

Dementia, Depression Common in Assisted Living

BY KERRI WACHTER
Senior Writer

SAN JUAN, P.R. — Dementia and depression appear to be quite common among residents in assisted living facilities, based on two analyses of facilities in Maryland that were presented at the annual meeting of the American Association for Geriatric Psychiatry.

Both analyses looked at data from the Maryland Assisted Living Study that included 22 facilities—10 large facilities (more than 15 beds) and 12 small (15 beds or fewer). Assisted living facilities are regulated at the state level, and the levels of regulation vary widely.

For the Maryland Assisted Living Study, residents of assisted living facilities were evaluated by a geriatric psychiatrist, a nurse (who was experienced with dementia evaluation), and a research assistant specializing in psychometrics.

Comprehensive evaluations of residents included information from caregivers and family members, a clinical exam and history, assessment with quantitative scales (function, behavior, depression, medical comorbidity, quality of life, caregiver activity/burden), and neuropsychological battery.

A consensus conference specialist determined diagnoses for residents and assessed whether residents had been worked up and whether they were being treated appropriately.

In particular, participants were assessed using the Cornell Scale for Depression in Dementia (CSDD), a 19-item clinician-administered instrument that uses information from interviews with both the patient and a nursing staff member. Those with scores greater than 7 were considered clinically depressed. The General Medical Health Rating was used to describe comorbidity and health status.

In the first analysis, researchers looked at levels of depression among 196 residents of assisted living facilities. "This is an important study for several reasons, but it is the first comprehensive assessment of psychiatric disease in the assisted living industry," said Dr. Lea C. Watson, professor of psychiatry at the University of North

Carolina at Chapel Hill. Subjects were an average of 86 years old, and were primarily women (79%) and white (84%).

Overall, 24% (47 subjects) met the criteria for clinical depression and 8% (15 subjects) met the criteria for severe depression (CSDD score greater than 12). Roughly two-thirds (67%) of participants had dementia. The third of the participants who did not have dementia—those with Mini-Mental State Examination scores greater than 22—were evaluated with the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID IV). Of those, 13 met the criteria for depression.

Bivariate analysis revealed no differences between depressed and nondepressed individuals based on age, gender, number of social visits, or facility size. However, depressed individuals did have a greater number of comorbid conditions, required more assistance with activities of daily living, spent a greater number of days in bed per month, and participated in organized activities less frequently than did nondepressed individuals.

After the investigators controlled for several pertinent factors, (global health, supervision of activities of daily living, and social interaction), assistance with activities of daily living alone remained significantly associated with depression (odds ratio 3.8), while medical comorbidity showed a trend toward significance (odds ratio 1.9).

Only 43% of those who were currently depressed were being treated with antidepressants. Likewise, only 40% of those who were severely depressed were being treated with antidepressants. Those with depression were more likely to be treated

with antidepressants if they lived in a larger facility (51% vs. 17%).

"Interestingly, 60% of those in these facilities with depression had no source of psychiatric care," Dr. Watson said.

In the second analysis, researchers looked for any differences between large and small facilities for dementia frequency, detection, and management.

"Large facilities have most commonly arisen out of the hospitality industry and are more likely to be part of a chain," said Quincy M. Samus, a graduate student at Johns Hopkins University in Baltimore, who presented a paper for Dr. Iracema Leroi of the University of Manchester

(England), who could not attend the meeting. "Small facilities have evolved from the traditional board-and-care homes or group homes" for mentally ill individuals, Ms. Samus said.

This analysis included 198 residents (150 from large facilities and 48 from small facilities). Residents in smaller facilities were somewhat younger than were those in larger facilities—average age 82 years vs. 87 years.

Residents in both types of facilities were admitted primarily because of functional limitations. Those in large facilities were significantly more likely to be admitted for medical reasons than were those in small facilities.

Significantly more residents in small facilities had dementia than those in large facilities. Residents in small facilities also were slightly more likely to be diagnosed with Alzheimer's disease, though not significantly so, Ms. Samus said.

Almost all residents (98%) in small facilities had either dementia or some other psychiatric diagnosis. In comparison, 74% of those in large facilities had de-

mementia or some other psychiatric diagnosis. Likewise, residents in small facilities had more cognitive difficulties as measured by the Mini-Mental State Examination, with an average score of 13 compared with 20 for those in large facilities.

Residents in small facilities also had a greater number of behavioral symptoms, as measured by the Neuropsychiatric Inventory (17 vs. 10). More residents living in small facilities had psychotic disorders as well (10% vs. 1%). There were no differences in mood or anxiety disorders between the two facility sizes.

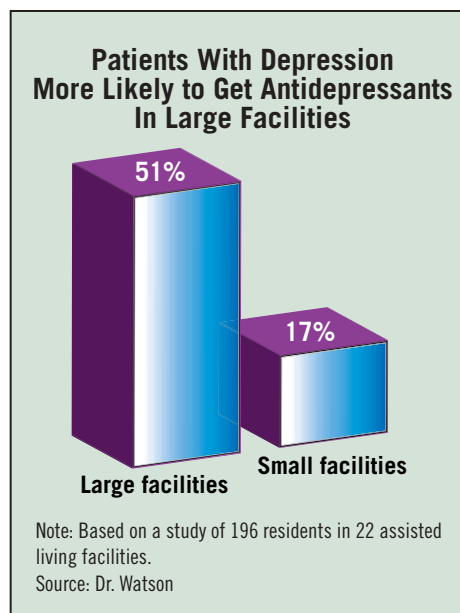
Of the 39 residents with dementia in small facilities, the caregiver was slightly more likely to recognize dementia symptoms than were family members. The opposite was true for the 95 residents with dementia in large facilities.

In terms of treatment, small and large facilities were comparable in the percentage of patients considered completely treated (around 50%). However, smaller facilities had a greater percentage of residents (41%) receiving at least partial treatment for dementia than those at large facilities (29%). These results were not statistically significant.

"Residents who are living in large facilities actually were more likely to have a private duty [caregiver] stay with them," Ms. Samus said. Residents in large facilities also were more likely to undergo physical therapy. Large facilities offered more activities for residents. Small facilities were more likely to use restraints and bedrails.

"Small care providers were actually spending more than 400 minutes a day caring, supervising, or doing activities of daily living with their residents compared with a little over 100 minutes for the large facilities," Ms. Samus said. The difference may be partly explained by the higher likelihood of having a private-duty caregiver at large facilities.

Residents at small facilities had fewer falls per month (0.13, compared with 0.33). No difference was found in emergency department visits in the last month. Also in the last month, residents of small facilities spent slightly more time in the hospital (0.65 days, compared with 0.5 days). ■



Testosterone Doesn't Significantly Improve Cognition, Study Finds

BY PATRICE WENDLING
Chicago Bureau

CHICAGO — Exogenous testosterone, taken either alone or with finasteride for 36 months, did not significantly improve cognition in a randomized, placebo-controlled trial involving healthy older men.

The findings do little to settle the debate over the effect of hormone therapy on cognition in elderly men. About half of randomized, controlled trials of testosterone therapy in older men have shown positive effects on cognitive function, particularly spatial cognition, Dr. Camille Vaughan said at the annual meeting of the American Geriatrics Society.

She presented data from a study in which 70 healthy men, aged 65-83 years, with low levels of testosterone (less than 350 ng/dL) and normal performance on the Mini-Mental State Examination (MMSE) were random-

ly assigned to receive one of three regimens: 200 mg of IM testosterone enanthate every 2 weeks with placebo pills; 200 mg of IM testosterone enanthate every 2 weeks with 5 mg of finasteride daily, or placebo injections and placebo pills.

At baseline, there were no significant differences in hormone levels between groups. Their mean age was 72 years. All patients had a MMSE score of 28 or higher, out of 30. Patients in the placebo group did have higher scores on the Spielberger State-Trait Anxiety Inventory, reported Dr. Vaughan, an internal medicine resident at Emory University in Atlanta, and colleagues.

Cognitive testing performed at baseline, 4 months, and 36 months included a comprehensive battery assessing attention, executive function, visuospatial skills, and visual and verbal memory skills. Serum hormone levels also were measured at the indicated intervals.

Sixty-nine men completed baseline testing, 65 com-

pleted at least 4 months, and 46 completed all 36 months.

Serum total testosterone, bioavailable testosterone, and estradiol levels increased significantly in the treatment groups throughout the study period. Hormone levels did not change for the placebo group at any time.

The three groups didn't demonstrate significant differences in cognitive performance on any of the tests at the 4-month or 36-month evaluations, Dr. Vaughan said.

There was a trend in the active treatment groups toward improved performance in the Benton Visual Retention Test and in visuospatial skills on the Visual Patterns Test. But scores were not significantly different from the placebo group at any time. All groups improved slightly over time on parts A and B of the Trail Making Test, but this was most likely due to the effects of practice, she said.

Further studies are warranted to determine if hormone therapy in men with preexisting cognitive impairment is beneficial, Dr. Vaughan concluded. ■