Chronic Serious Mental Illness and Dementia – Optimising Quality Care

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Cognitive Course of Early Onset Mental Disorders (before age ~55)

May be a risk factor for dementia in late life (e.g. depression, bipolar disorder) but likely to happen via shared comorbidity e.g. vascular disease, smoking, diabetes, obesity, substance abuse

- Chronic Serious Mental illness (schizophrenia, bipolar disorder) – high rates of mild cognitive impairment e.g. Mackin & Arean (2009) found 60% of patients aged >55 attending a CMHC were cognitively impaired
- Overall the comorbidity is most likely to be coincidental
Bipolar Type VI disorder – dementia following bipolar disorder?
(Lebert et al, 2008; Ng et al 2008)

- People with long standing bipolar disorder exhibit persistent cognitive impairment, in old age the severity can reach level of dementia
- Case studies suggest it might be different to other established types of dementia but main differential dx is FTD
- Most have features of frontal lobe syndrome not explained by other organic factors
- Mood lability & cyclothymia, refractory to antidepressants, do better with mood stabilisers
- High rate of extrapyramidal signs
Management Comorbid Early-Onset Serious Mental Illness and Dementia

- Pharmacotherapy considerations
- Carer issues
The Literature - Serious Mental Illness & BPSD

No RCT found of antipsychotics in the treatment of BPSD examined effect of SMI - either an exclusion criterion e.g. CATIE-AD or not mentioned in the analyses
Antipsychotic withdrawal studies e.g. DART do not mention SMI
No RCT found of antidepressants for depression and/or agitation in dementia that examined effect of SMI (including premorbid depression)
No BPSD review article in last 5 years considered issue of comorbid SMI
Major studies of BPSD prevalence & characteristics e.g. Cache County do not mention SMI
Pharmacotherapy in Dual Diagnosis – Schizophrenia and related Psychoses

• There is a very limited evidence base to inform decision-making when patients with schizophrenia develop dementia

• Antipsychotic drugs including the older traditional antipsychotics (e.g. haloperidol, chlorpromazine) and the newer atypical antipsychotics (e.g. risperidone, olanzapine, quetiapine) have been developed specifically to treat the delusions, hallucinations and thought disorder of schizophrenia (rather than behaviour)

• They are dopamine blocking drugs – dopaminergic abnormalities often drive the psychotic features of schizophrenia – this is not as often the case in dementia
Pharmacotherapy in Dual Diagnosis – Schizophrenia and related Psychoses

- EOS often requires higher doses of medication for therapeutic efficacy than late onset psychoses (with or without dementia)
- As patients with EOS get older, there is often a lessening of the psychotic features – relatively few have severe psychoses, some no longer require meds.
- Depot antipsychotic drugs are best NOT used in comorbid schizophrenia and dementia due to safety
Pharmacotherapy in Dual Diagnosis – Schizophrenia and related Psychoses

Do not assume behavioural change is due to schizophrenia.

Follow the first principles of assessing any BPSD and focus on psychosocial interventions first - unless the psychosis is bizarre or resembles the psychosis the person had when unwell with schizophrenia in the past.

If antipsychotic drugs are needed to control a schizophrenic psychosis in a person with dementia, they are likely to need continuation for longer (~6 - 12 months) than for BPSD & require much higher doses than usually used in BPSD e.g. 2-4mg risperidone; 10-20mg olanzapine.
Case - Schizoaffective Disorder & Dementia

MR 80 year old married woman
Recurrent episodes of depression & psychosis since age 26 requiring regular psychiatric admissions
From age 70 frequency of depressive/psychotic relapses increased, usually requiring ECT for recovery. Carer stress mounting.
Increasing cognitive impairment noted, by age 80 Alzheimer’s disease diagnosed, donepezil commenced
High dose antidepressant/antipsychotic combination required for maintenance therapy but efficacy diminished as dementia worsened
For her husband, coming to grips with transitioning from carer style required for chronic serious mental illness to that required for dementia was a challenge
Placement into residential care was an important if challenging transition
Carer issues – the comorbidity paradigm shift

• Carers of people with chronic mental illness often have difficulty in adjusting their style of caregiving when dementia develops.

• One common issue relates to the reluctance to take over decision-making on key issues when the PWD has obviously lost capacity – often this relates to respect of their autonomy and the difficulty the carer might have in understanding the different impacts that mental illness and dementia have in this area.

• Another issue relates to estrangement that might have occurred through the mental illness and the difficulties in overcoming this when dementia is present.
Differentiating Mood & Psychotic Disorders from Dementia & Delirium in Hospital

Complex comorbidity in the acute hospital setting hampers accurate diagnosis

In general, the psychiatric approach is to allow sufficient time for delirium to resolve before diagnosing another separate disorder

Cognitive disturbance evolves and fluctuates
  – improving after delirium,
  – worsening in the course of late onset bipolar, depressive or psychotic disorders
  – amplified by contextual factors
Pharmacotherapy in Dual Diagnosis
Bipolar Disorder - Maintenance

Maintenance treatment involves mood stabiliser drugs (e.g. lithium, Sodium Valproate, lamotrigine, carbamazepine) or atypical antipsychotics (e.g. olanzapine, quetiapine) and these should probably be continued as long as possible to prevent relapse.

Maintenance lithium requires 3 monthly lithium levels (aim for serum level 0.4-0.6 µmol/l), thyroid & renal function.

Lithium toxicity (levels ≥ 1.0 µmol/l) can cause increased confusion, sedation, gait problems, GIT upsets, severe tremor.

Lithium toxicity can be precipitated by dehydration, UTIs, commencement on diuretics or NSAIDS.
Pharmacotherapy in Dual Diagnosis
Bipolar Disorder - Mania

• **Acute mania** in people with dementia may resemble delirium or worsening of dementia

• In a person with a history of bipolar disorder who is NOT on a mood stabiliser, once medical problems are excluded this should become the first consideration especially if the patient is agitated, overactive, not sleeping, rapid speech

• Treatment of acute mania involves use of atypical antipsychotic ± mood stabiliser
Case - Bipolar Disorder & Vascular Dementia

69 yr old male - Bipolar disorder since his 20s, mainly manic episodes
Numerous admissions but stable for over 10 years on lithium/valproate combination – usually required relatively high serum lithium levels (0.9-1.0)
Managed by GP for past decade, physical health issues include obesity, IHD, hypertension, AF
2010 – stroke with mild vascular dementia
Early 2014 – delirium with severe agitation due to respiratory failure & metabolic disturbance – lithium ceased by CL psychiatry – delirium gradually resolved but cognition declined, behaviour worse – remained this way for 3 months, NH placement planned by geriatricians
Reviewed by POA – no longer delirium but mood disorder – depressed, agitated – recommenced on lithium gradually – behaviour settled, mood & cognition improved over 2 months, discharged home
Conclusion

- Early onset psychiatric disorders are often coincidental with dementia and often require continuation of premorbid psychotropics
- Person-Centred approaches to psychosocial care are no different from routine dementia care
- Carers often have to adjust their approach to care
- Acute BPSD = Delirium until proven otherwise
Thank You!

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