

**Mental Health in Old Age Bulletin
Issue 15**

Editorial Board: Alistair Burns, David Challis,
Judith Dennis and Jane Hughes

Contributors: Alistair Burns, Judith Dennis,
David Jolley, John Killick, Iracema Leroi and
Deborah Collins

Layout by: Sue Martin

Discussion Paper M130
May 2005

PERSONAL SOCIAL SERVICES RESEARCH UNIT

The University of Manchester

Dover Street Building
University of Manchester
Oxford Road
Manchester M13 9PL
Tel: 0161 275 5250

The University of Kent at Canterbury

Cornwallis Building
University of Kent at Canterbury
Canterbury
Kent CT2 7NF
Tel: 01227 823963/823862

London School of Economics

London School of Economics
Houghton Street
London
WC2A 2AE
Tel: 020 7955 6238

MENTAL HEALTH IN OLD AGE BULLETIN ISSUE 15

Editorial

Development of specialist services for older people with mental health problems ... 3

Article

Pharmacologic treatment of cognitive impairment and dementia in
Parkinson's disease 7

Current Key Issues

Cerebral emboli and paradoxical embolisation in dementia: a pilot study 13

Book Review

A guide to the spiritual dimension of care for people with alzheimer's
disease and related dementias: More than body 14

Website Review 15

EDITORIAL

Development of specialist services for older people with mental health problems

Old age psychiatry:

Specialist services for older people with mental health problems began to appear in the UK from the 1960s onwards.

They were for the most part created within the framework of a local mental health service, usually working from a base in a large mental hospital. There were exceptions, which used the geriatric medicine hospital base or a general hospital base. All had in common that they created a specialist mental health team for older people, which sought to work closely with other agencies addressing the health of the elderly: geriatric medicine, primary health care, the local authority, and voluntary and other agencies. A good deal of community activity was generated and although the hospital (mental hospital) base remained important, a major feature was to work with people in their own homes or in other settings including the wards of geriatric medicine, general hospital, residential home or nursing home.

Considerable use of 'partial hospitalisation', i.e. day hospitals or respite admissions became a feature of services. These initiatives were designed to enable people to remain at home and in contact with their families whilst, at the same time, reducing pressures upon families arising from the care necessary.

Services established during the 1960s and early 1970s were the product of enthusiasts and pioneers.

There was general agreement, strongly supported by the Health Advisory Service, that a great deal was achieved by such specialisation, and through the work of The Royal College of Psychiatrists and other agencies, a specialty of Old Age Psychiatry within the NHS became established by practice through the 1970s and 1980s, and confirmed on a formal basis in 1988.

It is now expected that every population within the UK will have a specialist Old Age Psychiatry Service. This will usually be part of the Mental Health Service but will have strong and effective links to other agencies concerned with the health, well-being and care of older people.

The size of population served by particular services varies considerably depending to a large degree upon local organisation. As a general rule, each service will be the sum of units of Community Mental Health Teams serving roughly ten thousand people over the age of 64 years, each team to include one whole time equivalent of a dedicated consultant old age psychiatrist and representatives of other disciplines. Within England, the publication of the NSF for Mental Illness and the NSF for Older People in 1999 and 2001 respectively, has generated new expectations for the future.

Latterly, Old Age Psychiatry Services have become more truly comprehensive. That is that they seek to take responsibility for most older people with mental health problems, including people with dementia of all age groups, though there may be established a specialist service for younger people with dementia (early onset dementia).

The majority of older people with mood disorders and paranoid states, problems of addiction, etc, will come to the specialist old age service. There is a progressive shift toward these services accepting, almost as a matter of routine, ongoing care of people who are now old but have had long-standing psychoses supported by general adult psychiatry up to their acquiring retirement age. These changes reflect an increase in growth of confidence and knowledge within the specialist Old Age Services. These derive from their ability to recruit, train and retain staff of all the appropriate disciplines.

In addition, the balance between what is provided by general psychiatry and old age psychiatry will depend on what is available locally and what is decided to be the best balance for the future.

The population to be served is almost always defined by geography. Most services aim to be co-terminus with other agencies working with older people, particularly the local authority, and sub-divide the population into segments or sectors for community work, each containing roughly ten thousand older people.

Whilst most Old Age Psychiatry Services began life in mental hospitals, this is now a very unusual place for them to be. All will have active involvement in community services but most have assessment and treatment beds on a general hospital campus. This may be sited within a mental health unit or within a health care of the elderly unit, or there may be combinations of the two.

There are strong arguments in favour of having assessment and treatment beds based in a general hospital. Many older people with mental health problems, particularly when they are in most severe difficulties, have both mental health and physical health problems and they will therefore benefit from the expertise of psychiatry and geriatric medicine or general medicine.

Similarly, it is the case that many older patients admitted to general hospitals with physical problems have an associated mental health problem, be it confusion, dementia or a mood disorder, and they too will benefit from input of a combined nature.

Nevertheless, there is a contrary move that is seeing mental health emphasising its involvement with community, liaison with primary care, liaison with local authority, social care and providing inpatient facilities in resource centres or community hospitals. This has the advantage that the mental health requirements of patients can be the prime consideration in planning and producing a milieu. The hustle and bustle, limited space and preoccupation with emergencies on the general hospital site can be difficult to live with.

Where units are placed away from a general hospital site, there is a need to establish appropriate supportive input from geriatric physicians or other specialists, and there is a need for there to be on site availability of competent medical staff.

For the most part, Old Age Psychiatry is managed as part of a mental health unit or directorate. However, there are increasing tensions, for the delivery of Old Age Psychiatry Services is very much more closely involved with other aspects of care of the elderly than other aspects of care of the mentally ill.

This is reflected in the NSF context: the NSF for Mental Illness excludes consideration of dementia and excludes consideration of the illnesses of late life. The NSF for Older People includes dementia and includes the mental health of late life as one of its standards. This suggests that there will be change in coming years to encourage the inclusion of Old Age Psychiatry within management arrangements for care of the elderly.

It will need to retain its status as part of the spectrum of services for the mentally ill.

Bibliography/reference sites

Laura.Morris@walsall.nhs.uk Contact for Black Country Mental Health network
www.creative-remedies.org.uk database of arts for health projects in the West Midlands.

www.nice.org.uk/pdf/ALZHEIMER_full_guidance.pdf

www.nnah.org.uk National Network in Arts and Health.

Audit Commission. Forget-me-not Mental Health Services for Older People 2001.

Challis D. et al. Care management study: Report on National Data. Department of Health 1998.

Clare et al. Cognitive rehabilitation.

Cochrane review in Cochrane library, Issue 4, 2001.

Department of Health. National Service Framework for Older People, Standard seven. 2001.

Department of Health (2003) The art of good health. The Stationery Office.

Forbes D.A. Strategies for managing behavioural symptomatology associated with dementia of the Alzheimer type; a systematic overview. Canadian Journal of Nursing Research, 30(2) 67-86, 1998.

Godkin M.D. and Onyskiw J.E. A systematic overview of interventions to reduce physical restraint use in long-term care settings. Online Journal of Knowledge Synthesis for Nursing, 6(6) 1999.

Help the Aged. Dignity on the Ward. Help the Aged and Sheffield School of Nursing and Midwifery. 1999.

Innes A. and Hatfield K.(2002) Healing arts therapies and person-centred dementia care. Jessica Kingsley. London.

Judd S Technology p144-149, in Marsall M. (edit) State of the Art in Dementia Care. Centre for Policy on Ageing . London 1997.

Kitwood T. (1997) Dementia reconsidered: the person comes first. Open University Press.

Levin et al. Families, services and confusion in old age. Avebury. Aldershot. 1989.

Lovestone S. Clinical genetics of Alzheimer's Disease. Chapter 3 (p31-44) in Howard R.(ed) Old Age Psychiatry, Wrightson. Petersfield 1999.

Lishman A. Alcohol and the brain. British Journal of Psychiatry, 156, 635-644, 1990.

Lishman A. Head Injury. Chapter 5 (p191-261) in Organic Psychiatry, the psychological consequences of cerebral disorder. Blackwell Scientific Publications. Oxford, 1978.

Liebson C.L. Rocca W.A. et al. Risk of dementia among people with diabetes mellitus. American Journal of Epidemiology 145, 301-308, 1997.

Mimori et al. Thiamine therapy in Alzheimer's Disease. Metabolic Brain Disease 11(1) 89-94 1996.

McKeith et al. Efficacy of rivastigmine in dementia with Lewy Body disease. Lancet 2000 356, 2031-2035.

Neal M.and Briggs M. Validation therapy for dementia. Cochrane Review in Cochrane Library Issue 4, 2001.

Opie J. et al. The efficacy of psychosocial approaches to behavioural disorders in dementia. Australian and New Zealand Journal of Psychiatry, 33, 789-799. 1999.

Ott A. Breteler M.M. et al. Prevalence of Alzheimer's disease and vascular dementia. British Medical Journal, 310, 970-973, 1995.

Pitchumoni S.S. and Doraiswamy P.M. Current status of antioxidant therapy for Alzheimer's Disease. Journal of the American geriatric Association 46(12) 1566-72 1998.

Roberts S. and Bond A. (1995) Arts in community care packages in Sandwell.

Rosequist K. Tariot P. and Loy R. Treatments for behavioural and psychological symptoms in Alzheimer's disease and other dementias. Chapter 45, (p 571-602) in : O'Brien J. Ames D. and Burns A. (eds): Dementia: 2nd edition. Arnold, London, 2000.

Royal College of Psychiatrists and Royal College of Physicians. The care of old people with mental illness 1998.

Royal College of Psychiatrist. Services for younger people with dementia. 2001
Smith R. (2002) Spend (slightly) less on health and more on the arts. British Medical Journal 325 1432-1433.

Spector A et al. Reminiscence therapy for dementia. Cochrane Review in Cochrane Library Issue 4, 2001.

Spector et al. Reality orientation for Dementia. Cochrane Review in Cochrane Library Issue 4, 2001.

Thorgrimsen L. Spector A. et al. Aroma Therapy for dementia. Cochrane review in the Cochrane library, Issue 4, 2001.

Vatassery G.T. Vitamin E and other endogenous antioxidants in the CNS. Geriatrics 53 (supplement 1) 25-27 1998.

Whalley L.J. Can dementia be prevented? Practitioner, 242, 34-38, 1998.

David Jolley

Director, Dementia Plus
WOLVERHAMPTON
email: dessjol@yahoo.co.uk

ARTICLE

Pharmacologic treatment of cognitive impairment and dementia in Parkinson's disease

Introduction

Parkinson's disease is defined by the motor features of tremor, bradykinesia, and rigidity, and is almost invariably (in up to 93% of PD patients) associated with some degree of cognitive impairment. As the disease progresses, about 75% of PD patients develop more widespread and severe impairments and the prevalence of frank dementia ranges from 15-30%. In the earlier stages of the disease, the deficits manifest in the domains of attention, recall, visuospatial, and executive functioning (Pirozzolo *et al.*, 1982). The dementia syndrome in PD is commonly characterized as a progressive dysexecutive syndrome with memory deficits in the absence of aphasia, apraxia, or agnosia. The underlying pathophysiology of frank dementia syndromes in PD is not uniform and includes dementia due to "mixed" pathology, the presence of Lewy bodies, vascular pathology, and Alzheimer disease-type changes.

Today there are several treatments for the primary motor symptoms of the disease as well as the frequently occurring psychiatric disturbances; however, there are no definitive treatments for the cognitive symptoms or their progression. This is unfortunate because it is well established that compared to non-demented PD patients, those who develop dementia have a significantly worse prognosis: they respond less well to anti-Parkinsonian medications; have worse psychosis; are admitted to nursing homes sooner; and have a higher mortality rate. The following article discusses established and potential pharmacologic treatments for patients suffering from dementia and cognitive impairment associated with PD.

Pharmacologic strategies for treatment of dementia in PD

Cholinesterase inhibitors

Significant subsets of PD patients, particularly those with dementia, have been found to have cholinergic deficits due to neuronal loss in the nucleus basalis of Meynert. In addition, brain histology in some reveals Alzheimer-like pathology such as neuritic plaques, neurofibrillary tangles, and granuolovacuolar degeneration (Hakim, 1979). Reports that cholinesterase inhibitors (CIs) are beneficial for the cognitive and neuropsychiatric symptoms in Alzheimer's disease (AD) and Lewy Body Dementia (DLB), without aggravating parkinsonism have provided impetus for attempts at reversing this cholinergic deficit in PD (Cummings, 2000). Hence, treating dementia in PD with cholinergic augmentation is a reasonable strategy.

The first report of the use of a CI in a parkinsonian-dementia syndrome was by Levy *et al.* (1994). They demonstrated a positive response of patients with DLB to tacrine, a reversible, non-competitive CI with a short half-life. Tacrine is relatively non-selective in that it binds to both acetylcholinesterase (AChE) and butyrylcholinesterase (BChE). Unfortunately, the utility of tacrine is limited, even in AD, due to its unacceptable side effects. In spite of this, later reports of open trials of tacrine in PD patients with dementia were undertaken and had the treatment of hallucinations as a primary outcome measure. Significant improvements in both cognition and psychosis were reported. Motor function did not appear to be compromised (Hutchinson and Fazzini, 1996, Weber and Rabey, 2001).

Galantamine, a CI with dual mechanism of action (acetylcholinesterase inhibition and allosteric nicotinic receptor modulator) has been studied in at least two open trials of up to 15 PDD patients (Aarsland *et al.*, 2003 and 2002). In both studies, global cognition and hallucinations were felt to have improved in a majority of the PD patients. The effect on motor function was mixed with some patients deteriorating slightly and others showing a marked improvement.

Donepezil, which is the most widely prescribed agent for cognitive impairment due to Alzheimer's disease, is a reversible, non-competitive CI. Compared to tacrine and galantamine, donepezil more selectively blocks AChE, and therefore has fewer peripheral cholinergic effects. One case report, four prospective open-label studies, and three randomized placebo-controlled, double-blind investigations (RCTs) have been conducted for donepezil in PDD and reveal mixed findings. The most robust RCT examining donepezil's efficacy and safety in PDD is our own study in which we examined 16 PD patients over a mean of 13 weeks (Leroi *et al.*, 2004). We used

various outcome measures, including assessments of global cognition (MMSE and Dementia Rating Scale (DRS)) and a detailed neuropsychological battery. There was no difference from baseline to termination visit in measures of global cognition in either of the donepezil or control groups. However, the donepezil group improved significantly in the DRS memory sub score compared to controls ($p < 0.5$). There was also a trend toward improved performance in the Trail Making Test (TMT-A) (Partington, 1949) in the donepezil group, whereas the control group actually performed slower from baseline to termination visit. The TMT-A is a measure of cognitive processing speed and attention. Unfortunately, the drop-out rate from both the donepezil and the control groups was high, as reflected by only 62.5% of the patients completing the full 18 weeks of the trial, rendering the findings of this study less robust.

The most extensively studied of the CIs in PDD is rivastigmine. Like tacrine, rivastigmine is an inhibitor of both AChE and BchE, and therefore may be clinically more effective than the other more selective CIs. Rivastigmine may also target frontal brain regions, deficits in which could underlie the executive dysfunction seen in PD patients. There are now several studies of rivastigmine specifically targeting PDD (Bullock and Cameron 2001; Giladi *et al.*, 2003; Reading *et al.*, 2002). These open label studies and case series have laid important groundwork in the pharmacotherapy of PD. However, the gold standard has now been set with the publication of the EXPRESS study, a large double-blind, placebo-controlled trial of rivastigmine in PDD (Emre *et al.*, 2004). In this, 541 PDD patients, on either rivastigmine or placebo, were examined over a 16-week period and maintained for a further 8 weeks. Results showed that rivastigmine provides significant improvements in patients with mild to moderate PD dementia across all symptom domains with effect size similar to studies of rivastigmine in Alzheimer disease.

In summary, CIs in general provide an intriguing and apparently useful therapeutic option for the treatment of cognitive impairment, and possibly psychosis in PD. Aside from the multi-centred RCT of rivastigmine, the level of evidence supporting the use of these agents in PD is still quite poor due to the small number of subjects enrolled in the studies and the relative lack of detailed outcome measures. Hence, if CIs are to be used in this population, very low doses and slow titration should be employed with careful monitoring of the patient's clinical, particularly motor, condition.

Glutamate antagonists

Dopamine deficiency is the hallmark lesion in PD and gives rise to imbalances in other, particularly glutaminergic, neurotransmitter systems. It is possible, therefore, that blocking glutamate input to the striatum with NMDA receptor antagonists improves motor functioning and protects against glutamate-mediated toxicity, the latter of which is thought to play a role in the pathogenesis of Parkinson's disease dementia. Hence, memantine, a glutamatergic modulator, may be useful in the management of PDD. It is a low affinity, noncompetitive NMDA antagonist already shown to be effective in improving functional ability and caregiver burden in Alzheimer disease (Winblad, 1999). Memantine has been previously studied in PD patients in a few trials and has been well tolerated (Rabey *et al.*, 1992; Merello, 1999; Schneider, 1984). However, until recently, the outcome measures in these studies focused on change in motor symptoms only. Two small recent open trials

have mentioned the use of memantine in PDD, and showed moderate tolerability and improvement in global cognition (Lokk, 2004; Levin *et al.*, 2004). A RCT of memantine in PDD is currently underway by our group (Leroi and colleagues) at the University of Manchester, and preliminary results will soon be available.

Another NMDA receptor antagonist, amantadine, is much more widely used in PD for the management of dyskinesias. In contrast to memantine, amantadine has often been reported to cause confusion and even delirium, particularly on withdrawal (Factor *et al.*, 1998). However, in spite of this, amantadine might have a role in the management of mild executive dysfunction in early stage PD since there are some reports of amantadine improving executive function in non-PD dementia patients (Drayton *et al.*, 2004). This has not yet been formally examined in a clinical trial.

Noradrenergic agonists

PDD also involves deficits in norepinephrine (NE) and its metabolites (Cash *et al.*, 1987). Hence, pharmacological strategies that modify NE levels may have a role in the treatment of PDD. Such strategies include the use of naphthoxazine, a selective noradrenergic alpha 1 agonist, which has been shown to improve attentional deficits in PD (Bedard *et al.*, 1998). Atomoxetine, a new and highly selective inhibitor of the presynaptic norepinephrine transporter, has been shown to improve executive functioning, attention, and impulsivity in patients with attention deficit disorder. It is currently being studied in PDD, particularly with the aim of improving dysexecutive syndromes (Marsh, verbal communication). However, before such agents can be used to clinically manage patients with PDD, careful evaluation of their efficacy and safety is critical.

Neuroprotective agents

Piracetam, deprenyl, tocopherol, and phosphatidylserine agents have been studied as neuroprotective agents, but have not shown efficacy for the improvement of cognitive impairment in PD (Anderson, 2004).

New agents

Novel “bifunctional” neuroprotective drugs such as ladostigil (TV3326), which is currently in Phase II studies, combine the neuroprotective activity of rasagiline (VK-28, an anti-Parkinsonian iron chelator) with acetyl and butyryl cholinesterase inhibitor activity (Youdim *et al.*, 2003). Hence, these agents may potentially increase brain cholinergic, dopaminergic and serotonergic activity as well as reverse the ongoing neurodegeneration seen in PD. These agents may prove to be more efficacious than the current cholinesterase inhibitors but still have to be formally studied in PDD.

Summary and recommendations

The cornerstone of effective management of dementia in PDD is individualized treatment. As is always the case in dementia care, the first step in a treatment plan is to rule out and correct any reversible problems such as urinary tract and other infections, and sensory deprivation. Next, anticholinergic medication and delirium-causing agents such as amantadine should be tapered and discontinued wherever

possible. Management of motor impairment should be optimised with L-DOPA and the dopamine agonists while remaining alert to the potential for inducing psychosis and delirium. Finally, if these steps do not result in an improvement in cognitive functioning, the careful use of a CI on a case by case basis can be considered. The key to successful use of the CIs in PDD is to start with very low doses and slowly titrate up. The drug treatment plan should be complemented by basic multidisciplinary dementia care such as carer support, education and respite.

References

Aarsland D, Hutchinson M, Larsen JP. Cognitive, psychiatric and motor response to galantamine in Parkinson's disease with dementia. *International Journal of Geriatric Psychiatry* 2003;18:937-941.

Aarsland et al. Donepezil for cognitive impairment in PD: a RCT study. *J Neurol Neurosurg Psychiatry* 2002;72:708-712.

Anderson KE. Dementia in Parkinson's Disease. *Current Treatment Options in Neurology* 2004;6:201-207.

Bedard MA, el Massioui F, Malapani C, Duboid B, Pillon b, Renault B et al. Attentional deficits in Parkinson's disease: a partial reversibility with naphthoxazine (SDZ NV1-085), a selective noradrenergic alpha 1 agonist. *Clin Neuropharmacol* 1998;21(2):108-17.

Bullock R, Cameron A. Rivastigmine for the Treatment of Dementia and Visual Hallucinations Associated with Parkinson's Disease; A Case Series. *Current Medical Research and Opinion* 2002;18(5):258-264.

Cash R, Dennis T, L'Heureux R et al. Parkinson's disease and dementia: norepinephrine and dopamine in locus coreuleus. *Neurology* 1987;37:42-46.

Cummings JL. Cholinesterase inhibitors: expanding applications. *The Lancet* 2000;356(9247):2024-2025.

Drayton SJ, Davies K, Steinberg M, Leroi I, Rosenblatt A, Lyketsos CG. Amantadine for executive dysfunction syndrome in patients with dementia. *Psychosomatics* 2004;45(3):205-9.

Emre M, Aarsland D, Albanese A, Byrne EJ, Deuschi G, De Deyn P et al. Rivastigmine for Dementia Associated with Parkinson's Disease. *The New England Journal of Medicine* 2004;351:2509-18.

Factor SA, Molho ES, Brown DL. Acute delirium after withdrawal of amantadine in Parkinson's disease. *Neurology* 1998;50(5):1456-1458.

Folstein MF, Folstein SE, McHugh PR. "Mini-Mental state". A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;12(3):189-98.

Giladi N, Shabtai H, Gurevich T, Benbunan B, Anca M, Korczyn AD. Rivastigmine (Exelon) for dementia in patients with Parkinson's disease. *Acta Neurol Scand* 2003;108:368-373.

Hakim AH, Mathieson G. Dementia in Parkinson's disease: a neuropathological study. *Neurology* 1979;29:1209-1214.

Hutchinson M, Fazzini E. Cholinesterase inhibition in Parkinson's disease. *J Neurol Neurosurg Psychiatry* 1996;61(3):324-5.

Leroi I, Brandt J, Reich S, Lyketos C, Grill S, Thompson R et al. Randomized placebo-controlled trial of donepezil in cognitive impairment in Parkinson's disease. *Int J Geriatr Psychiatry* 2004;19:1-8.

Levin OS, Amosova NA, Naimushina TV, Smolentseva IG. [Comparative study of Parkinson's disease and dementia with Lewy Bodies]. *Zh nevrol Psikhiatr Im S S Korsakova* 2004;104(1):3-10.

Levy R, Eagger S, Griffiths M et al. Lewy bodies response to tacrine in Alzheimer's disease. *Lancet* 1994;343:176.

Lokk J. [Memantine can relieve certain symptoms in Parkinson disease. Improvement achieved in two out of three described cases with dyskinesia and cognitive failure]. *Lakartidningen* 2004;101(23):2003-6.

Mattis S. Mental status examination for organic mental syndrome in the elderly patient. In: Bellak L, Karasu T, eds. *Geriatric psychiatry: a handbook for psychiatrists and primary care physicians*. New York: Grune & Stratton, 77-101.

Merello M, Nouzeilles MI, Cammarota A, Leiguarda R. effect of memantine (NMDA antagonist) on Parkinson's disease: a double-blind crossover randomized study. *Clin Neuropharmacol* 1999;22(5):273-6.

Pirozzolo FJ, Hansch EC, Mortimer JA, Webster DD, Kuskowski MA. Dementia in Parkinson's disease: a neuropsychological analysis. *Brain Cogn* 1982;1(1):71-83.

Partington, J.E. & Leiter, R.G. Partington's Pathway test. *The Psychological Service Centre Bulletin* 1949;1:9-20.

Rabey Jm, Nissipeanu P, Korczyn AD. Efficacy of memantine, an NMDA receptor antagonist, in the treatment of Parkinson's disease. *J Neural Transm park Dis Dement Sect* 1992;4:277-82.

Reading PJ, Luce AK, Mc Keith IG. Rivastigmine in the Treatment of Parkinsonian Psychosis and Cognitive Impairment: Preliminary findings from an Open Trial. *Movement Disorders* 2001;16(6):1171-1195.

Schneider E, Fischer PA, Clemens R, Balzereit F, Funfgeld EW, Haase HJ. [effects of oral memantine administration on Parkinson symptoms. Results of a placebo-controlled multicenter study]. *Dtsch Med Wochenschr* 1984;109(25):987-90.

Weber EA, Rabey JM. The beneficial effect of cholinesterase inhibitors on patients suffering from Parkinson's disease and dementia. *J Neural Transm* 2001;108(11):1319-25.

Winblad B, Poritis N. Memantine in severe dementia: results of the 9M-Best Study (Benefit and efficacy in severely demented patients during treatment with memantine). *Int J Geriatr Psychiatry*. 1999 Feb;14(2):135-46.

Youdim BHM, Amit T, Bar-Am O, Weinstock M, Yogev-Falach M. Amyloid Processing and Signal Transduction Properties of Antiparkinson-Antialzheimer Neuroprotective drugs rasagiline and TV3326. *Ann. N. Y. Acad. Sci* 2003;993:378-386.

Iracema Leroi

email: ileroi2002@yahoo.co.uk

CURRENT KEY ISSUES

Cerebral emboli and paradoxical embolisation in dementia: a pilot study

Purandare N., *et al.* (2005) Cerebral emboli and paradoxical embolisation in dementia: a pilot study. *International Journal of Geriatric Psychiatry* 20: 12-16.

This study reports the results of a pilot project looking at venous to arterial shunts in people with dementia. Twenty-four people with Alzheimer's disease and 17 people with vascular dementia, along with 16 controls had a transcranial Doppler examination and an assessment of the presence of a venous to arterial circulation shunt (usually a patent foramen ovale or hole in the heart). Emboli were found in nearly 30% of people with dementia and 7% of controls, being more frequent in people with vascular dementia, and a venous to arterial circulation shunt was found in 61% of patients and 44% of controls. This pilot study suggests that cerebral embolisation and venous to arterial circulation shunts are common in both types of dementia and probably marginally more so in people with dementia of a vascular type. This study clearly has implications for assessment and management of people with dementia from a vascular point of view.

Alistair Burns

Professor of Old Age Psychiatry

University of Manchester

email: a.burns@manchester.ac.uk

BOOK REVIEW

A guide to the spiritual dimension of care for people with Alzheimer's Disease and related dementias: More than body

Eileen Shamy, *A guide to the spiritual dimension of care for people with Alzheimer's Disease and related dementias: More than body* Jessica Kingsley Publishers, 2003, 224 pp. Pbk ISBN 1 84310 129 7

Eileen Shamy's book has a cumbersome title, and a confused structure. It is not the first book in the field: that honour goes to Debbie Everett, a pioneer work that is much better organised. But that title is not available in the UK. This book was brought out first in the author's native New Zealand in 1997, and has now been given a new life from Jessica Kingsley. It has named editors (Eileen Shamy died before her book first came out) but their timidity has led them to tinker with the NZ references but not to attempt a wholesale reorganisation.

What do I mean by 'confused' in relation to this text? Well Chapter 2 titled 'Understanding Alzheimer's Disease and Other Primary Dementias' begins with brief descriptions of kinds of dementias, an account of the development of these based on Reisberg's stages theory (discredited), a glossary of terms such as acalculia, prosopagnosia and agraphia (of no earthly use to the ministry and lay people for whom this text is avowedly intended, or apparently to the author herself), and concludes with a moving account of the onset of her mother's dementia, which should have come in Chapter 1.

It isn't all as messy as this. Chapters 5 and 6 are the best of the bunch. The first of these 'Being Present to the Person With Dementia' is the longest in the book and is to all intents and purposes a consideration of Communication and related matters. As such it should have come earlier but it is would be welcome anywhere. The author takes us through concepts such as mutuality, acceptance, identity, relationship, orientation, affirmation, memory cueing, the use of symbols, touch and humour. There is a discussion of mirroring which Shamy calls 'mimesis', and a most interesting account of the use of a clown doll to enhance interaction.

Chapter 6 'Caring for the Care Giver' makes an important contribution to the literature. Shamy takes us through the various burdens caregivers face, most of them familiar but well-rehearsed here with telling examples, and then moves into a neglected area: that of the transitions of care, most notably that of home to institutional care. She places special emphasis on this as a time of difficult adjustment for family members as well as individuals with the condition, and provides examples of religious services which could be used to aid the process.

So this book is a kind of hold-all. You can pick out items of real value from its pages, but you have to seek them out, and they aren't always in the context where you would expect to find them. There are lots of good anecdotes and they are unfailingly well told. What does give the text a certain unity, and causes one to forgive many of its blemishes, is the undoubted sincerity and warmth of its author. The spirit of Eileen Shamy shines out from these pages and carries its own message of passionate concern.

Reference

Debbie Everett Forget Me Not: The Spiritual Care of People with Alzheimer's Disease Edmonton, Inkwell Press 1996

John Killick

Writer in Residence
Dementia Services Development Centre
University of Stirling
email: e.j.killick@stir.ac.uk

WEBSITE REVIEW

Spirituality and Dementia

The Park Ridge Center is an independent, nonprofit, non-sectarian organisation which explores the interaction of health, faith and ethics through research. They produce a resource list on spirituality and dementia which is available at www.parkridgecenter.org. There is also an online article about the relationship between personhood, self-identity and God in persons with Alzheimer's Disease at www.parkridgecenter.org/Page482.html, and one on spiritual traditions and aging, in which seven issues concerned with how older people experience the religious and spiritual aspects of life are identified, see www.parkridgecenter.org/Page109.html. From this site is a link to 'a comprehensive collection of spirituality links to organisations providing resources and services for health care professionals and care givers'; this may be consulted at the site of an organisation called Alternative Solutions in Long Term Care www.activitytherapy.com/spirit.htm. They also produce a listing of resources (books and articles) on the subject at www.activitytherapy.com/spiritlist.htm. There is a link to the Center for Aging, Religion and Spirituality www.aging-religion-spirituality.com. This body provides educational programmes, consumer research and publishes items which explore the relationship between aging and spirituality. There is also a link to www.nfcacares.org which makes available three downloadable faith services (Interfaith, Lutheran and Catholic) to use for worship with caregivers (follow the How to Guides on the Home Page). An article about providing pastoral, caring ministry to people suffering from AD is also linked from this site. It helps build a theological foundation for the spiritual care of persons with AD and offers practical advice on conducting home visits and worship services. The discussion is divided by the stages of the disease.

Dementia Voice in Bristol, UK have produced a report based on their project on the spiritual care of people with dementia; it is to be found at www.dementia-voice.org.uk/spiritualityreport.doc.

A short article called God and memory: can dementia and spirituality co-exist? Is published by the US based Golden Years Consultants at www.goldenyearsconsultants.com/dbfiles/God and Memory 020823.doc.

Available from Medscape General Medicine is an online article which tells about a Rabbi praying the Vidui – a Jewish confession of one's sins- for his dying father who

has AD. This article may be freely viewed, but initial registration is required, www.medscape.com/viewarticle/450696.

The text of an interview with Stephan Sapp, who serves on the Ethics Advisory Panel of the US Alzheimer's Association and has lectured widely on AD called Dementia, Religion and Spirituality is available from the online journal Advice and Advances at www.agelessdesign.com.nL/vol20/Spirit-Winter02-03.htm.

Other helpful material is available from Alzheimer's Disease Associations in the UK, US and Australia. The US Alzheimer's Association provides a list of resources on this topic at www.alz.org/Resources/Resources/rtrls spir.asp : this comprises a list of articles and theses, giving an indication of the kind of research taking place in this area. From this site is a link to an article produced by the Mayo Clinic Staff on spirituality and AD; this may be viewed at www.mayoclinic.com/invoke.cfm?objectid=8E184EA1-DOC2-459A-891CE75B96C2D3DD .

There is also a link to an online version of a 2004 article from First Things: the Journal of Religion, Culture and Public Life entitled Alzheimer's and Grace. This is at www.firstthings.com/ftissues/ft0404/opinion/post.html.

Google has produced an html version of a PowerPoint presentation of the Australian Alzheimer's Association Conference held in March 2003 on Dementia, Spirituality and Finding Meaning; view this at [www.google.com/search?q=cache:uBSNNa/HIK8J:alzheimers2003:conferencemedi a.com.au/CMWS/03-034/ppt/Garrat\(Weds1100\).pps+spirituality+dementia+hl=en](http://www.google.com/search?q=cache:uBSNNa/HIK8J:alzheimers2003:conferencemedi a.com.au/CMWS/03-034/ppt/Garrat(Weds1100).pps+spirituality+dementia+hl=en)

The UK Alzheimer's Association offers a report published in 2002 of a study undertaken jointly by Dementia North and Northumbria University in pdf format about Younger People with Dementia. This includes consideration of their spiritual needs, www.alzheimers.org.uk/Younger-people-with-dementia/PDF/YPwD%20evaluation%20report.pdf.

Judith Dennis

Library and Information Officer
North West Dementia Centre / PSSRU
email: judith.dennis@manchester.ac.uk

Mental health disorders are complex and can take many forms. The underlying sources of the data presented in this entry apply specific definitions (which we describe in each relevant section), typically in accordance with WHO's International Classification of Diseases (ICD-10). This broad definition incorporates many forms, including depression, anxiety, bipolar, eating disorders and schizophrenia. Mental health disorders remain widely under-reported in our section on Data Quality & Definitions we discuss the challenges of dealing with this data. This is true across all countries, but particularly in the U.S. *Psych Bulletin*. Volume 45 Issue 2. Patients with young-onset dementia in an older people's English Français. Although the incidence of dementia increases with age, those who develop dementia at a young age have a different profile of diagnosis compared with older people. A greater proportion of YoD patients suffer from frontotemporal lobar degeneration, and they may experience delays in diagnosis. Reference Mercy, Hodges, Dawson, Barker and Brayne³, Reference van Vliet, de Vugt, Bakker, Pijnenburg, Vernooij-Dassen and Koopmans⁴ Furthermore, studies have shown a higher neuropsychiatric symptom burden and greater carer stress. Reference Bakker, de Vugt, van Vliet, Verhey, Pijnenburg and Vernooij-Dassen⁵. lead commissioner for mental health in West Suffolk. *The Bulletin on Health*. *The Bulletin on Entrepreneurship*. Periodicals Archive. *Data & Business Cycles*. Issue Date October 2015. In many developed countries, children now begin their formal schooling at an older age. However, a growing body of empirical studies provides little evidence that such schooling delays improve educational and economic outcomes. However, the estimated effects of school starting age on other mental-health constructs, which have weaker links to subsequent student achievement, are smaller and less persistent. *Why Mental Health Issues Are Not Addressed with the Elderly*. Despite what the statistics reveal, it can be difficult to pick up on mental health issues among seniors because of the unique age-related health and life challenges they face. Sometimes symptoms can be very subtle or attributable to a variety of other health conditions or life changes. Additionally, older adults are less likely to notify a health care provider of symptoms related to mental health problems than for physical symptoms they are experiencing. This can be due to the stigma attached to mental health problems, or because they... Risk Factors for Anxiety Disorders in Old Age. Anxiety in the elderly is linked to a number of risk factors, including but not limited to: [ix]. *Mental Health Problems in Older Adults*. It is estimated that 20% of people age 55 years or older experience some type of mental health concern (6). The most common conditions include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder) (6). Mental health issues are often implicated as a factor in cases of suicide. This issue brief reports on six indicators related to mental health that were part of the 2006 BRFSS survey, both from core questions and the Anxiety and Depression module. Data are provided for the U.S. population age 50 years or older, with a focus on age, racial/ethnic differences, and sex. such as smoking, physical inactivity, and heavy drinking (10). Nearly 95% of adults age 50 or older reported being "satisfied" or "every".