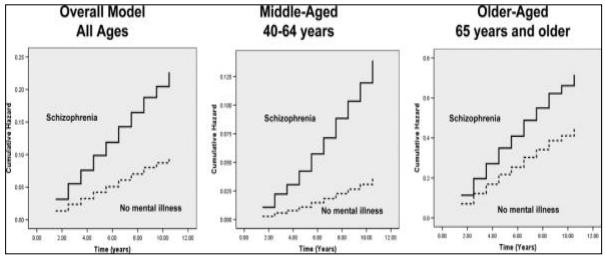
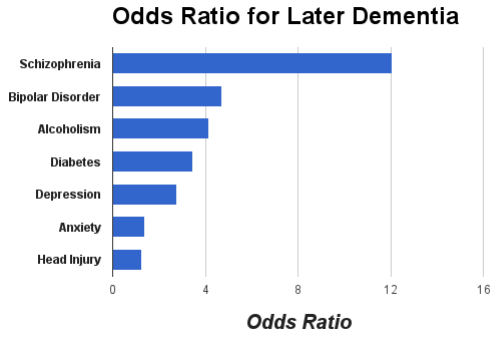
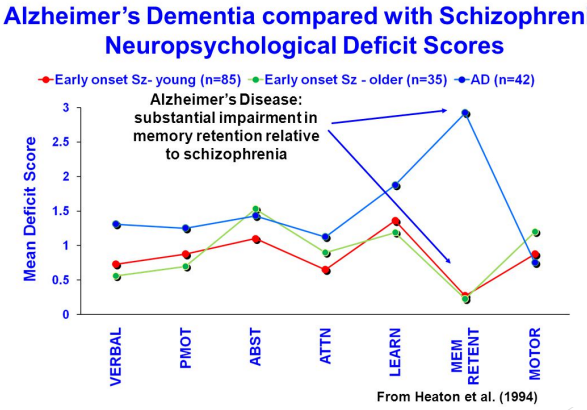


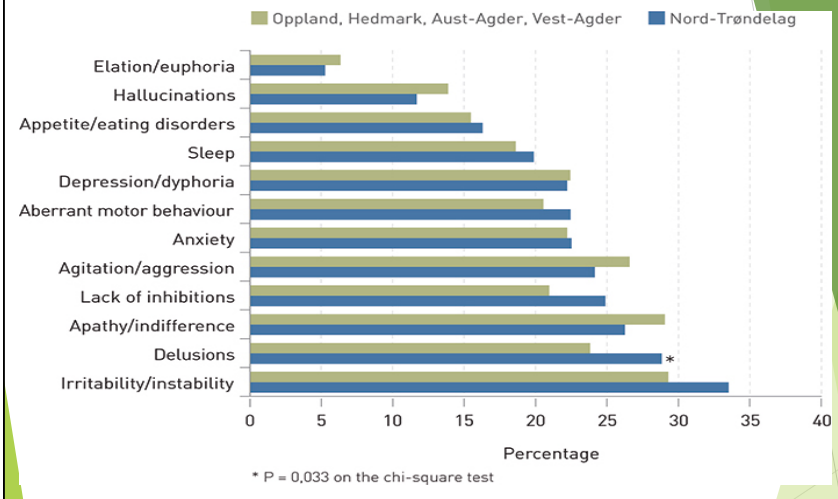
FIGURE 1 Schizophrenia Versus No Mental Illness

Severe Psychiatric Disorders in Mid-Life and Risk of Dementia in Late- Life (Age 65-84 Years): A Population Based Case-Control Study *Current Alzheimer Research, 2014. 11* (7), 681-693



Neuropsych testing comparing a group of people with Schizophrenia vs Dementia



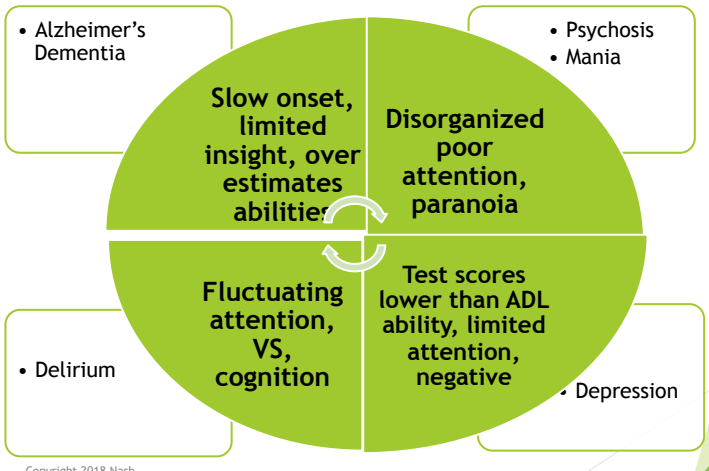


Bergh S et al **Dementia and neuropsychiatric symptoms in nursing-home patients in Nord-Trøndelag County.** Nr. 17 – 18. september 2012 Tidsskr Nor Legeforen 2012; 132:1956-9. doi: 10.4045/tidsskr.12.0194

Cognitive Deficits in those with Psychiatric Illnesses

- Schizophrenia
  - Used to be referred to as dementia preacox (premature dementia)
  - Attention deficits
  - Executive functioning deficits
  - Anosognosia-impaired awareness of being ill
- Bipolar Disorder
  - When ill, anosognosia and attentional deficits
  - Do not recall what happened when manic
  - More time depressed, usually

Using cognitive screening tools: What do low scores mean?



Cognitive Impairment in a Sample of People with SMI

- 52 people followed at community MH clinic
- Cognitive Impairment documented in 17% of charts
- Measurement with the Mattis Dementia Rating Scale showed 60% with cognitive impairment

Incidence and Documentation of Cognitive Impairment Among Older Adults with Severe Mental Illness in a Community Mental Health Setting. Mackin RS, Arean PA. Am J Geriatr Psychiatry 17:1. Jan 2009

National Partnership to Improve Dementia Care

- Established in 2012
- Goal: Decrease antipsychotic prescriptions to those residing in nursing facilities
- Controversial aspects to this campaign:
  - No measure related to the quality of dementia care
  - **Penalizes all prescribing of antipsychotic medications – except for those with schizophrenia, Tourette's and Huntington's**

Concerns about CMS campaign to improve dementia care leading to decreased quality of life and increased suffering for those with serious mental illness

There are several conditions for which there is a clear evidence-based indication for the use of antipsychotics not excluded in the CMS campaign: Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder,

Nursing facilities penalized: especially those that care for a high proportion of residents with Medicaid. Poor reputations and fewer "stars."

Leads to increased symptoms and suffering for those with serious mental illness and increased evictions.

Indications where there is an FDA indication for use of at least one antipsychotic medication

CMS doesn't penalize:

- Schizophrenia
- Tourette's syndrome
- Huntington's Disease

CMS penalizes:

- Bipolar D/O (BD)
- Major Depressive D/O (MDD)
- Schizoaffective D/O (SAD)

Other conditions where evidence exists for use of an antipsychotic medication

- MDD with psychosis
- Delirium
- Generalized Anxiety Disorder
- Psychotic symptoms in other illnesses
- Psychosis prior to a final determination of actual diagnosis
- Life-threatening aggression in someone likely to be psychiatrically/neurologically ill or psychotic due to substance use

Schizophrenia Guideline: Patient Outcomes Research Team (PORT): Maintenance treatment in those who respond

- Use the antipsychotic dose required to achieve response during acute treatment
- Continuous treatment recommended rather than intermittent treatment- otherwise there are more frequent and more severe relapses
- 5 years without ANY overt symptoms before even considering a lower dose

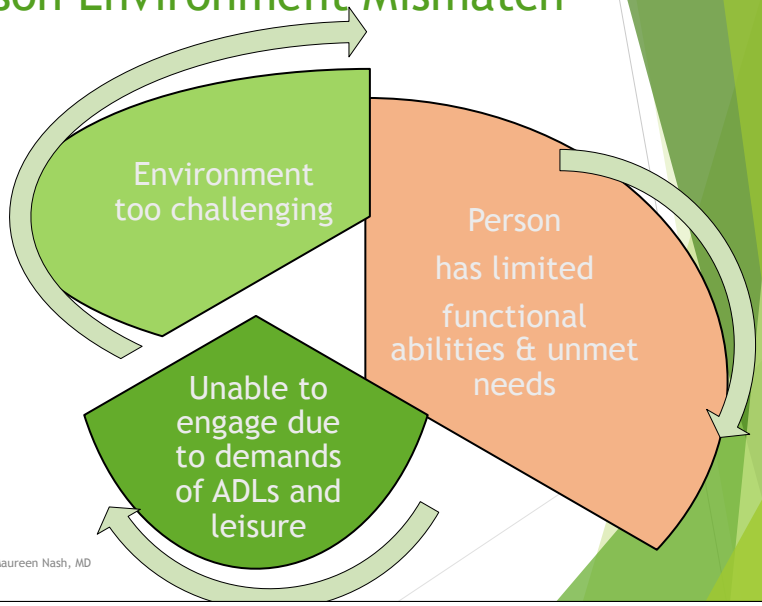
Schizophrenia Guideline: Patient Outcomes Research Team (PORT): For those who have not responded

- Trial clozapine, especially if suicidal
- rTMS of left temporoparietal lobe for auditory hallucinations
- Cognitive Behavioral Therapy if pharmacotherapy not enough to eliminate symptoms

General guidelines for those with MDD and BD

- If recurrent illness and now stable on medications, recommendation is for indefinite treatment with dose needed to achieve remission
- With BD, there is some evidence that each relapse makes the next one more difficult to achieve and will require higher doses of medications
- American Psychiatric Association has guidelines for both MDD and BD.

Behavior Challenges Caused by Person Environment Mismatch



Communication Strategies

- Nonverbal vs. Verbal
- Identify the world in which they live, avoid reality orientation
- Positive eye contact, greet, get at person's level
- Supportive Communication/ Validation
  - Listen for the message, not the content
  - Watch for emotions, not words
  - Validate feelings
  - Redirect with purposeful activity
  - Do not ask questions, provide simple information

Person Centered

People with dementia cannot change, you can

- Reframe "bad behaviors" to symptoms
- Respect personality, dislikes, interests
- Stop, Look, and Listen: Be present
- "Sensing is Believing"
- Gather information about occupational and personal history
- Retain composure, non reactive responses

Donna:

69 year old woman

history of schizoaffective disorder

admitted for increased psychosis, possible catatonia decreased level of ADL function, screaming, uncooperative with care

lives dementia specific care facility due to an unspecified cognitive disorder.

Care facility complains she has stopped walking but knows she gets up and moves things in her room when they are not watching.

References

- American Psychiatric Association has Practice Guidelines on treating Major Depressive Disorder, Bipolar Disorder, PTSD, OCD, Schizophrenia as well as Treating Agitation and Aggression in those with Dementia.

- Kreyenbuyl J, et al. The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2009. Schizophrenia Bulletin 36:94-103.