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Distinguishing The 3 Ds: Dementia, Delirium, and Depression

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11/18/2025

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Objectives: By the end of this presentation, you will:

1. Understand the hallmark/characteristic features of dementia, delirium, and depression in older adults.
2. Know the contributing factors to dementia, delirium, and depression in older adults.
3. Understand the DSM-5 diagnostic criteria for dementia, delirium, and depression and other guidelines.
4. Apply evidence-based screening tools in the assessment of dementia, depression, and delirium in older adults.

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	Dementia	Delirium	Depression
Onset	Slow and insidious onset	Sudden onset/acute (over hours or days)	Gradual – may coincide with life changes/events
Duration and Course	Gradual deterioration. Progressive, irreversible, Eventually ends in death	Hours to less than one month Usually reversible with treatment of underlying cause(s)	Variable – can last from months to years; Usually reversible with treatment
Attention Concentration	Generally normal except in late stages	Acute disturbance Greatly impaired	Maybe impaired or decreased
Psychomotor	Wandering/exit seeking or agitated or Withdrawn (may be related to co-existing depression)	Hyperactive: agitation, restlessness, Hypoactive: very sleepy, slow-moving Mixed: alternating features of the above	Usually withdrawn May include agitation
Thinking Speech	Difficulty with word fluency, word retrieval and abstraction Perseverates	Disorganized, distorted, fragmented, incoherent	Intact/maybe slowed
Mood	Depression may be present in early dementia	Fluctuations in emotions i.e., outbursts, anger, crying, fearful	Depressed mood; Diminished interest or pleasure in usual activities; Change in appetite

DSM-5 CRITERIA

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Dementia: Major Neurocognitive Disorder (NCD)	Delirium	Depression (MDD)
• Evidence of significant cognitive decline from previous level of performance in 1 or more cognitive domains such as attention, executive function, learning and memory, language, perceptual motor, and social cognition. • Cognitive decline must interfere with independence in everyday activities.	• Disturbance in attention and awareness. • Acute onset; represents change in baseline and fluctuating course. • Additional disturbance in cognition. • Change in cognition not better accounted for by pre-existing, established, or evolving NCD and does not occur in the context of severely reduced level of arousal, i.e., coma.	• 5 or more present during the same 2-week period and represent a change from prior functioning. • At least one of the symptoms is either depressed mood or loss of interest or pleasure. • Depressed mood • Marked diminished interest /pleasure • Significant weight loss or gain • Insomnia or hypersomnia

DSM-5 CRITERIA

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Dementia: Major Neurocognitive Disorder	Delirium	Depression (MDD)
• Cognitive deficits do not occur exclusively in context of a delirium and are not better explained by another mental disorder. • Cognitive impairment not attributable to another condition – Symptoms must be confirmed by clinical assessment and/or cognitive testing.	• Evidence from Hx, PE, or Lab findings that the disturbance is a: ○ direct physiologic consequence of a general medical condition, intoxicating substance or withdrawal, or exposure to a toxin, or multiple etiologies	• Psychomotor agitation or retardation • Fatigue • Feelings of worthlessness or excessive/inappropriate guilt • Decreased concentration • Recurrent thoughts of death or suicide ideation, or attempt

MMD Continued

Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Episode not attributable to the physiological effects of substance use or another medical condition

- Occurrence of major depressive episode not better explained by schizoaffective disorder (d/o), schizophrenia, schizophreniform d/o, delusional d/o, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- Absence of manic or hypomanic episode
  - This exclusion does not apply if all manic or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Examples of Risk Factors

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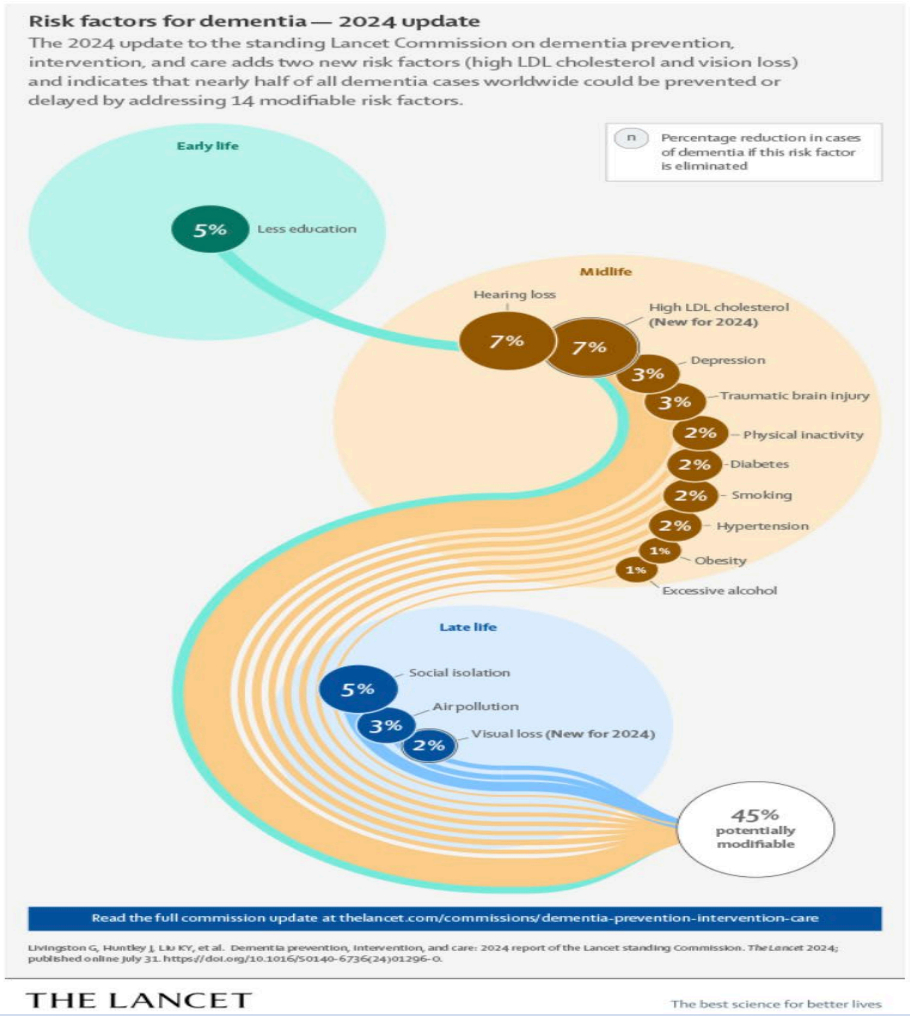
Dementia

2024 update



Delirium

- Physiological
- Infection
- Medications
- Hospitalization/length of stay
- Malnutrition or dehydration
- Hypoxia
- Surgery
- Iatrogenic event
- Uncontrolled pain
- Sleep deprivation
- Alcohol withdrawal

Depression

- Chronic health condition – poor physical health
- Personal/family history
- Social isolation and loneliness
- Chronic pain
- Functional limitations
- Disability
- Substance abuse/misuse
- Other – single, unmarried, divorced or widowed, lack of supportive network, stressful life event

Delirium in Older Adults with Dementia

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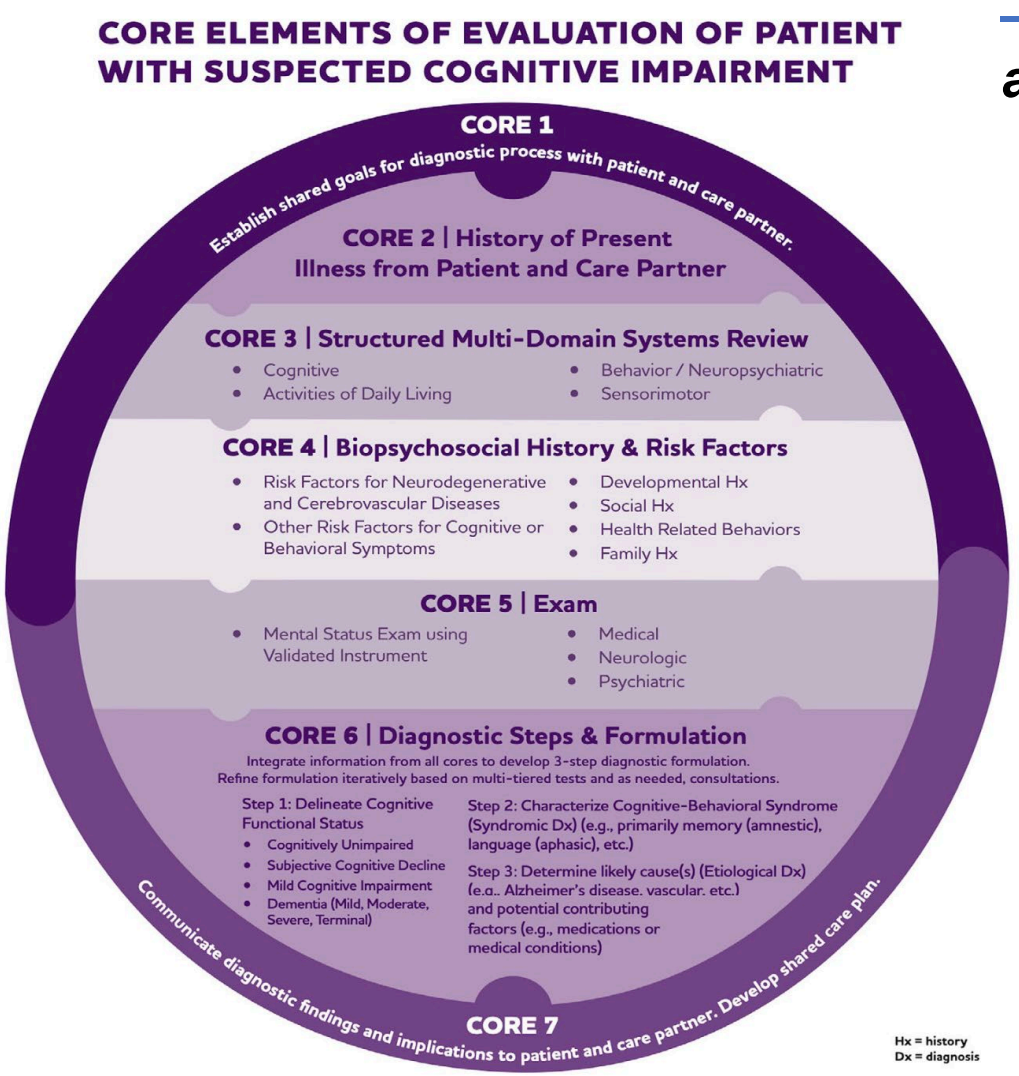
Occurs 4-5 times more often in persons with dementia – Delirium superimposed on dementia. Delirium in patient with AD associated with twice the rate of cognitive decline a year later and accelerated decline at 5 years relative to patients without delirium at index hospitalization.

Identification is particularly challenging. Often missed, mislabeled, or mistakenly attributed to the underlying or worsening of dementia.

Important to distinguish between delirium and Lewy body dementia – both present with cognitive fluctuations, inattention, sleep disturbances, and other neuropsychiatric symptoms (vivid hallucinations)

Associated with poorer clinical outcomes than with dementia alone, i.e., accelerated trajectory of cognitive decline, higher rates of rehospitalizations, greater functional impairments, and increased mortality.

https://pmc.ncbi.nlm.nih.gov/articles/PMC10413471/



— First comprehensive guideline applicable to primary and specialty care —

REFERENCES – SOURCE MATERIAL

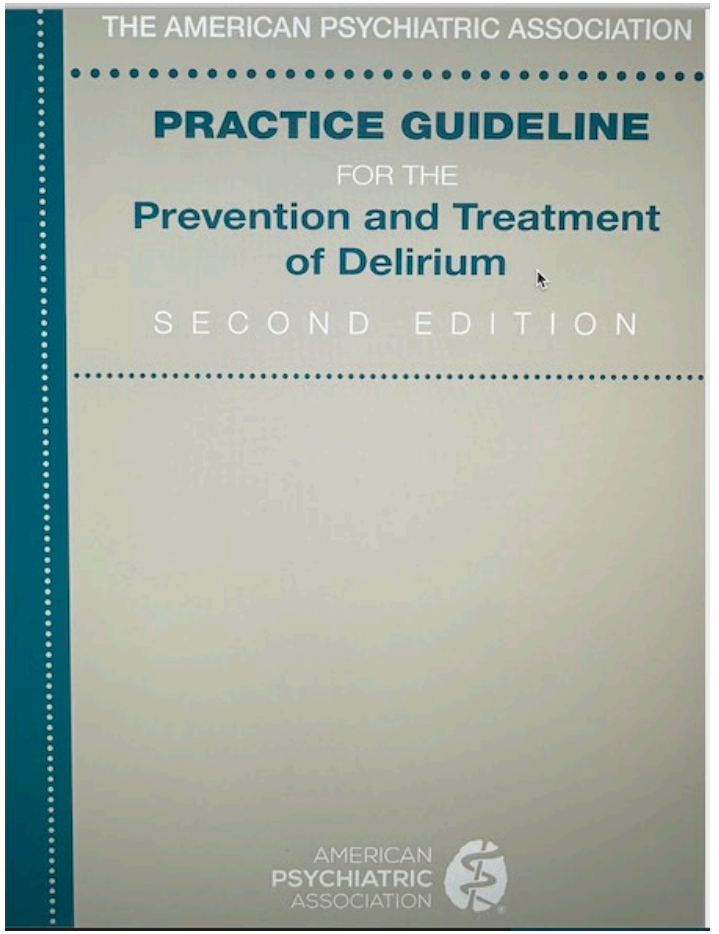
"The Alzheimer's Association Clinical Practice Guideline for the Diagnostic Evaluation, Testing, Counseling and Disclosure of Suspected Alzheimer's Disease and Related Disorders (DETeCD-ADRD): Executive Summary of Recommendations for Primary Care," Atri, et al. https://doi.org/10.1002/alz.14333

"The Alzheimer's Association Clinical Practice Guideline for the Diagnostic Evaluation, Testing, Counseling and Disclosure of Suspected Alzheimer's Disease and Related Disorders (DETeCD-ADRD): Executive Summary of Recommendations for Specialty Care," Dickerson, et al. https://doi.org/10.1002/alz.14337

"The Alzheimer's Association Clinical Practice Guideline for the Diagnostic Evaluation, Testing, Counseling and Disclosure of Suspected Alzheimer's Disease and Related Disorders (DETeCD-ADRD): Validated Clinical Assessment Instruments," Atri, et al. https://doi.org/10.1002/alz.14335

APA Practice Guideline for the Prevention and Treatment of Delirium

- First update to the guideline in 25 years.
- Reviews current evidence-based interventions to treat delirium in adults.
- Includes statements related to assessment and treatment planning.
- Provides clinicians with evidence-based strategies to improve detection, management, and patient outcomes.
- Describes approaches to implementing recommendations and suggestions in clinical practice.



https://www.appi.org/Products/Geriatric-Psychiatry-Alzheimer-Disease-and-Dementi/American-Psychiatric-Association-Practice-Guid-(1)

ISBN 978-0-89042-803-0

Guideline Components

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- Assessment and Treatment Planning: Statements
  - Structured assessments for delirium
  - Determination of baseline neurocognitive status
  - Review for predisposing or contributing factors
  - Detailed review of medications
  - Use of restraints only in situations when injury to self or others is imminent
  - Person-Centered Treatment Planning
- Nonpharmacological Interventions
- Pharmacological Interventions
- Transitions of Care

https://www.psychiatryonline.org/doi/epdf/10.1176/appi.books.9780890428023

APA CLINICAL PRACTICE GUIDELINE for the Treatment of Depression Across Three Age Cohorts

GUIDELINE DEVELOPMENT PANEL FOR THE TREATMENT OF DEPRESSIVE DISORDERS

APPROVED BY APA COUNCIL OF REPRESENTATIVES
FEBRUARY 2019

AMERICAN PSYCHOLOGICAL ASSOCIATION

https://www.apa.org/depression-guideline/guideline.pdf

Cognitive Screening Tool: MMSE

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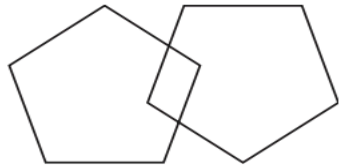
The Mini-Mental State Exam

Patient_____ Examiner _____ Date_____

Maximum	Score	
		Orientation
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we (state) (country) (town) (hospital) (floor)?
		Registration
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____
		Attention and Calculation
5	( )	Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward.
		Recall
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		Language
2	( )	Name a pencil and watch.
1	( )	Repeat the following "No ifs, ands, or buts"
3	( )	Follow a 3-stage command: "Take a paper in your hand, fold it in half, and put it on the floor."
1	( )	Read and obey the following: CLOSE YOUR EYES
1	( )	Write a sentence.
1	( )	Copy the design shown.



_____ Total Score

ASSESS level of consciousness along a continuum _____

Alert Drowsy Stupor Coma

"MINI-MENTAL STATE." A PRACTICAL METHOD FOR GRADING THE COGNITIVE STATE OF PATIENTS FOR THE CLINICIAN. *Journal of Psychiatric Research*, 12(3): 189-198, 1975. Used by permission.

Cognitive Screening Tool: Mini-Cog

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Mini-Cog™ Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

https://mini-cog.com/download-the-mini-cog-instrument/

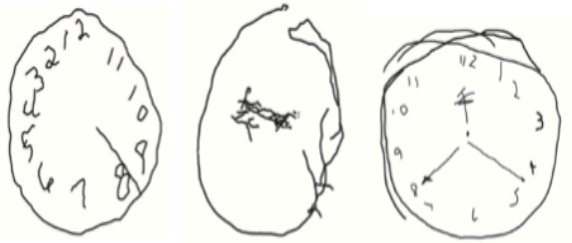
CLOCK DRAWING CRITERIA

Normal if the drawing has all the numbers placed in approximately the correct positions AND the hands pointing to the 4 and 8.

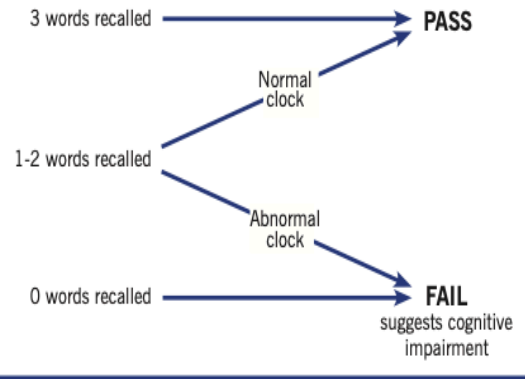
Abnormal for any of the following reasons:

- Refusal to draw the clock
- Patient takes longer than 3 minutes
- Incorrect drawing of the clock

SAMPLES OF INCORRECT CLOCKS



INTERPRETATION



https://mini-cog.com/wp-content/uploads/2022/04/Graphical-Mini-Cog-for-pocket-card-mar2018-2.pdf

Screening Tools: PQ9 and the Geriatric Depression Scale

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PQ-9

Patient Health Questionnaire (PHQ-9)				
Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
	Nearly every day 3	More than half the days 2	Several days 1	Not at all 0
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
* Thoughts that you would be better off dead, or of hurting yourself in some way				

0-4 (no notable depressive symptoms), 5-9 (Mild), 10-14 (Moderate), 15-19 (Moderately Severe), 20-27 (Severe)

https://integrationacademy.ahrq.gov/sites/default/files/2020-07/PHQ-9.pdf

Geriatric Depression Scale

No:	Questions:	Answer:	Test Answers:
1.	Are you basically satisfied with your life?	Yes / No	No
2.	Have you dropped many of your activities or interests?	Yes / No	Yes
3.	Do you feel that your life is empty?	Yes / No	Yes
4.	Do you often get bored?	Yes / No	Yes
5.	Are you in good spirits most of the time?	Yes / No	No
6.	Are you afraid that something bad is going to happen to you?	Yes / No	Yes
7.	Do you feel happy most of the time?	Yes / No	No
8.	Do you feel helpless?	Yes / No	Yes
9.	Do you prefer to stay at home, rather than go out and do things?	Yes / No	Yes
10.	Do you feel that you have more problems with memory than most?	Yes / No	Yes
11.	Do you think it is wonderful to be alive now?	Yes / No	No
12.	Do you feel pretty worthless the way you are now?	Yes / No	Yes
13.	Do you feel full of energy?	Yes / No	No
14.	Do you feel that your situation is hopeless?	Yes / No	Yes
15.	Do you think that most people are better off then you are?	Yes / No	Yes
	Total Score		

When a score of more than five is indicated, a more thorough clinical investigation should be undertaken

Sheikh, J. I., & Yesavage, J. A. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist, 5*, 165-173.

Screening Tool: Delirium

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The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset or Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized thinking

This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of consciousness

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

https://hign.org/sites/default/files/2020-06/Try%20This%20General%20Assessment%2013.pdf

Additional Information Sources

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- NIDUS: Network for Investigation of Delirium: Unifying Scientists:
  - https://deliriumnetwork.org/
- American Delirium Society
  - https://americandeliriumsociety.org/
- Depression: Early warning sign or risk factor for dementia?
  - https://med.stanford.edu/news/insights/2023/08/depression-early-warning-sign-or-risk-factor-for-dementia.html
- Clinical Practice Guidelines for the Treatment of Depression Across Three Age Cohorts: Children, Adolescents, Adults and Older Adults

  https://www.apa.org/depression-guideline/guideline.pdf
- Cognitive Assessment Tools – Alzheimer's Association

  https://www.alz.org/professionals/health-systems-medical-professionals/clinical-resources/cognitive-assessment-tools

Questions?

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THANK YOU

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Contact us: WellAhead@la.gov

Please also feel free to visit the Well-Ahead website at:

http://wellaheadla.com

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