Keywords: advanced dementia, electroconvulsive therapy, agitation, aggression, BPSD, vulnerable population, decisional capacity, surrogate decision making

Topic: Capacity

Abstract:

Agitation is experienced by over 90% of individuals with Alzheimer's disease (AD) which increases morbidity and mortality and contribute to caregiver burden. There are no FDA-approved treatments for severe agitation in people with advanced dementia. Behavioral interventions are first-line management strategies but are not effective in the most severely agitated patients. Off-label use of psychotropic medications have limited efficacy and risk for adverse effects. New management strategies for severe agitation in AD refractory to psychopharmacologic and behavioral interventions are timely and warranted. Preliminary studies provide evidence for the safety and efficacy of acute electroconvulsive therapy (ECT) in reducing agitation in this population.

The ECT-AD study is a multi-site NIH-funded randomized single-blind randomized controlled trial to investigate the safety and efficacy of ECT in severe and treatment refractory agitation and aggression in AD. In a vulnerable population with advanced dementia and lack of capacity to provide informed consent, there are ethical and consent issues that need to be considered. In this presentation, we will describe the human research subject aspects of working with this population, the process of informed consent and variation of state laws, and efforts to ensure participant safety and minimize undue influence or coercion.

214 - End-of-life decision-making capacity in older people with serious mental illness

Carla Kotzé, Louw Roos, René Ehlers

ABSTRACT

Objectives:
The study's main aim was to assess the end-of-life decision-making capacity and health-related values of older people with serious mental illness.

Design, Setting, and Participants:
This was a cross-sectional, observational study, done at Weskoppies Psychiatric Hospital, Gauteng Province, South Africa that included 100 adults older than 60 years of age and diagnosed with serious mental illness.

Measurements:
Socio-demographic, diagnostic, and treatment data were collected before administration of the Mini-Cog and a semi-structured clinical assessment of end-of-life decision-making capacity. Finally, the standardized interview, Assessment of Capacity to Consent to Treatment, was administered. This standardised instrument uses a hypothetical vignette to assess decision-making capacity and explores healthcare-related values.

Results:
According to the semi-structured decision-making capacity assessment, 65% of participants had decision-making capacity for end-of-life decisions. The Assessment of Capacity to Consent to Treatment scores were significant ($p<0.001$) when compared to decision-making capacity. Significant correlations

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with impaired decision-making capacity included: lower scores on the Mini-Cog (p<0.001); a duration of serious mental illness of 30-39 years (p=0025); having a diagnosis of schizophrenia spectrum disorders (p=0.0007); and being admitted involuntarily (p<0.0001).

Conclusions:
Two thirds of older people with serious mental illness had decision-making capacity and were able to engage in end-of-life care discussions. Healthcare providers have a duty to initiate advance care discussions, optimize decision-making capacity, and protect autonomous decision-making. Chronological age or diagnostic categories should never be used as reasons for discrimination, and older people with serious mental illness should receive end-of-life care in keeping with their preferences and values.

Keywords: End-of-life, decision-making capacity, values, elderly, serious mental illness

215 – ECN Awards: Anticholinergic Burden: A Study in a Psychiatry of Later Life Cohort

Liam C. Kennedy, Chinyere Nwogbunyama

Background
Medications with anticholinergic activity are widely prescribed for a variety of medical, surgical, and psychiatric illnesses. There is strong evidence that the cumulative anticholinergic properties of such medications (i.e., the anticholinergic burden) contributes to significant longer-term adverse effects, including dementia, impaired mobility, and increased mortality. Despite this, the anticholinergic burden is often not given due consideration when cliniciansprescribe or review medications in routine clinical practice. This is of particularrelevance in services working with elderly patient populations, who are both more likely to experience polypharmacy and more vulnerable to medication adverse effects. Greater awareness of the risks of anticholinergic prescribing may lead to improvements in longer-term cognitive and physical functioning,and subsequently decreased disease burden on individuals and society as a whole.

Objectives/Aims
To identify and quantify anticholinergic burden among all patients currentlyattending a rural Psychiatry of Later Life service.

Methods
This was a cross-sectional observational study. Chart reviews were carried out on all patients open to the service at the time of the study in November 2020. Each patient's medication regime was analysed to calculate its overall score onthe Anticholinergic Effect on Cognition Scale (AEC), using an online tool developed by South London and Maudsley NHS Foundation Trust. Other variables such as each patient's age, sex, and cognitive status (categorized as no cognitive impairment; mild cognitive impairment (MCI); or dementia) were also documented. Data was anonymised on collection. AEC scores of 2 or morewere deemed to be at threshold for 'review and withdraw or switch' of medications.

Results
A total of 80 patients were included in the study (48 female; mean age 77 [SD = 6.5] years). 45% of patients had a documented diagnosis of dementia, 11%had a documented diagnosis of MCI and 44% had no documented cognitive impairment. Overall, the majority of patients (53.75%) were found to have an AEC score of 2 or greater (AEC range

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