Brief Scales Can Measure Dementia, Mental Illness

Each battery should measure patient's memory, executive function, and activities of daily living.

BY ALICIA AULT
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NEW ORLEANS — The dizzying array of scales available for measuring dementia and mental illness in the elderly can be whittled down to create an essential picture of an individual patient. Most importantly, these scales can be used to establish a baseline to monitor progression or worsening and to meet federal documentation requirements in nursing homes, speakers said at the annual meeting of the American Association for Geriatric Psychiatry.

"You should choose scales that are brief, easy to score and have proven validity and reliability," said Dr. Allan Anderson, director of geriatric psychiatry at Shore Behavioral Health Services, Cambridge, Md.

Scales can enhance clinical practice and measure the effectiveness of psychiatric treatments, Dr. Anderson said.

Deborah Weber helps administer scales to patients at Shore Behavioral Health. Usually, she said, she spends an hour or more with patients and their caregivers. The tests are not used to make a diagnosis, she said.

The Mini-Mental Status Exam is one of the most frequently administered scales at Shore Behavioral Health, Ms. Weber said. Although this is a common exam measuring cognitive ability, it has some limitations. Patients have to be fluent in English, or they may not do well, she said, adding that they also have to be literate. If they can't spell "world" forward, then they won't be able to spell it backward, she notes. The MMSE usually only takes 10 minutes to administer, but, she said, "don't rush the patient—some patients take longer."

Ms. Weber also uses several executive function tests, which occasionally require family or caregiver input. Examples include the Tinker Toy Test, Tower of Hanoi, and Proteus Mazes. Failure doesn't automatically mean dementia, she said, noting that medical illness or other mental disorders can interfere with executive function. Fluency tests—such as asking patients to categorize items—are also good ways to measure executive function, she said.

The clinician-administered CLOX test, developed by Dr. Donald Royall, has rapidly gained followers, Ms. Weber said. It is a good test, but "it's important that you understand the nuances of this scoring," she said.

To measure depression, she uses the Geriatric Depression and the Cornell Scale for Depression in Dementia. Independence can be assessed with the Physical Self-Maintenance Scale or the Functional Activities Questionnaire, which takes only 5-10 minutes to complete, rating the patient's abilities in 10 areas.

Another test she likes is the Dementia Rating Scale II, which is clinician administered and computer scored, measuring competency in attention, initiation/preservation, construction, conceptualization, and memory. However, this test is not sensitive enough to detect mild forms of dementia in people who are intelligent or well educated, Ms. Weber said.

The choice of scales should be based on each patient's specific needs, she said. However, each battery should measure memory, executive function, and activities of daily living, she said.

For nursing home patients, there are several scales that will help establish a baseline of behavior and help meet federal documentation requirements under the Omnibus Reconciliation Act, said Dr. Alan Siegal of the department of psychiatry at Yale University, New Haven, Conn.

The Behave-AD can be done in as little as 10 minutes once the test-giver is familiar with the format, he said. This exam should be given by certified nurses' aides, as nurses are generally too overwhelmed, Dr. Siegal said.

The patient is asked questions covering behaviors over the last 2 weeks in seven domains: paranoid and delusional ideation, hallucinations, activity disturbances, aggressiveness, diurnal rhythm disturbances, affective disturbances, and anxieties and phobias. There are 25 questions with answers rated from 0 to 3. The staff is then asked to assign a global rating from 0 (not at all troubling to the caregiver or dangerous to the patient) to 3 (severely troubling or dangerous).

The scale establishes a baseline documenting the behaviors that led to a medication, or some other intervention, he said.

Another useful scale is the Cohen Mansfield Agitation Inventory. It provides "a wonderful thesaurus for 'agitation,' " Dr. Siegal said. It also allows the caregiver to give the physician a descriptive picture of what's happening with the patient. It only takes about 10-15 minutes to complete. The short form rates 14 areas of distressed behavior, including hitting, verbal aggression, grabbing, constant requests for attention, repetitive sentences, weird laughter, and hiding or hoarding things. The frequency of these behaviors is tabulated on a 5-point scale, from never to a few times an hour. Documenting the initial frequency allows the institution and the clinician to show what progress has occurred after a few weeks of intervention, he said.

Another scale that rates frequency and severity of behaviors is the Neuropsychiatric Inventory for Nursing Homes. The NPI is a little more difficult to complete but becomes easier with experience, Dr. Siegal said.

It has good concurrent reliability with both the Hamilton Depression Scale and the Behave-AD, he said, measuring behaviors in 12 domains. If the symptom has been present within the past month, the rater answers yes and then rates the frequency and severity on a 4-point scale and caregiver distress on a 0-5 scale. These scales are often used to establish baselines for medication-based intervention, but pharmaceuticals are not always necessary, Dr. Siegal said.

Sometimes, it's as simple as giving the patient a little attention, asking them how they are doing, and acquiescing to some requests, no matter how delusional they might seem. This approach can head off escalation and the need for a pharmacologic intervention, he said. ■

Pain Called a Major Sign of Depression in Older Patients

BY TIMOTHY F. KIRN
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SEATTLE — Pain complaints are so common in older patients with depression, and vice versa, that pain can be used as a signal to pick up depression that would otherwise be missed, Dr. Sumer Verma said at the annual scientific meeting of the American Geriatrics Society.

"Pain is a core symptom of depression, [and] physical symptoms are a major part of the depressive disorder," said Dr. Verma, director of the Geriatric Psychiatry Education Programs, McLean Hospital in Belmont, Mass. "Not recognizing them, and not taking account of them, is basically not diagnosing depression, and if you don't diagnose it, you are not going to treat it adequately."

A study of 1,146 patients who met criteria for a major depressive disorder found that 69% came to the doctor with just complaints of physical symptoms.

Most patients with depression are not treated aggressively enough, creating the impression treatment is not very effective, Dr. Verma said. Many patients are told they may stop their medication when they first have a response, but that is generally not long enough, he said.

There are several pain and depression studies, Dr. Verma explained at a symposium sponsored by Eli Lilly & Co.

One study of 1,146 patients who met criteria for a major depressive disorder found that 69% came to the doctor with just complaints of physical symptoms. In another study, of 685 patients meeting criteria for depression, 80% reported painful physical symptoms. And, finally, a survey that used data from 118,533 Canadian patients said that the strongest predictor of major depressive disorder was chronic back pain.

There also appears to be a direct correlation between depression and how many physical symptoms a person has. In one study, 1% of those individuals with no physical symptoms or one symptom were depressed. But the rate increased as the number of symptoms increased, until, among those who had nine or more symptoms, the rate was 48%.

In addition, a study in 2003 reported that depression tended to last much longer in those with painful physical symptoms, an average of 19 months, compared with those without pain for an average of 13 months.

This evidence means that older patients who have pain should be queried about mood and/or evaluated for depression, especially since depression is so common in the elderly, Dr. Verma said.

Despite the fact that acknowledgement of depression has improved in recent years, it is still vastly underaddressed, he added. In 2003, one report from a household survey of more than 9,000 persons found that only 22% of persons with a major depressive disorder received adequate treatment. In that study, 48% of those with a major depressive disorder received no treatment at all. Of those who received less than optimal treatment, 58% received inadequate treatment, and 42% received minimally adequate treatment.

The reason that so many patients are not adequately treated is because drug treatment often stops after a few months when the patient has a response, but also still has some symptoms. But, persons with some improvement who still have a few symptoms when their treatment ends have a threefold higher risk of relapse than those with no symptoms, Dr. Verma said. That same study also reported that patients with residual symptoms relapsed three times faster.

Patients need to be pushed all the way into remission, he said. That often means 8-9 months of aggressive treatment, and maybe longer.

"Once you've got someone responding, you've got to keep treating them with the same dose of the drug for at least 9 months," he said.

The drug chosen for a patient should be the one most likely to be effective, not the drug with the most acceptable side-effect profile, as many experts used to advise, he said. The most effective drug may be one the patient previously used that worked.

If one drug does not work, then another can be tried, he noted.

Remission can be judged by scores on standardized tests, but the definition of remission is the easiest metric to use in clinical practice, and the definition of remission is complete functional restoration, Dr. Verma said.

"What should be most important is that there are no symptoms or very few symptoms left, and the person is back to usual function. Anything short of that is inadequate treatment," he said.

When patients are treated aggressively, 65% will have significant improvement and fully 50% will achieve remission, he said. But the treatment must be aggressive. Moreover, in the patients with pain, the depression is more likely to be significantly improved by depression treatment than is the pain, but that is no reason not to do it, Dr. Verma said."Treat them to the point they are well, and keep them there," he said. ■