

5.3 Assess cognition



Cognition is a process associated with thinking, that includes reasoning, remembering, judgement, problem-solving and planning. An important step, before any diagnostic tests for cognition, is to identify and treat any reversible causes (◆). → 5.5

Almost all standard cognitive assessments used for the basic assessment or diagnosis of cognitive decline assume a minimal amount of education (Table 5.1, p. 55). If a person has low levels of education, or they are illiterate, cognitive assessment can be limited (24)(25). Other sociocultural factors, such as language to be used and socioeconomic status, can also affect the efficacy of an assessment. These factors should be considered and where necessary interview and clinical judgement should be used instead. For these individuals, enrolling in an adult literacy programme (if available) is highly recommended, as it promotes brain health.

The care pathway outlines two different paths based on the results of an in-depth cognitive assessment. Those assessed to have normal cognition should still be assessed for diseases and risk factors and social and physical environments.

A person with cognitive decline, should also be assessed for difficulty with ADL or instrumental activities of daily living (IADL). Their basic assessment results for other linked domains of intrinsic capacity, such as limited mobility, hearing loss and depressive symptoms should also be verified and an in-depth assessment conducted as necessary. → 6 9 10 This information is important for integrating interventions related to other losses in intrinsic capacity and social care and support needs as part of a personalized care plan. → 11

5.4 Manage cognitive decline



Interventions to manage cognitive decline should always be provided as part of a comprehensive personalized care plan addressing the underlying diseases (e.g. CVD), symptoms such as delirium and risk factors, along with interventions that address other domains of intrinsic capacity.

For a person with dementia, a more specific, targeted or tailored approach is appropriate. Referral to those with specialized knowledge might be needed in cases with multiple associated diseases or delirium and with behavioural and psychological symptoms such as walking about, apathy, agitation, aggression, delusions and hallucinations.

In addition to physical exercise and cognitive stimulation, which can be provided in the community, there are multiple other ways to manage cognitive decline. Cognitive stimulation therapy, cognitive training, CBT, and referral to rehabilitation services (→ 4.2.1), should be considered in alignment with the WHO *Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders*. These interventions are often provided by psychologists or occupational therapists, but can be delivered by a trained health worker at a primary care facility with supervision. Local protocols should be applied for referral to specialists.

Prescription of anti-dementia medicines for cognitive decline without diagnosis of dementia is not recommended. Health workers need to be trained and supervised to ensure competence in diagnosis and monitoring for the prescription of anti-dementia medicines.

5.4.1

Cognitive stimulation therapy

Cognitive stimulation therapy encompasses a variety of approaches including reality orientation, validation, and/or reminiscence. The standard group approach emphasizes social interaction by stimulating multiple cognitive functions simultaneously and involves up to 14 themed sessions of about 45 minutes each, held twice a week. Typically, a session might start with some non-cognitive warm-up activity and then move to a variety of cognitive tasks, including reality orientation (for example, a board displaying such information as place, date and time), led by a facilitator. Sessions focus on different themes, for example, childhood, use of money, word games, cooking or music. These activities generally avoid factual recall but instead focus on questions such as: “What do these (words or objects) have in common?”

5.4.2

Cognitive training

Cognitive training refers to a range of techniques that are applied to engage thinking and cognition with various degrees of breadth and specificity. It targets isolated cognitive functions (e.g. memory) with individual, repetitive practice of standardized cognitive tasks. For example, placing five everyday items (e.g. cup, pen, key) on a table, studying them for a minute, covering them with a cloth and then trying to recall the items. To progress the exercise, a greater number of items can be used and the time between covering the items and recall can be extended. The goals include improving or maintaining cognitive processes or addressing the impact of impairment in cognitive processes on associated functional ability in daily life.

It is important to encourage family members and carers to regularly provide older people with information such as day, date, weather, time and names of people, which helps them to remain oriented in time and place.

Providing materials such as newspapers, radio and TV programmes, family albums and household items can promote communication, orient an older person to current events, stimulate memories and enable the person to share and value their experiences.



5.4.3

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is an umbrella term covering a wide range of psychological approaches that aim to improve affective function. CBT focuses on the process of thought rather than content to help people accept their thoughts. CBT can have positive effects on everyday functioning and quality of life, and reduction of depressive symptoms as a comorbid condition. → 10.4.2

MORE INFORMATION

 *Optimizing brain health across the life course: WHO position paper.* WHO; 2022 (<https://iris.who.int/handle/10665/361251>).

 *mhGAP guideline for mental, neurological and substance use disorders, [3rd ed.].* WHO; 2023 (<https://iris.who.int/handle/10665/374250>).

 *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0.* WHO; 2016 (<https://iris.who.int/handle/10665/250239>).



5.5

Assess and manage associated diseases and risk factors



An assessment of diseases and risk factors for cognitive decline should start by identifying and treating possible causes (◆). Common reversible conditions and risk factors that can cause cognitive decline include delirium, medication(s) and cerebrovascular diseases. In some cases, treatment of these conditions results in improvement in cognition. If cognitive decline persists, further assessment will be required.

Uncovering a reversible cause of cognitive decline involves a full diagnostic work-up, sometimes including blood tests. It may be necessary to explore several different potential explanations of symptoms to arrive at an accurate approach for a care plan.

5.5.1

Delirium ◆

Delirium is acute, fluctuant loss of the ability to direct, shift, sustain and focus attention. People also become confused about where they are and what the time is. Delirium develops over a short period of time and tends to come and go during the course of a day. It can be accompanied by other disturbances of perception, memory, thinking, emotions and concentration. For a person with significant cognitive decline, including dementia, any sudden change in circumstances such as moving home or a bereavement may precipitate a worsening of confusion or delirium. In most people, the common precipitating factors are illness particularly infection, dehydration, new medication, metabolic abnormalities (such as hypoglycaemia, hyponatraemia, hypothyroidism, vitamin deficiency), injury, substance intoxication or substance withdrawal.

5.5.2

Inappropriate medication(s) ◆

Two or more medicines may interact and cause adverse side-effects. → 4.2.4 The potential harm of these medicines can also outweigh their benefits for some people. These include, but are not limited to: opioids, antidepressants, psychotropic medicines, dihydropyridines, antihistamines and anti-muscarinics (26).

5.5.3

Cerebrovascular disease ◆

Vascular disease in the brain is closely associated with cognitive decline. If the patient has a history of stroke or transient ischaemic event, then prevention of further events is the primary approach to stop further declines in cognition.

5.5.4

Cardiovascular diseases and risk factors

Cardiovascular diseases and risk factors, such as hypertension, diabetes and high cholesterol, are modifiable factors for cognitive decline. The risk of developing CVD can be reduced by adopting a healthy lifestyle. Early diagnosis and treatment of CVDs are essential to prevent complications. Screening for hypertension can be integrated in the community by measuring blood pressure, followed by a prompt referral. → 3.1.5, 3.2.2 The early detection of diabetes at a primary care facility is encouraged by testing those who are symptomatic, overweight or obese. For those with CVD, support should be provided to ensure adherence to treatment, including medication.

5.5.5

Urinary incontinence → 13

Urinary incontinence is common in people with cognitive decline and should be assessed for and managed as appropriate.