Disruptive Behavior in Long Term Care

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Goals

- Learn the appropriate & inappropriate use of psychoactive medications in NHs
- Learn about the models of disruptive behavior in residents with dementia
- Learn about person-centered approaches to PWDs

“I have no actual or potential conflict of interest in relation to this presentation”
MH problems in NHs

- Most NH residents have some MH problems
- Depression (40%); Anxiety (3.5-20%); SMI (10%); Dementia (50%) with behavior problems (59%)
- 3 types of NH residents with MH problems:
  - SMI
  - Adjustment problems (anxiety/depression)
  - Dementia with behavior problems/agitation
- Need very different interventions – not one size fits all – require training & professionals
OBRA – 87  Improve MH treatment of NH residents

1. MH screening for those with SMI (PASRR)
2. Guidelines for use of restraints & psychoactive med usage
3. Encouragement of non-pharmacotherapy

- OBRA intent not fully realized –
  - Lower # of inapp SMI admits; Less restraints
  - Anti-psychotic usage reduced – recent ‘black box’ warnings have helped
  - Anti-depressant use increased
Side effects – Psychoactive meds

- Anti-depressants linked to falls in older adults
- Anti-psychotics (traditional & atypical) associated with greater mortality in AD residents – led to ‘black box’ warnings
- Sedative drug use related to mortality, cognitive impairment, and balance problems
- Total psychoactive drug load increases risk of hospitalization for NH residents

Need judicious use of psychoactive meds!
Disruptive Behaviors

- Aggression
- Anxiety & Agitation
- Catastrophic reactions
- Crying, Screaming, Yelling
- Repetitive questions
- Suspiciousness, Paranoia

Only 5% of NHs use EBPs for non-pharmacological interventions
ASCP Report - Psychopharmacology for PWDs

- 2% of older adults and 25% of NH residents receive anti-psychotic meds
- No meds have been approved by FDA for the management of behavior problems for PWDs
- Back box warnings for atypical and traditional anti-psychotic meds for those with dementia
- Meds should only be used in emergency situations
- Meds should only be used after non-pharmacological approaches have been tried first
Evidence to support behavioral interventions:

- Functional analysis of specific behaviors, CBT
- Token economies
- Habit training
- Progressive muscle relaxation
- Communication training

Not enough evidence for validation therapy, acupuncture, aromatherapy, music therapy, massage, exercise, pet therapy – may have promise
Effective Treatment of Behavior Problems Include:

- Problem-solving approach: Antecedent-Behavior-Consequences – “training family or staff to carefully observe problem behaviors, identify antecedents, and modify physical environment, schedule or interpersonal interactions”

- Strategies to increase positive behaviors such as pleasant events and exercise

- Multicomponent programs that include environmental mods & staff education in ADL’s

A trained MH provider consults with NH staff to implement interventions for difficult cases

- **ABC approach** - Identify & change antecedents and consequences of problem behaviors
- Increase pleasant events (meaningful activities)
- Promote effective communication
- Create realistic expectations for PWDs

Reduces disruptive behavior & depression & anxiety; improves staff knowledge & skills—but labor intensive
Models of Disruptive Behavior – not mutually exclusive

- Kunik - Focus on mutative factors (depression/pain/UTI)
- Antecedent-Behav-Consequences CARES; DICE
- Volicer - understimulation-overstimulation
- Algase & Teri / Teepa Snow - Need-Driven Dementia-Compromised Behavior Model (NDB)
- Progressively lowered stress threshold
- Lawton – match between person & environment
- Validation approach e.g. Naomi Feil – change our behavior to accommodate residents’ reality
Kunik

- Many paths to disruptive behavior
- Disruptive behavior not a normal part of aging or even dementia
- Individualized approach
- Evaluate & treat for mutable causes such as pain, anxiety, delirium, over-medication, depression, personality problems or psychosis that could be causing disruptive behavior
A-B-C Approach

- Evaluate the ANTECEDENTS of behavior – what triggered the event?
- Describe the BEHAVIOR – is it aggressive towards someone or is it confusion etc.?
- What are the CONSEQUENCES of the behavior – does the person get more attention or gets left alone like the person wants?
Volicer

- Agitation (e.g., yelling, crying etc.,) is often due to under-stimulation – treatment is to provide more stimulation

- Aggression (e.g., fighting, hitting, yelling at someone) often caused by poor caregiver technique – treatment is to train the caregiver
Need-driven Behavior

- All behavior reflects communication
- Person is trying to communicate a need
- Treatment is to identify and satisfy the need
- For example, those with narcissistic personality disorders may be trying to gain attention
- Those who are anxious & dependent may be clinging and sending out signals that they can’t manage on their own
Frail older adults, particularly those with dementia, may have less internal resources to manage stressful situations.

We need to plan for an environment that is low stress so that the demands (e.g. paying bills, buying groceries) don’t overwhelm the person.

However, the environment should be stimulating enough to provide meaningful challenges congruent with the PWD’s cognitive level.
Validation Therapy – Person Centered Care

- For PWDs, we need to ‘enter their world’ and not expect them to enter ours
- We need to try to put ourselves in their shoes
- Confronting PWDs with reality can be frightening and does not work to calm people down and behave normally
- If the person believes that they need to go to work – don’t tell them that they are retired but discuss the importance of work in their lives
Needs of All People With Dementia

- Have Physical Needs Met: Hunger, Thirst, Restroom, Pain/Discomfort, Rest
- Feel Safe and Secure
- Positive Human Contact
- Meaningful Activity
- Feel That They Are Contributing
- Have Success Experiences
How to Frustrate a Person with Dementia

- Tire Them Out
- Bore Them
  - Low Frustration Tolerance
  - Need to Alternate Periods of Rest & Periods of MEANINGFUL ENGAGEMENT
- Make Them Feel Like a Failure
  - Talk Too Fast; Correct Them All The Time; Are they Always Getting Help? Never Getting to Help?
How to Help a Person with Dementia

- Give Them Success Experiences!
- Find Ways for them to Contribute
- Can They Keep Up??? If not - *Slow It Down*
- Can They Hear??? If not, *Speak Loudly, Clearly, Slowly*
- Can They See??? If not, *Use High Contrast, No Glare*
- Be Enjoyable to Be Around!
  - Implicit Learning & Emotional Memory are Preserved Skills: People with dementia remember people they Like so be Rewarding to be around and Deliver Person-centered Care
CARES: Person Centered + Behavioral Approach
Basic Online Training for all NH staff

- **Connect with the Person**
- **Assess Behavior**
- **Respond Appropriately**
- **Evaluate What Works**
- **Share with Others**
CARES (cont.)

- Person-centered approach
- Show that one cares
- Help residents in a sensitive, thoughtful, and respectful way, like one would do for a good friend or family member
- Focus on what residents *can* do rather than what they can’t
- Add meaning to residents’ lives & celebrate moments of success
The “C” step is about making a connection with people each time you interact with NH residents.

It’s about taking time to greet them and doing so in a respectful, friendly, and non-threatening way.

It’s about noticing their individualities.

Making a connection and being perceived as safe is especially important for NH residents.

If NH residents feel connected to you, they are more likely to listen to you.
A = Assess

- Figure out what might be causing this person to respond in a certain way or become upset.
- If you have had a chance to get to know the person, it will be easier to figure out why he or she is behaving in a certain way.
- When a person becomes upset, there is something or someone that has triggered the reaction. What is the trigger?
- Was it the TV or a harsh roommate?
Assessment Questions

1. Does the behavior need a response? Some irritating behaviors are harmless.

2. Is this person’s behavior dangerous to himself or herself or other people?

3. Is this behavior a change for the person?

4. What do you think might have caused this person to behave in this way? Is it because of something in the environment? Is it because of someone? Is there a physical or medical reason?
R = Respond Appropriately

- After you have assessed a person’s behavior, you will need to decide on the best way to respond
- The key is to make your response fit the person and the situation e.g., reduce stimulation while eating; bathe person at another time
- If the person is fearful, think about the best way to make him/her feel safe
It’s important to understand that the ways you respond—the tone of your voice, your body posture, the words you choose—are as important as the response itself.

No matter what kind of response a situation requires, put the dignity of the person first.

Think about who the resident is & what she needs.
E = Evaluate What Works

- Did the person you are caring for become calmer or happier based on what you said and did? Or, did he or she become more upset?

- Keeping track of what works will help the next time you are in a similar situation with that person.

- What worked one time may not work every time.

- The more time you spend with a person and note what’s working, the more effective you will become.
S = Share with Others

- Sharing information helps everyone to do their job better. Sharing successes is a simple way to create a more positive environment.

- If the information you need to share is not about a success, the simple act of sharing can foster concern and encourage everyone to work together to reach a goal.

- Discussing with family, staff, or even with the person how well a certain response worked promotes consistency.
Resources


Resources (cont.)
