

Best Practices for Medication Management of Dementia-Related Behaviors

TRANSCRIPT

Jennifer Inker:

Good afternoon. Happy Friday, and welcome to today's live event. We are so pleased you could join us. My name is Jenny Inker and I'm a gerontologist and the joint program director of the Assisted Living Administration specialty area at Virginia Commonwealth University Department of Gerontology. I'm also your host and moderator for the webinar. Today, my VCU colleagues, Lyons Hardy and Adam Rosenblatt, will present Best Practices for Medication Management of Dementia-Related Behaviors. This series was created by the Virginia Geriatric Mental Health Partnership. This is the second webinar and our sixth series hosted by VGMHP. If you missed the first webinar, it was recorded and is now posted on the website. We would like to thank the Virginia Center on Aging for the geriatric training and education grant that funds this series. The Geriatric Mental Health Planning Partnership, in collaboration with the VCU Department of Gerontology and the Riverside Center for Excellence in Aging and Lifelong Health, is organizing this series of webinars dedicated to mental health and aging training.

Today, we have two very accomplished presenters. Lyons Hardy is a psychiatric mental health nurse practitioner and is the concentration coordinator for the psychiatric mental health nurse practitioner program at the VCU School of Nursing. Dr. Adam Rosenblatt is a neuropsychiatrist and professor at the VCU School of Medicine. He is also the co-director of the Huntington Disease Program at the VCU Parkinson's and Movement Disorders Clinic.

A couple of housekeeping items before we begin. Once again, these webinars are funded in part by a Virginia Center on Aging GTE grant, so it is part of our grant agreement to collect demographic data. We therefore kindly ask that you help out in continuing this free offering by taking five minutes to complete the demographic survey, which we shall send tomorrow by email. Certificates of attendance will be made available one week after the event. To receive your certificate, you will need to complete the exit survey, which should pop up following your exit from the webinar and which we'll also repeat by email tomorrow.

Today's webinar will begin with Lyons' and Adam's presentations. These will be followed by a question and answer period. To submit your questions, please use the questions tab on the control panel on your screen. Please feel free to submit your questions at any time throughout the presentation. Following the presentation, I will share your questions with Lyons and Adam and we will address as many as possible in the time remaining. Without further ado, I will now ask our presenters to begin. Lyons and Adam, take it away, please.

Lyons Hardy:

Hello. This is Lyons Hardy.

Adam Rosenblatt:

This is Adam Rosenblatt. Welcome, everyone.

Lyons Hardy:

We are glad to have everyone on the line. We will go ahead and get started. We have a couple disclosures and non-disclosures here. We also wanted to mention that off-label use of medications will be discussed. I just wanted to provide a little bit of background on what off-label use means because I know we have some people in the audience who may not necessarily be medication prescribers. Off-label use means a medication that is not officially FDA approved for whatever it's being used for and there's quite a lot of that that happens. Not all medications are officially approved and that's not necessarily a bad thing. That doesn't mean that they may not be effective or safe to use for a given condition.

Next up, we have a little glossary with some of the terminology that you may see in the presentation. This is just for you to be able to refer back to in case there's any terms that you're not familiar with. Anhedonia, inability to feel pleasure, bid, I think we also have tid in here, so bid is taking a medication twice a day, tid is three times a day. Chorea is a movement disorder and dysarthria, difficulty speaking, slurred or slow speech. MMSE, hopefully most people are familiar with that, the mini mental status exam, and SSRI or selective serotonin reuptake inhibitors. Those are antidepressants. Then there's some other ones, as well, but those are the most commonly used. Then the DSM, Diagnostic and Statistical Manual, which is used for diagnosing psychiatric disorders.

What we're going to talk about today are behavioral disturbances in dementia. I also wanted to mention another term that you may hear used to describe this, which is neuropsychiatric symptoms of dementia. We use the more commonly known terminology and so these are psychiatric or psychological symptoms and behavioral problems that may be characteristic of people that have dementia. They can include a variety of types of symptoms and we will go through these in more detail throughout the presentation, as well. They're pretty common, so we see about 30 to 90% of patients with dementia have some type of issue with behavioral issues that cause problems for them in their functioning.

Now, why would we want to treat these? They're very common, as I mentioned. A lot of them are fairly severe and cause functional impairments. They can cause suffering for both the person experiencing them and also the caregivers who are managing some of the issues. Again, they can be associated with burnout and depression in the caregivers and may lead to nursing home placements that could be premature. If they're untreated, they tend to persist, so a lot of good reasons for treating them in some way.

We identified a four-stage process for looking at these type of behaviors. I have to credit Adam with this and I told him earlier that this is very similar to the nursing process, so if we have any nurses out there, you'll recognize some of this. I appreciate working with him because he's one of the few physicians that uses something similar to the nursing process in his care, so I appreciate working with someone like that. The first step is observation. I'll go through these in a little more detail, as well. Then we have diagnosis, treatment, and evaluation.

For the observation component, we need to look at the behaviors that the person is exhibiting and place them in context. Try to obtain a very careful history. This is really important, so looking at the course, triggers, what brings these behaviors on, when they started, getting as much detail as possible on the background and how they present themselves. A careful physical exam, neurological and mental status, also very important, and potentially laboratory studies that may be indicated, so looking at some different issues that could be going on physically that could contribute to some of these behaviors.

Then looking at diagnosis, we want to be sure of what we're treating, so there's a lot of symptoms that can be caused by different diagnoses and these may be treated in different ways. It's important to determine what the underlying cause is as much as possible. There may be some issues with mental status that could be contributing to the behavioral problems, disruptions of drive, and abnormal reactions to the environment.

Then the treatment component, so, of course, if possible, we would recommend removing what's causing the issues, if that can be done, treating specific diagnoses or syndromes, and looking at problems that may be able to be addressed in different ways. We definitely recommend non-pharmacological interventions first, choosing target symptoms, looking at

the difference between treating the symptom and just sedating someone, and always checking to make sure that the treatment is still needed, so trying to reduce whatever the treatment is and see if the problems return.

Then for evaluation, looking back at the target symptoms, looking for side effects, and to define akathisia, in case anyone's not familiar with that, that's a side effect that can occur in response to any psychotic medications and can cause a lot of agitation, psychomotor restlessness that could be potentially contributing to the behavioral issues. Looking at whether the treatment is successful, so it helps to decide what targets we have ahead of time and then we can look at how much it's impacting those. Have a backup plan, so the next thing that you're going to try if the first thing doesn't work.

I also just wanted to highlight that medications are another tool that are our toolbox. We always have to look the risk-benefit analysis. They're not a bad thing inherently. It's just something that there's many other things that can be helpful, as well, so we both prescribe medications and we also use this process to make sure that we don't excessively use medications.

Adam Rosenblatt:

This is Adam. I'm going to take over for a little bit. I want to get more specific about how we might categorize types of behavioral disturbances and their underlying causes. This doesn't cover every possible thing that could happen, but I would say that four of the most common sorts of behavioral disturbances that we deal with in patients with dementia include mood disorders such as depression and apathy. Apathy is different from depression. Apathy is a loss of interest in activities. Apathetic people, they're not sad, but they can't generate the list of things to do and they'll often just go back to bed and go back to sleep if they're not otherwise engaged. Then rarely, you'll see somebody who's actually too happy, who may have symptoms of mania. They may be euphoric.

Next category is the dreaded agitation. I almost don't even use this word anymore because oftentimes, it doesn't mean anything, so somebody who's failed to apply that four-step process will say, "Hey, doc, what have you got for agitation?" I'll say, "Well, you're going to have to give me a better description than that. That's so nonspecific." They usually want some kind of sedative, but that might be in this category with the patients that pace or wander, patients that are physically aggressive or sexually disinhibited and so they reach out for other people or they may make unwelcome remarks. They may masturbate in public, things like that. Sleep disorders, of which insomnia is probably the most common problem, but some people sleep all the time and other people sleep in the daytime and are awake at night. Some people have a complete breakdown of their sleep-wake cycle, and psychotic symptoms, by which I mean delusions and hallucinations.

Let's talk about depression as a common specific syndrome that we see in patients with dementia. It's highly prevalent, is found in maybe 15 to 25% of patients with Alzheimer's disease. This can always be a little bit hard to tease out. Elderly people have usually lived long enough that they've had more life disappointments than younger people, so they've had loved ones die. They have physical illnesses that might make someone feel despondent. They may be aware that they have dementia and this may be upsetting to them in the earlier stages where people may have more self-awareness about it.

You always try to decide should I see this person's low mood as understandable given their circumstances or should I see it as abnormal? If I see it as abnormal, is it part of a disease process that might respond to something like a medication? Things that might tip you off that it's that lasting might be if they've had depression before or if there's a strong family history of

depression or if they have a lot of the symptoms or if it seemed to come about for no apparent reason. There was no recent stressful event or life change.

Depression is characterized by sadness. Anhedonia, which we defined before as an inability to take pleasure. A diminished vital sense, which is a sense of feeling sick and rundown and exhausted, and diminished self-attitude. Patients may feel like they're a failure or a bad person. Now, people with dementia may not be able to tell you about all of these symptoms and so you may have to guess as to whether they have depression. They might not be able to talk at all in some cases or the depression might manifest itself not by being tearful or withdrawn, but by being agitated or not eating or something like that. Again, things that might tip you off, if somebody has had depression 52 times and now they're depression is bad and they can't communicate very well, but they suddenly become tearful and stop eating, you might guess this could be a recurrence of that or if there were a strong family history, if there were some strong precipitant, like the person's spouse died.

Being successful at treatment for depression requires persistence. The conventional wisdom is that, for example, with medications, you can't say it's failed until they've been on an adequate dose for six to eight weeks. Sometimes, people make the mistake of changing medicines every week or two and crossing them all off the list. You just end up usually with a mess.

Let's talk about aggression. Again, you don't want to just say, "The patient's agitated. Hand me a sedative." You want to look at it and learn something about the pattern. What's the pattern of the aggression and what's its context? Some patients may be in an activated state where they're aggressive all the time. Maybe they've had a head injury to the front of the brain or they are manic. It may be that it happens in a predictable way, like every time you have to toilet the patient or every time they have to change their clothes. Rarely, it may be genuinely unprovoked and that's the hardest thing to treat. I find that if you look closely, there usually are tip offs that you're in a danger area or a danger time.

Then if we think about behavioral approaches to manage aggression, first of all, if we found that there's something that provokes it, remove it. Maybe noise upsets this person or a bright light or unpleasant smells or something like that. We educate the patient's family and the staff that may be taking care of them about what we've observed about the pattern or how to do that. You try to distract them when they're becoming aggressive and replace it with other sorts of behaviors. If the person, there's another resident that they don't like at the nursing home and they start yelling at them and moving toward them, you might hand them an ice cream cone. They might be distracted by something pleasant that would take their mind off it. One lucky thing about people with dementia is that they are usually fairly easy to distract and so you can turn their attention away to something else and they'll forget the thing they were upset with.

There's a wide range of drugs that are used, including antiseizure medicines, anticonvulsants, antidepressants, buspirone, which is a medicine for anxiety, beta blockers, which are blood pressure medicines, benzodiazepines, which are tranquilizers, neuroleptics, which are antipsychotics, and more, most without a lot of hard scientific evidence that it works. What we usually do if we're going to use medicine, we try to think about what would be the safest and mildest things to try first and we see whether we're getting any response. We're not trying to deliberately sedate the person. It's really a last resort. Sometimes, it breaks my heart and they'll be somebody where I say this person's behavior is very dangerous. If we don't control it, he's either going to hurt someone or get hurt himself or he's going to end up in a very uncongenial place to live, like a state hospital instead of a nice assisted living and so he's

probably going to have to carry a burden of sedation. We realize we're doing that, but that should be at the end of a long process of thinking about it before you move to that choice.

Psychosis really means a break with reality, so people have delusions, which are fixed, false, idiosyncratic beliefs, so nobody else shares their belief that someone is beaming rays into their brain. You can't change their mind about it and it's not true. Typical delusions are persecutory delusions, someone's stealing from me, someone's trying to hurt me, someone's a danger to me. A mood congruent delusion, so people that are depressed may have delusions that they're a bad person, that they're guilty of something, that they're going to die, that they're sick, that sort of thing. Delusions can drive behavior, so you'll see an example in a little bit of a patient with delusional jealousy, where the person thinks their spouse is being unfaithful. That can drive a lot of problematic interactions, so if you could eliminate the delusion, the person would get along better.

Hallucinations are perceptions without stimuli, so a person hears something that isn't there, sees something that isn't there. If you have a patient with visual hallucinations, first examine the patient's eyes. Visual hallucinations are uncommon in psychiatric conditions and so people that see things often have eye disease, glaucoma, macular degeneration, cataracts, or they may be delirious. They can be auditory. They can be visual. They can even occur in other areas like people may smell smells that no one else can detect.

Psychosis doesn't always respond to treatment and it doesn't always require treatment. Somebody who has an erroneous belief that isn't hurting anything, I wouldn't give that person Thorazine because they thought that their wife was still alive even though she isn't, something like that. I think that hallucinations are delusions that you would see say in someone with schizophrenia. They may come from a different place sometimes than in somebody with dementia. For example, people may misinterpret things that are really around them. A patient doesn't recognize their clothes and so they look in their closet and see unfamiliar clothes and think that a stranger has moved in with them. I have people that don't recognize their own reflection in the mirror and they think that there's an interloper in their house. That's probably not going to respond to antipsychotic medication. That's caused by their cognitive impairment.

Likewise with hallucinations, a person will say, "My father is seeing people that aren't there." I'll say, "What do you mean?" He'll say, "I went to the grocery store. When he came back, he said Uncle Bob had been in to visit and Uncle Bob has been dead 10 years." I'll say, "Well, did you see your father having a conversation with a nonexistent person?" He'll say, "No, no. He just told me he'd been there." This may be what we call a confabulation where a person with dementia just fills in information because they don't remember what's happened in the last hour. They'll tell a fanciful story, but again, it probably wouldn't respond to antipsychotic medicine.

Delirium is usually found when somebody has some medical disturbance that's interfering with their ability to remember, perceive, take in information. It doesn't always have to be the agitated, foaming at the mouth delirium that we expect. Many delirious patients are quiet and withdrawn and we don't realize how confused they are. As you might imagine, elderly people are much more vulnerable to it than young people and people with dementia are much more vulnerable to it than people without dementia. Fundamentally, it's an impaired ability to pay attention. They typically have waxing and waning of consciousness, so they may be really with it for an hour and then really out of it for an hour. They can have lots of psychiatric symptoms as part of the delirium, like they can see things or hear things or be mistaken about people trying to hurt them.

You want to look for a relatively sudden change in someone's mental status. If there's a sudden change, don't ascribe it to a chronic condition. If a person with Alzheimer's disease suddenly starts seeing things overnight, don't say, "Oh, well, I heard people with Alzheimer's disease sometimes see things." This is a brand new change.

The treatment of delirium is to remove the cause. Three very common causes in the elderly include polypharmacy. That is the person is just on too many medicines and the way they're interacting in the person's body is interfering with their cognitive abilities. Urinary tract infection is a very common one, so as soon as there's a change, we send off the urine specimen. Pneumonia is a pretty common one. Then I think another one I didn't put on the list is that people with dementia often fall down, sometimes in an unwitnessed way. They may have a head injury or something like a subdural hematoma, so sometimes a CAT scan might be called for if somebody suddenly becomes delirious.

Sleep disturbances are a common problem. Insomnia is the most common complaint. The patients can have a complete reversal of their sleep-wake cycle and it can be hard to get out of it. Sometimes a family, for example, is paying a hired caregiver to watch the person. That caregiver watches soap operas all day while the dementia patient sleeps. They then take their paycheck, leave, and then the family comes home and has an awake, lively dementia patient to take care of all night long. We usually try to fix this by working the stay awake part of it than the go to sleep part. Instead of giving the person sleeping pills, we try to stimulate them and get them out of bed, get them exposed to sunlight, doing stimulating activities so that they're worn out at the end of a day and get out of the cycle of daytime sleepiness and nighttime insomnia.

Sometimes something like depression may be causing insomnia. As I mentioned, we try to improve the person's sleep hygiene. Sedatives are the last and not the first resort. There is no perfect sleeping pill. There's no substance known to man that you can take every night that will make you sleep eight blissful hours. Everything will eventually lose its efficacy and many of them are frankly dangerous in the elderly so that's never the first place to go.

Catastrophic reactions are an interesting phenomenon. It's really just sort of a phenomenon rather than a symptom. Dementia patients that are confronted with an impairment can have an outburst of emotion or behavior. It can be fueled by being depressed or something like that. I'll give you two quick examples. I had a patient whose daughter worked all day and she was at home. There was a storm and she couldn't get the windows closed and water was coming in. She called her daughter and was crying and screaming on the phone, couldn't even express what was wrong. Her daughter thought the house must be on fire. She ran home from work and found out that it was only this. That's a catastrophic reaction.

A more cognitively impaired patient than that, maybe he's supposed to get into a van to take him to daycare and he gets to the steps of the van and can't figure out how to work his feet. Then the person behind him starts shoving him to try to get him up the steps and he begins swinging and yelling. That's a catastrophic reaction. When you see this happening, keep your head. Try to speak gently and talk the person down and try to minimize their exposure to these kinds of things.

Executive dysfunction is something near and dear to my heart. By executive, we mean the parts of the brain or the parts of the mind that make decisions, so they are involved in planning and forethought and decision making, good judgment, that kind of thing. They tend to be associated with injuries and diseases of the front part of the brain. Sometimes we'll call a patient like that frontal, but it's a pseudoanatomical term. Not all these people really have

something wrong with the frontal part of their brain. They may have something wrong with different parts of their brain.

The hallmark is this juxtaposition of both apathy and disinhibition. Patients with frontal executive dysfunction, like Linus, the guy will sit in front of the TV watching all day without even bothering to turn the channel. If you turn the TV off because it's time for dinner, he'll throw an ashtray at your head. They can be both apathetic and impulsive at the same time. They're found in various dementias, but maybe especially in some of the non-Alzheimer's ones, Parkinson's disease, Huntington's disease, which is near and dear to my heart, frontotemporal dementia, stroke patients, head injury patients. There's often a profound loss of insight and so they may be able to say the right kinds of things, but they don't really understand that what they're doing is wrong. They may be out of proportion to their cognitive impairment, so sometimes these patients end up, I think, getting blamed for things that they really can't control because they seem so normal in some ways, but just have such terrible judgment and behavior.

Some conditions associated with disinhibition, loss of impulse control, include frontal lobe tumors, head trauma, strokes, ADHD, which you're, I hope, not going to be diagnosing in elderly dementia patients, but you find it in young patients. Tourette's syndrome, various neurodegenerative disorders like Parkinson's, frontotemporal dementia, Alzheimer's, mania, and intoxication, which is something that should always be in the back of your mind if you have a disinhibited elderly patient.

Lyons Hardy: Okay. Now we're going to go into discussing some of the more specifics on medications that do have some evidence behind them and/or that are commonly used for the treatment of some of these issues. We have a poll for you. Keeping patients on dementia drugs such as Aricept and Namenda is no longer necessary when they're in the advanced stages of dementia. Do we have some results on that?

Jennifer Inker: Yes. We're just trying to get at least 70% of the audience to vote, so just a few more seconds and then I'll close and show the results.

Lyons Hardy: All right.

Adam Rosenblatt: Vote, you slackers.

Jennifer Inker: Okay. I think we are there. Can you see the results, Lyons, Adam?

Lyons Hardy: Nope.

Jennifer Inker: Okay. Would you like me to read those out? I'd be happy to. We have got results to the poll from our audience. The question was keeping patients on dementia drugs such as Aricept and Namenda is no longer necessary when in the advanced stages of dementia. 43% of our audience today say this is true and 57% say it's false, so Lyons, almost evenly split there. Over to you.

Lyons Hardy: All right. Actually, it is recommended that patients that should stay on these drugs even when they're at the later stages of dementia. Most people know that these drugs don't modify the course of the disease, but there is research that shows that they can improve some of these behavioral issues that are challenging for people with dementia. Typically, unless there's some kind of side effect problem that's going on with these medications, it would be recommended to keep them on.

Adam Rosenblatt: If I could just contribute to this a little bit, Donepezil, Aricept, and memantine, Namenda, both do have FDA indications for severe Alzheimer's disease. It's a little bit of taking the argument on faith. There's a study that looked at functional abilities in people with advanced dementia. I think this was a study of Donepezil, if I remember correctly. In the course of the study, everybody's functional abilities declined, but the people who were on the Donepezil did not decline as badly as the people that were on the placebo. That's a result that will be invisible to the people that are actually taking care of the person. You just have to take it on faith that if you give it to 500 people and don't give it to 500 other people, you get a better outcome. That might influence things like caregiver burden, who gets institutionalized, those kinds of things.

There are many treatments like that. If you take aspirin to prevent strokes and you have one stroke this year, does it mean the aspirin failed or would you have had two strokes without it? Or if you take a medicine for osteoporosis and you don't break a hip this year, is that because of the medicine or not because of it? I think earlier in the course these medicines, you may observe an improvement and you may be reassured that the patient actually got better. Later on, you have to take it on faith, but I tend to be a maximalist and I believe that the research data supports continuing them even into the advanced stages.

Lyons Hardy: Next up is talking about antipsychotic medications. I know most people are probably familiar with this terminology because there has been quite a big push to reduce the use of antipsychotic medications in people who have dementia. Other terminology for this are neuroleptics. You may hear atypical antipsychotics, second generation antipsychotics, all referring to the same thing for the majority of these drugs.

The studies on these do show mixed results, but there is some efficacy with some of these medications. Some of the more commonly used drugs would be quetiapine or Seroquel, risperidone, Risperdal, olanzapine, which is Zyprexa, and haloperidol, which is one of the older antipsychotics or first generation. Some of the risks and side effects associated with these drugs would be dizziness, falls, sedation, cardiac problems, all things that you would want to be looking out for in a patient who might be on these medications.

The next poll, when a number of studies were analyzed, it was found that antipsychotics increased rates of death in dementia patients by about how much, 10 times, 2 times, 5 times, or 100 times?

Jennifer Inker: All right. If our audience can go ahead and cast your votes. The question here is some studies' analyzes show that antipsychotics increased rates of death in dementia patients by about how much, by about 10 times, 2 times, 5 times, or 100 times? We'll just collect our results and we'll report those shortly. All right. We have the answers to the question some studies' analyzes show that antipsychotics increased rates of death in dementia patients by about how much? We have the largest percentage of our audience saying by about 2 times, that's 40%. 35% of our audience are saying it's about 5 times, 24% say about 10 times, and 1% 100 times. Lyons, again, over to you for the answer.

Lyons Hardy: The answer is about 1.7 times, so roughly 2 times. This is where the antipsychotic black box warning came from. This metanalysis came out in 2005 and they looked at 17 studies that had compared antipsychotics to placebo. They found that the rate of death in the groups that received the drugs was about 1.7 times the rate in the placebo group. This was over the course of a typical 10-week trial. The baseline rate of death for people who were not receiving antipsychotics was about 2.6% and that increased to 4.5% in the people who got the drugs. Most of the deaths appeared to be either cardiovascular or infectious, like something such as pneumonia.

I think it's important to highlight this because this black box warning has gotten a lot of press and a lot of government involvement in terms of CMS regulation. When we look at the actual numbers, it's not ideal, but it's not a huge, horrible hundred times kind of thing. Just important to keep in mind.

Next to talk about are what are typically known as mood stabilizers. That term gets applied to a variety of different kinds of drugs, so it is important to be a little bit cautious about terminology and what is meant when someone uses the term mood stabilizers. We use them to treat bipolar disorder, mania, depression, and preventing affective episodes in people who have bipolar. This is a little bit different from using them in people who have dementia. There also is some evidence to support using them in people with personality disorders. Then finally with the disinhibition or agitation in patients with dementia. There is some spillover with the term, but typically, it refers to anticonvulsants, which are seizure medications that also can help with some of these disorders.

We really don't have a lot of research on using these in people with dementia, but you'll probably commonly see Depakote being used. That's, I think, the most common one. Again, minimal evidence on that, so probably something that's better to avoid if possible. Some of the risks of Depakote are sedation and liver damage. Our next poll, antidepressants are only used to treat depression in patients with dementia.

Jennifer Inker:

All right. Time again for our audience to vote to tell us whether you think this is true or false that antidepressants are only used to treat depression in patients with dementia, so true-false choice here. We'll tally up the audience responses and report those back briefly, so antidepressants are only used to treat depression in patients with dementia, true or false? All right. We have 99% of our audience saying that this is a false statement. It's false that antidepressants are only used to treat depression in patients with dementia. Lyons?

Lyons Hardy:

Okay. You guys did a great job with that one. That is correct. It's false. There is some evidence showing that it may help with some of the "agitation" or other behavioral issues regardless of whether there's depression involved in patients with dementia. They can also be used to target some specific symptoms such as dysphoria or just feeling unhappy and down and irritated, perseveration, fixating on certain ideas or the apathy of not caring a whole lot about things. These are pretty well known. Most of you have probably heard of these medications, Zoloft, Celexa, Lexapro are brand names for them. We also see mirtazapine or Remeron being used fairly often in elderly patients.

In terms of side effects with these medications, they can sometimes cause some sedation, dizziness, and falls. They can cause low sodium levels, which can also lead to mental status changes, so that's something important to be aware of, so especially an elderly patient is on an antidepressant and they have some kind of sudden change in mental status, you would want to look at their sodium levels to see if those had dropped. Then potentially cardiac problems, as well.

A case example of using an antidepressant in a patient with dementia. This is an 82-year-old woman with mild dementia. She was diagnosed with Alzheimer's and she became convinced that her husband was having an affair. She was not able to recognize her own clothing and said that the clothing in her closet had to belong to the husband's floozy, which was the term she made up for this person that she thought he was having the affair with. She was misinterpreting things, seeing phone numbers and thinking it was from the girlfriend. She admitted she had never seen this girlfriend, but that the husband was sneaking her in and out. It turns out that the husband is 90 years old and blind and definitely does not have anyone

that he's having an affair with. The relationship was becoming very strained and the patient was very fixated on this topic and tended to bring it up frequently.

She had been treated with neuroleptics because if someone could look at this and think that she was having some kind of psychosis or delusion, but she wasn't getting any benefit from those and was also taking donepezil, or Aricept, which was helpful for her mental status exam, but continued to have these obsessive thoughts about the jealousy with the husband's girlfriend. She was started on sertraline, or Zoloft, and it had a marked improvement in her behavior and she said that she still felt that her husband was being unfaithful, but she didn't feel the need to worry about it or argue about it and she felt comfortable and was able to forget about that whole issue, so an example of using an antidepressant. Although she wasn't necessarily depressed, it was still helpful for the issues that she was having.

Adam Rosenblatt:

All right. This is Adam. I'll talk about some more classes. Amphetamines, this is kind of a fun class of drug to get to use. I probably use more of them than most psychiatrists that don't treat a lot of kids with ADD. This is speed. These are drugs like methylphenidate, or Ritalin, dextroamphetamine, or Dexedrine. They're useful for a number of things in dementia. They may target some of these so-called frontal symptoms like apathy, distractibility, and disinhibition.

You'll sometimes hear that people will say, "Oh, well, when they're given to children who are hyperactive, they have the opposite effect and they calm them down." That's not really true. It's not that they are tranquilizers. What they do is they allow people to focus. For the same reason that college students used to take them and stay up all night to study or pilots are given them by the military on these 14 hour flights across the Pacific, they allow people to focus their attention on one thing at a time. They sometimes motivate apathetic people. Some apathetic patients gain weight on them because they now can be bothered to eat.

Physicians fear making a disinhibited patient worse, so they don't like the idea of giving a stimulant to someone who's irritable. Sometimes, if luck is with you, they can be helpful. There are some promising results in studies. Caffeine has also been studied as a treatment for apathy. The risks and side effects are considerable, cardiac problems, insomnia, appetite suppression, but you have to think that you're going to be using small doses. You're going to watch closely and see if there's a benefit. Benefits tend to come pretty soon with these meds, so you're not going to be waiting months to see if it helps. You're giving them to patients with a relatively short life expectancy, so they're probably not going to really have enough time to develop a terrible problem with being habituated to them. Of course, you want to watch for diversion of the drug to someone who isn't supposed to be taking it.

Here's a nice amphetamine case example. A 79-year-old woman was brought in by her daughter. She had a moderately severe dementia, which I think in retrospect was probably frontotemporal dementia based on her early loss of speech and odd behaviors. She was a very conservative Catholic and was not a nun but kind of dressed like one. She was wearing a conservative dark suit and a large crucifix. She still attends church every single day, but otherwise spends most of the time sitting silently or telling the rosary over and over. She seldom speaks, even in response to questions, refuses most food, and had been observed emptying plates or cups of food into potted plants when she thought no one was looking, has lost a great deal of weight, and her apathetic presentation was punctuated by sudden bursts of odd behavior. For example, she was mostly silent during the interview, but at one point, got up, crossed the room to hug and kiss me, and then laid down on the floor of the office, refused to get up until the interview was over.

She was given a diagnosis of a non-Alzheimer's dementia. She has not responded to neuroleptics, which were tried on the assumption that she was paranoid about the food. She did not respond to an antidepressant that was started on the presumption that she was depressed. Targeting her apathy, she was treated with five milligrams a day of dextroamphetamine, with an increase to five milligrams bis in die, five milligrams twice a day. Within a few days of starting the stimulant, she'd begun to eat again and to communicate better. At a follow-up visit a month later, she was verbal and scored a 21 on the MMSE, indicating that the actual degree of cognitive impairment that she had was mild, but her dementia was causing a much greater problem with behavior and executive function, which is a reason to suspect frontotemporal dementia. She had gained some weight and there were no more odd behaviors.

I want to tell you about my hobby horse medication, amantadine. There is some literature on it, some of it with me as one of the authors, like the Drayton paper that you can see there. Amantadine is a drug that increases the transmission of the neurotransmitter dopamine, which is very active in the front part of the brain. This is the neurotransmitter that's reduced in Parkinson's disease, so Parkinson's patients are sometimes given amantadine, but they're usually given a drug called Sinemet, levodopa, carbidopa, which is more effective.

Amantadine, when I first started working with it, was regarded as a bottom of the barrel treatment for agitation. The precise mechanism isn't known, but I can remember like it was yesterday a patient who, at autopsy, turned out to have frontotemporal dementia. He was extremely disinhibited. He would see things. At one point, he thought that the hospital was a ship and that the ship was on fire. He managed to find a bucket in a janitor's closet and he dumped about five gallons of dirty water on the floor of the nursing station. Other times, he would be lucid and he would grab me by the lapels and say, "You've got to help me, doc. I know I'm losing my mind. I'm seeing things that aren't there." He had a dramatic turnaround with amantadine. He became much less disinhibited. He was able to focus.

I think it's particularly helpful in those patients that are very wandery and into everything. Their feet get swollen because they never stop walking. They lose weight because they won't sit down to eat. They sometimes respond very nicely to this medicine, so I'll sometimes pull it out of my back pocket when somebody's looking for something new to try.

Let's talk about a very important topic, which is behavioral management of disinhibition. Not every disinhibited patient needs to take a medicine. You want to try to reduce the opportunities for disinhibited behavior, so manage the environment. They do well in an environment where there are things to explore, but there's a few things that you can get into trouble with. I know one assisted living, for example, where the whole floor plan is a circle and the actual exit is concealed. Patients that wander are just encouraged to keep moving down the hallway and the hallway has lots of interesting things to see and do. Some places use rummage rooms where patients can fold and unfold clothing and towels and take things out of boxes and put it back in.

Disinhibited patients don't like surprises and broken promises, so if you say that they're going to be taken out to smoke every four hours, you have to take them out to smoke every four hours. Mealtime should be regular, that sort of thing. You want to try to establish a regimen of positive activities on a regular schedule. Allow them to rest, but avoid too much downtime. Idle hands are the devil's workshop. Don't adopt a punitive approach. Disinhibited patients are relatively insensitive to both punishments and rewards. If you say, "If you stop taking all the clothes out of that drawer, I'll give you a lollipop," useless. "If you don't stop taking all the

clothes out of that drawer, I'm not going to give you a lollipop," equally useless. You need to think big and avoid the conflict altogether.

I think a problem is that some disinhibited patients cognitively don't look as bad as other patients because they sometimes have non-Alzheimer's forms of dementia. They talk a good game and people will say, "He just needs to understand that he needs to stop doing this," or, "We need to increase the stakes." I'll say, "This man has frontotemporal dementia or he's had a head injury. I really don't think he can do any better. If he can do any better, he's never given any evidence of his ability to do so in the 12 years that I've known him. I think we need to think of him as somebody who's got to be managed rather than punished."

Let's talk about a nice amantadine case example. I think this is the one I already gave you. 63-years-old, progressive dementia of recent origin. He had been running an auto shop 18 months ago. For long periods a day, he would sit quietly and interact congenially. He'd served in the Navy and often believes he's at sea. Other times, he would be restless, anxious, intrude in other people's rooms, try to leave the unit, have visual hallucinations, engage in bizarre behavior. Told you about the bucket example. His need for 24-hour-a-day supervision was really placing a strain. You could imagine that someone like that is unplaceable in a longterm care setting because nothing but a state hospital could provide that level of supervision.

What really happens to them is they end up sedated into the danger zone. People begin to give these patients more and more tranquilizers or antipsychotic medications until they aspirate or fall and break something. Really, the medication that's given to control their behavior can kill them. We were looking for a better example. He had a terrific response to this. Then actually, what happened is that he was placed in a nursing home. In a few days, he decided to escape and he was so young and robust he kicked out a section of the fence to run on down the road. He was readmitted to the hospital. We raised his dose and he did even better. Six months later, his problem behaviors had reemerged. He returned to the hospital. His dose was raised again with good results. I've even found that some amantadine patients you can bring them into the hospital and you can make a gradual reduction in their dose. It cheapens their habit and then you can go back to the old dose again. I've been successful with that. Don't stop a high dose of amantadine suddenly. It can produce a really bad delirium that can make the patient extremely confused.

Lyons Hardy:

A few other drugs just to throw in here that most of them don't have a whole lot of evidence, but you may see them being used. Trazodone, which is actually an antidepressant, but typically is only used for sleep, can be used in some people with dementia, occasionally used for daytime agitation. There's a little bit of evidence using it for sleep. Benzodiazepines, which most people are probably familiar with also. This is things like Ativan, Xanax, Klonopin, valium, those type of medications. They are somewhat commonly used for sleep and daytime agitation, but really don't have a lot of evidence behind them. They do have quite a few risks associated with them, such as falls and oversedation.

Ambien not really researched in dementia, but appears to be fairly safe in elderly. Again, this would be something that would be a last resort when all of the other things have been exhausted and there seem to be nothing else that could be effective for someone for sleep. Then you may see gabapentin, which is also called Neurontin, or pregabalin, Lyrica. These can be used for anxiety and sleep and do have a little bit of research behind them.

Here's a few drugs that are currently being researched or have a few small studies to support using them. Some of these are already approved for other indications, so Nuedexta is a drug that's approved for a diagnosis called pseudobulbar affect, which maybe Adam can talk a little

bit about if we have time. That's been researched and used with dementia patients. Rexulti is what we would call a third generation antipsychotic, so it's in that category, but slightly different from some of the other ones. Prazosin is a blood pressure medication that's typically used for PTSD symptoms such as nightmares and that has been researched in dementia. Cannabinoids, which is kind of interesting. Not the same thing as smoking marijuana, but it's one of the components of marijuana and it can be given in more of a medication or pill form. This new drug that just got approved you may have heard of called Nuplazid, which is currently approved for psychosis in Parkinson's. I think they're researching that for dementia patients, as well. Then there's a few brand new drugs that don't even have names yet and that don't have FDA approval that are under investigation.

Our last poll for you, medication should be the first intervention to use for challenging behaviors associated with dementia.

Jennifer Inker:

All right. Over to you, our audience, so the question for you now in our final poll is medication should be the first intervention to use for challenging behaviors associated with dementia. Given what you've heard from Lyons and Adam, do you think that's true or do you think that's false? Here's your chance to cast your vote. While you're casting your votes, please let me encourage you to continue sending in questions. We've had some great questions coming in and Lyons and Adam will be able to address those at the end of their presentation, so if you have things you'd like to know, this would be a great time to go ahead and type them in.

All right. We've got our poll results. We have 100% of our audience, Lyons and Adam, saying that medication should ... They're saying it is false that medication should be the first intervention to use for challenging behaviors associated with dementia.

Lyons Hardy:

Okay. Thank goodness. We at least got that message across pretty well.

Adam Rosenblatt:

I love it. These are a few pithy maxims to close off and then I'm going to give you one more case example and then we'll take some questions. Remember, behavioral problems in dementia are the most treatable aspects of the disease. There's nothing I can do to halt the progression of Alzheimer's disease or to reverse it. I can bring about some symptomatic improvement in cognition with the drugs like donepezil that are used for that, but that's a temporary benefit. If I can cure somebody's depression or I can get them to calm down in their behavior so that they can continue living in a nice place, that may be the most powerful thing that I can do.

Number two, think about that four-step process. To choose the right tool, you have to know what the job is and so you can't go stampeding to treatment if you haven't made observations and formulated some kind of a plan and a backup plan. Families are very happy when I say, "You know, I'm not 100% positive what the right thing is to do, but here's why I want to do this first and here's what I think I'll do if it fails." They say to themselves that guy has very honest and he's really thought about my loved one's case.

Number three, not every psychiatric disorder is in the DSM and there's some disorders in DSM that probably don't belong there. Not everything that's real is in the book and not everything in the book is real. The DSM does not do a great job of capturing these disorders in people with dementia and so sometimes, you don't want to shoehorn something into a diagnosis that it doesn't fit very well.

Finally, not all unusual behaviors in dementia require pharmacologic or any treatment. Sometimes they just need to be appreciated and not that much else needs to be done. Let me

give you a nice example here. This is an example of nonintervention. A 45-year-old man with Huntington's disease was brought to the clinic by his brother for concerns of depression. His brother reports that he spends all day sitting on the couch watching television. What does that remind you of? It should remind you of apathy. He eats and sleeps normally and attends to his hygiene with reminders.

Recently, it was the patient's birthday and his brother arranged for the two of them to go fishing, which was an activity he'd previously enjoyed. He was reluctant to leave the house, but once he was outdoors, he behaved more or less normally while fishing and actually caught several fish. Again, the apathetic person, when given a planned activity, usually can behave much more normally than if left to his own devices. When they came home, he sat down in front of the television. He didn't say thank you. He didn't want to discuss it. He went right back to staring at the screen.

His brother brought him in. He was casually dressed. He didn't smell bad. He had intermittent chorea in all four extremities, so he had these involuntary movements typical of Huntington's disease. His speech was a bit slurry. He described his mood as good. He denied being depressed. He denied a change in self-attitude or his vital sense. He wasn't pessimistic. He wasn't suicidal. When asked if he was able to enjoy things, whether he was anhedonic, he said he enjoys television. He was puzzled by why it was so important to his family that he leave the house every now and then. He had no delusions or hallucinations and he had a mild degree of dementia, scoring 24 out of 30 on the MMSE.

I explained to his brother that this apathy and constriction of activities was a common symptom of Huntington's disease, that the patient is not depressed and does not appear to be suffering. He is told that his brother will have more trouble initiating rather than sustaining behaviors, so he was able to participate when his brother planned the fishing trip. His brother felt reassured. He adjusted his expectations. When his next birthday came around, he and his brother just watched a football game together on television and they had a nice time. That was an example of something that might've caused some people to give him antidepressants or stimulants or antipsychotic or whatever the thing might've been and just some explanation and appreciation of the changes in him had taken place.

This is to mention it's like I always try to portray to people that it's possible to have a happy life despite the fact that you're demented. It's not a death sentence. It's not the end of the world. If you appreciate the ways that people with dementia are more like other human beings than the ways in which they're different, then you can take them as they are. You can do things to try to help them to do better and you can enjoy the time together with your family members or your patients or your clients or the people that you care for by having a more relaxed attitude. I think that's the end of our programmed material.

Lyons Hardy:

I have one other quick case example I wanted to share that I didn't get a chance to put on a slide, but another example of looking beyond what the family member may initially say. I had a patient who she was taking olanzapine, or Zyprexa, for some agitation that was related to dementia. She was pretty severe, so she would become aggressive and violent and extremely agitated and was living with her daughter, I believe, at home. The daughter said, "Well, the medication's not working. It's not helping. She's taking the medication. It's not doing anything." When I further questioned her about what she was doing, it turned out that she was only giving her the medication when she started to become agitated, so by that point, it was too late. Once she started giving it twice a day on a schedule, the patient's behavior improved quite a bit. That's something else to think about, what other things may be contributing to why the medication isn't working if it's a medication issue.

- Jennifer Inker: All right. That's great. Thank you so much, Lyons. Thank you, Adam. We've got some wonderful questions that have come in from our audience, so I suggest that we turn to those now. We have a number of questions about specific medications and some broader questions, too, so why don't we start with a specific medication questions about Aricept. A member of our audience says, "There is research indicating that Aricept can often cause an increase in behaviors, especially sexual disinhibition in later stages. What is your position on this?"
- Adam Rosenblatt: This is Adam. I'm not aware of those studies. I'd be happy to look at anything that somebody would like to show me. I suppose it's certainly not impossible in any given case. Patients with dementia can have a lot of problem behaviors and it can be sometimes difficult to attach them to a specific medicine. Sometimes, whatever was given last gets blamed for it. Sometimes, people may come out of their shell when they have a medication and they may show an interest in sex that they weren't showing before, but I certainly would not say that Aricept was notorious for causing sexual behavior problems in patients with dementia. If you think that's what's happening, it's harmless to stop the medication. There are a number of other alternative drugs that can be given in its place and there are no withdrawal effects associated with it, so if you believe that's what's happened, you can stop it. I don't believe that appears as a warning in the package information and I wouldn't use it as a reason to avoid trying the drug.
- Lyons Hardy: Yeah, I'm not familiar with any studies like that either. I'd also say that I'd have to look at the actual study, but we have to make sure that if it really did show a difference that it's showing it between placebo and the drug and not just an association between the drug and the behavior because that does not imply that the drug is what caused it. It'd be important to look at the actual study and see what the methodology was.
- Jennifer Inker: Those are great points. Thank you very much for that. That's reassuring, I think. Here's another question about two medications. This audience member says, "Have you seen an increase lately in the use of Trazodone and melatonin to manage behaviors? Your opinion?"
- Lyons Hardy: I've heard of that. I forgot to mention melatonin in the slides, actually. Yes, I have heard of those being increasingly used for sleep and then potentially during the day for agitation, as well. What about you, Adam?
- Adam Rosenblatt: I've not personally seen melatonin. Trazodone certainly and there's a role for it. I didn't go into it because it's a bit esoteric, but Trazodone is an antidepressant that is almost never used as an antidepressant anymore because it is so sedating. It's usually used in much smaller doses to try to help people sleep at night and, like all sleeping pills, it eventually stops working, but is a fairly safe one to consider, fairly safe to try.
- Sometimes, very aggressive dementia patients, I have given them Trazodone in the daytime, usually at regular intervals to try to find some amount that wasn't punishingly sedating, but would help to reduce their aggression, sometimes with some degree of success. I think speaking anecdotally, there is a role for it in problem cases, but it's the fourth or fifth or sixth thing that I would try. I can't say whether there's been an increase in its use, but there is some reason to use it, I think.
- Jennifer Inker: All right. Thank you for that. We now have another question, a more general about medications. This audience member says, "Many of the medications talked about in this presentation this afternoon are on the Beers list. Also the CMS, which is Centers for Medicare and Medicaid Services is trying to decrease the use of many of these medications in nursing homes. How do you reconcile this? Obviously, some of these medications are absolutely

needed." Perhaps, Lyons and Adam, if you might just briefly touch on the Beers list. Probably some audience members are familiar. Maybe some are not. Then your thoughts about the fact that we are trying to decrease the use of some of these medications, but they're also needed in some cases.

Adam Rosenblatt: Sure. Dr. Beers was a wonderful physician who died young, I believe, of the lifelong consequences of juvenile diabetes. He was concerned that people were giving medications to elderly patients that were not well-tolerated by their aging bodies and produced things like cardiac and other organ complications and delirium and things like that. He began compiling a list of medications that might be problematic in the elderly. This included a lot of tranquilizers, some of the older antidepressants that are anticholinergic, like the tricyclic antidepressants, lot of other medications like that. The Beers list still bears his name, but it's continuously updated and you can go to a website and read it. They're categorized in terms of the sort of problems they should have and the degree of risk.

Yes, it's true there are a number of psychoactive medications where we don't really have a better alternative in terms of tolerability and it's always a balancing act. I think you should be aware of those medicines that are considered the most problematic and try to stay away from them unless you feel you have no alternative. If you're going to pick an antipsychotic, for example, don't pick Thorazine. You might pick haloperidol at the other end of the spectrum. It's not likely to cause constipation and blurry vision and things like that.

There should be a good reason for everything you do. You should try to prune the list of medications where possible to leave more room in the patient's brain for your new medication, so if there's something that clearly hasn't been helping, don't leave it there while you add something new. Take it away and then wait a little bit and then try your new medication.

There should be good reason for everything you do. You should slowly advance doses and try to use the smallest necessary dose. You should periodically look at the case again and see if the patient still needs the medication that you gave them. Is it working? Is it possible that the problem has run its course and it could be cautiously withdrawn now? Patients in nursing homes, they get periodically reviewed and a pharmacist will often say to the prescribing physician, "Should we do a trial dose reduction of this?" You would say, "Okay. Well, what do we know about it? Is this a drug where we tried taking it away before and the problem came back every time or is this a drug where it might be that he has settled in now and doesn't need it anymore?" I'm not saying you would never use a drug on the Beers list. You should be aware that you're using a drug on the Beers list.

Lyons Hardy: Yeah, that's how I feel about it, too. It's more of a guide and it's something that I take into consideration. I would typically use much lower doses in someone who is an elderly patient, but it's not an absolute contraindication. Then to address the part of the question about the CMS involvement, we touched on that a little bit with the black box warning. I think that it's important to put a lot of other processes into place in these longterm care settings so that there is a way of preventing the behaviors so that less medication is needed. I think of that as being more what we want to do to try to reduce the use of medications versus just coming in and taking everyone off the medications because that is not an effective way of addressing why they were placed on the medications in the first place.

Jennifer Inker: Thank you for those very, very thoughtful responses. I think those detailed answers are really helpful and I think this question of the Beers list, that was a particularly interesting answer for me, too, to understand that you're aware that you're using those drugs, not necessarily that

they could never be used. All right. We have another audience ... There's a comment and a question, so to you, Lyons and Adam, this audience member says, "Thank you. This is excellent. When people with dementia refuse to take their medications, what should staff do and not do to remedy the situation? In a particular instance, the remedy was to do nothing, resulting in missing a dose of medication. What are your thoughts? Should we give doses late? What should we do?"

Adam Rosenblatt: Good one. You're the nurse.

Lyons Hardy: Yeah, I'm the nurse. Hmm, yes, that's a good question because I think we probably all know that the practice may differ from official recommendations in this area. Officially, we would not force medications on someone who says that they don't want them, but people do behave a little more paternalistically in some cases and perhaps we could ethically debate that, whether that's in the patient's best interest or not. You will see people giving medications in pudding or sneaking them in places and things like that. I guess I can't really say I would strongly advocate for that, but also as a nurse having worked on a psychiatric unit, sometimes you do what you have to do.

Adam Rosenblatt: I think some of it depends on the drugs. Some rough guidelines are try to reduce the number of pills the patient is confronted with every day. If you're trying really hard to get them to take Zyprexa, maybe you don't give them a multivitamin and a stool softener and an aspirin for a while. You want to try to reduce the number of pills that they see every day by eliminating anything that's not absolutely necessary and maybe reduce the number of times that they have to be given the medicine. Sometimes we move to things like liquids or quick-dissolve forms or patches that may not bother them as much.

Obviously, you want wherever humanly possible to avoid a scenario in which you're holding someone down and trying to force them to take a medicine. If someone is very, very demented, then I think it's probably not immoral or unethical to use subterfuge. If someone literally has no idea what they're doing, then giving them medicine in a scoop of pudding the same way you would give medicine to a toddler or to your cat is probably okay in somebody who really doesn't know. In somebody who still has the capacity for autonomous decision making, it's not considered right to trick them into taking a medication.

Many medicines, the precise timing isn't that important, so if a medicine is long-acting, like an antipsychotic medicine, a lot of dementia patients will feel different an hour later. They may not remember that they refused it an hour ago. Maybe you just didn't catch them at a good time and so you can reapproach them several times during the day. As long as they get it in some point during the day, that may be fine. Other medications, if you don't make it into that window, then you have to wait until the next day, so it depends on the properties of the actual drug.

Lyons Hardy: I would also say that if it's a consistent problem that's repeatedly happening, then probably the treatment team should be involved and the patient's prescriber should be involved in making decisions about whether this is the best course of action or if something different needs to be considered.

Jennifer Inker: Thank you both for those really pragmatic and practical responses. I think that's very helpful for our audience. This puts me in mind of a broader question really. I don't know. Maybe I hesitate to go into this territory a little bit, but you clearly both have significant expertise and we also know that there's a severe shortage of geriatrically-trained psychiatrists and psychiatric nurses. What are your thoughts about the best ways to ensure that older adults

can still have access to the kind of expertise that you have that perhaps maybe not every healthcare practitioner is going to have this level of expertise.

Adam Rosenblatt: Beyond tripling the pay for geriatric specialists, bring more people into the field? You could participate in educational opportunities like this. Nobody wants to be inundated with contacts, but I don't mind when I get phone calls or emails from other people who say, "I'm a psychiatrist or I'm a primary care physician. I heard you speak at something last year and I'm wondering if I could run a tricky case by you?"

As somebody who's an academician, I see it as my mandate to try to help people that are out there in practice with questions like that by discussing them with them. I think you'll find that many of us will be fairly generous with having a discussion with you about something like that, so reaching out to colleagues. You may want to subscribe to a magazine or a journal on the topic, even if it's not your field and try to make yourself read some of the articles. I think there's probably never going to be quite enough of us to meet the demand with this aging bump in our population, so people that aren't specifically trained in the field are going to have to improve the depth of their knowledge in those areas.

Lyons Hardy: Yeah. In our program, we try to expose our students in some way to some geriatric experiences. This is totally anecdotal, but we found that a lot of times, people enjoy it more than they were expecting to, so that's part of the way that we try to increase their interest in the field. That actually happened to me. My background was primarily in pediatric psychiatry and also younger adults. Then I ended up getting a job that was with more geriatric patients and just found that I enjoyed that, as well. That may be a big piece of it is making sure that students get the exposure and find what they may really enjoy about it or find rewarding about it. Also, I always recommend increasing the numbers of psychiatric nurse practitioners is always a benefit, as well.

Jennifer Inker: Thank you for those very encouraging and hopeful responses to this dilemma. Meanwhile, questions continue to roll in here. We have about five minutes left for questions. I'd like to keep pitching these few lines and Adam, if you're okay with that?

Adam Rosenblatt: Sure.

Jennifer Inker: We have an audience member saying again, "Excellent presentation," and who goes on to say, "I've seen research that shows family caregivers who are dealing with depression or anxiety are not giving as good care as they could for their loved one with dementia. Have you ever found that you wanted to treat the caregiver in hopes that the patient with dementia will also improve? What are your thoughts on this?"

Lyons Hardy: I think that's a pretty common issue in mental health treatment in general with all populations, so yes, I would say that that can definitely play a role.

Adam Rosenblatt: There's been many times I've wanted to treat the caregiver. It's not really considered ethical to treat the caregiver if you're also treating the person that they're giving the care for. If it's really serious, then I try to help find a referral for that person, some trusted colleague that I could tell them would do a good job that they should go and see. We do do a lot of counseling that falls short of treatment where it's certainly very appropriate.

You may notice that somebody looks very haggard and say, "How are you holding up through all of this and what about your own mental health?" The caregiver will sometimes tell you that they're losing control of their drinking or that they feel very depressed and that they aren't

sleeping at night and so sometimes, giving them permission to take better care of themselves, giving them permission to use respite care or to have a family member sit with their loved one so that they can have some time away and recharge their batteries, encourage them to go to a support group for the Alzheimer's Association or to go back and look up the counselors they used to see can be very helpful interventions. I'm sure I'm not at all surprised by research to show that if you're depressed and anxious, you can't do as good a job at rendering care as if you're not. That doesn't surprise me at all.

Jennifer Inker: Indeed, indeed. Thank you for those very compassionate responses to that. That's quite an important issue, indeed. All right. We are back to a specific medication question here. What is your opinion of using Seroquel for use in dementia behaviors?

Lyons Hardy: That's one of the second generation antipsychotics that we mentioned. Just to reiterate, not a whole lot of evidence on those, but definitely does get used in practice. Seroquel in particular can have a high rate of dizziness and sedation, so that would be something to look out for. I think probably both of us have used some of these medications and seen results either positive or negative, so it really is individualized to the patient depending on how they respond to things. It would be one of the lower or next in line type of things because it does have more side effects than something like an antidepressant.

Jennifer Inker: All right. Thank you for that. We have another audience member making a comment here, "Your pills not first approach is refreshing and encouraging. Thank you." That's a comment I would like to underline. We often say and teach that behaviors are a form of communication, so clearly there are risks that we may be medicating people who are attempting to communicate with us. Thank you on all of our behalf for your wonderful message.

In the final minutes remaining, I'd like to ask you both, Lyons and Adam, out of all the fantastic information you've shared today and it's been quite a lot, what would be your one takeaway? If you could say to our audience today, "This is the one thing I'd like you to take away," what would your one thing each be?

Lyons Hardy: I think for me, what I try to impart to students and people that I work with is that the importance of digging with questions to get as much information as possible and analyzing what's really going on, so the four-stage process that we talked about, the observation stage, which is really trying to figure out what are all the different components that could potentially be contributing to this issue, so not stopping at the person's not sleeping at night, so I need to give them a medication. Hopefully, we got that across that we need to really look at why are they not sleeping? What's going on during the day? What are they engaged in? What's happening at night? Is it loud?

There's so many different factors that can contribute to these things, so really digging to try to find out as much information as possible before making a decision about what to do. Then the other component of that is that everything is multifactorial, so there's never typically one thing that's causing one outcome. There may be many different factor that are contributing and so as many things as can be addressed, typically that's going to improve the outcomes.

Adam Rosenblatt: I was going to say exactly the same thing. Basically, get the whole story. Speak to multiple people, read the old chart, make observations, ask questions. Get the whole story start to finish. The four-stage process is a very good basis for that. The person who asks the most questions gets the most complete picture of the case and makes the most sensible decisions.

Jennifer Inker:

That's wonderful. Thank you. I'm hearing use the four-stage process and embrace complexities, so great messages for our audience today. All right. I would like once again to thank Lyons and Adam for a fascinating and informative presentation. I'd like to thank our audience for joining us for today's webinar and asking such wonderful questions. This webinar has been recorded. If you missed any portion of our presentation or you would like to share it with a colleague, please visit the webinar page on our website. As a reminder, information alongside the survey links will be emailed to all registrants by tomorrow.

Next month's webinar is titled *The Use of Technology to Engage Persons With Dementia* and will be hosted on Thursday, May 11, 2017 at 1:30 p.m. Eastern time, so please do mark your calendars. This webinar will discuss current research related to the use of technology in the care of persons with dementia with examples of the specific modalities available. We do hope that you'll be able to join us again. Until our next live webinar, thank you once again for joining us this afternoon. Enjoy the rest of your day and your weekend.