Changed behaviours associated with Alzheimer's disease

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Welcome to Country

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Housekeeping

- Be sure to make yourself comfortable
- If you are sharing your space with other people, you may want to use headphones or ear buds, if you have them
- If you're experiencing any technical difficulty and need the assistance of a host, use the Q&A panel. You can also use this function to ask any questions.
- List of resources will be sent out to all registered participants after the webinar

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Introducing the panelists

- Dr Marita Long
- Dr Stephanie Daly
- Professor Dimity Pond

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Learning Outcomes

- Identify behaviour changes associated with Dementia
- Implement a patient-centred approach to managing changed behaviour associated with dementia
- Implement a multidisciplinary approach to the management of changed behaviour associated with dementia

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What is the definition of Changed Behaviours/BPSD

- When do they occur
- What do we mean by changed behaviours

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Definition – any behaviour which causes stress, worry, risk of actual harm to the person, their carer, family members or those around them

VERBAL DISRUPTION	APATHY	DEPRESSION/IRRITABLITY/ MOOD CHANGES	REFUSAL TO ACCEPT SERVICES
PHYSICAL AGGRESSION	PROBLEMS ASSOCIATED WITH EATING	SOCIALLY INAPPROPRIATE BEHAVIOUR	WANDERING OR INTRUSIVENESS
REPETITIVE ACTIONS OR QUESTIONS	SLEEP DISTURBANCES	RESISTANCE TO PERSONAL CARE	HALLUCINATIONS/ DELUSIONS

Meet Anna

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- 86 years old
- Lives in granny flat at her daughter's
- Finding it hard to do daily ADL
- Towards the evening anna's behaviour becomes more aggressive
- Conflict occurs between daughter and mother
- Anna can wake several times a night and rings her daughter on the phone

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Any considerations first? - the 3 D's

- Drugs
- Delirium
- Depression

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Anticholinergic load

ACUTE	CHANGE	IN	M(ental) S(tate)
Antiparkinsonian	**C**ardiac	**I**nsomnia	**M**uscle relaxants
Corticosteroids	(antiarrhythmics)	medications	**S**eizure
Urologic (antispasmodics)[1]	**H**2 blockers (cimetidine)	**N**arcotics	medications
Theophylline	**A**nticholinergics		
Emesis (antiemetics)	**N**SAIDs		
	Geropsychotropic		
	Etoh		

[1]**U**rologic (antispasmodics) such as oxybutynin or tolterodine

[2]**G**eropsychotropic medications (such as antidepressants, antipsychotics, sedatives)

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The impact of medications – adverse effects

- beta-blockers,
- anticonvulsants,
- benzodiazepines,
- tricyclic antidepressants,
- corticosteroids,
- narcotics,
- fluoroquinolones,
- H2 receptor antagonists,
- antiparkinsonian drugs,
- antihypertensives
- anticholinergics

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Differential Diagnosis

Dementia vs Delirium

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Delirium vs Dementia

Characteristics	Delirium	Dementia
Onset	Acute to sub acute	Insidious
Course	Fluctuation	Stable and progressive
Duration	Hours to days – sometimes months	Months to years
Attention	Fluctuates	Steady
Cognitive Function	Impaired poor attention	Poor memory and poor attention
Perception	Hallucinations/delusions are fleeting	More structured and permanent
Sleep/Wake cycle	Disrupted	fragmented

Delirium Action Plan

Delirium Action Plan

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Models for understanding behavior

Theory of unmet needs[1]

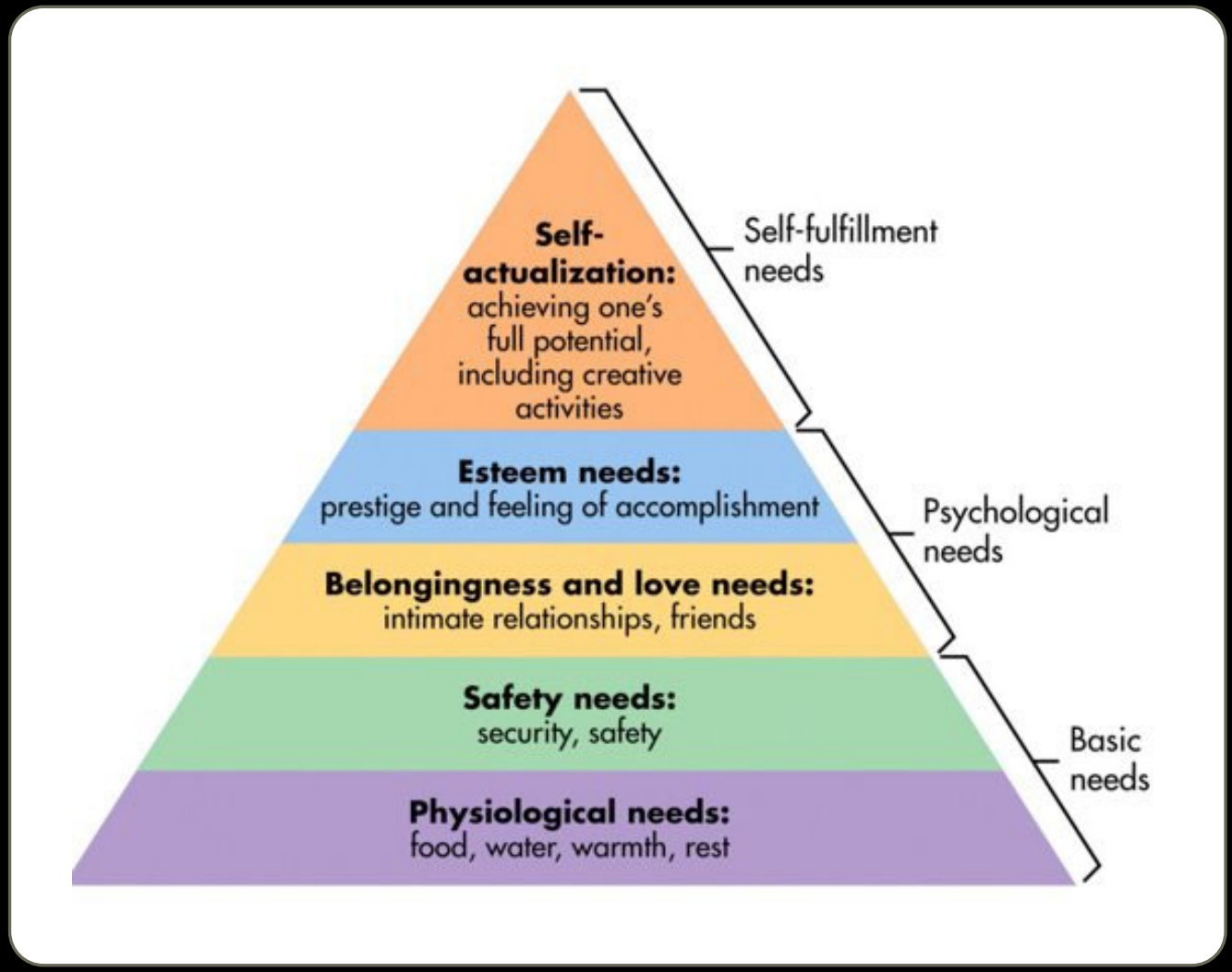
ABC method[2]

Progressively lowered stress threshold[3]

Biomedical Model

CAUSEd[4]

Maslow's Pyramid – the Hierarchy of Needs[5]



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Examples of unmet needs: person-centered

- Pain
- Hunger
- Thirst
- Toilet
- Fatigue
- Over/under stimulation
- Social engagement

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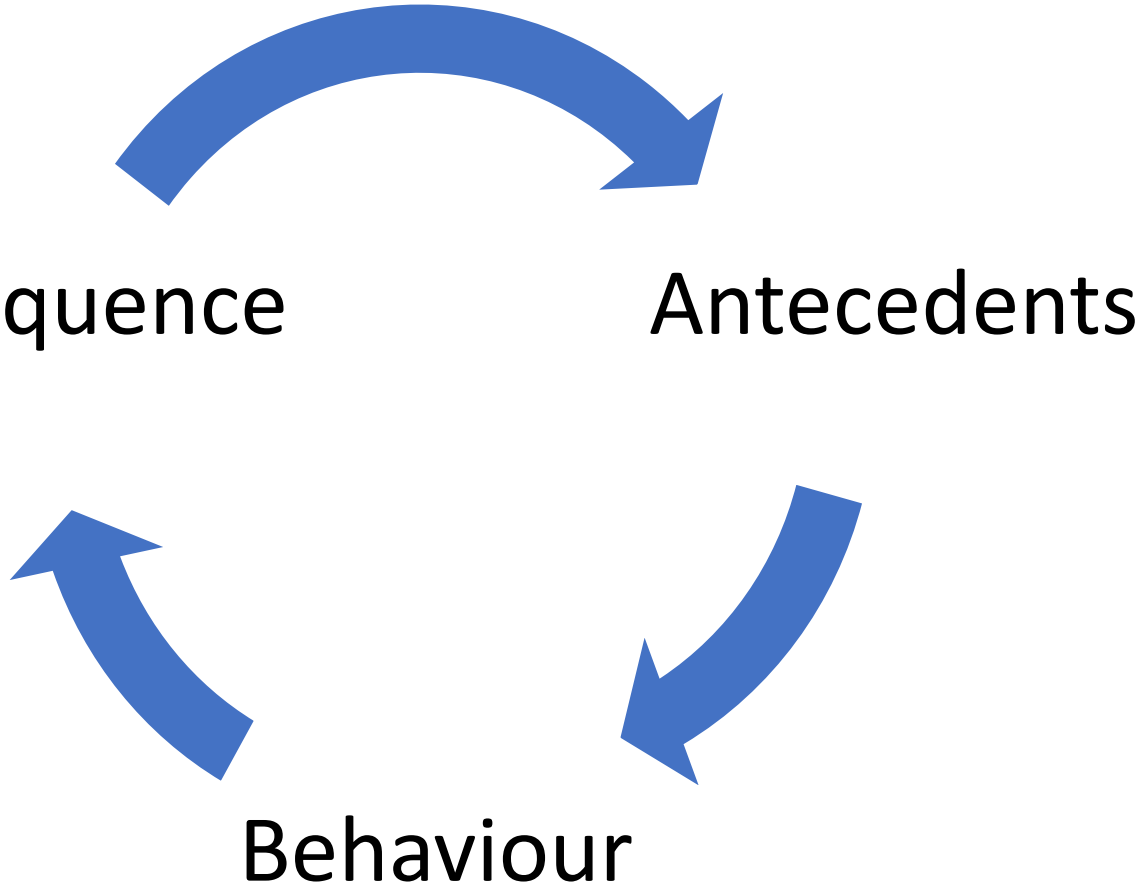
ABC model



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Progressively lowered stress threshold

- Dementia lowers a person's ability to deal with daily stress and increases the susceptibility to environmental stressors.

- Accumulated stressors such as noise, temperature and light can contribute to behaviours of concern.

Biomedical Model

Pathological changes to the brain in dementia impair normal brain functions and cause behavioural symptoms. Behaviours of concern are a part of dementia

Why a person-centered approach is important

(The Long Goodbye, Australian Broadcasting Corporation. 2011)

Simplifying the models - CAUSEd

- C – Communication
- A – Activity
- U – Unwell/unmet needs
- S – Story
- E – Environment
- d – Dementia

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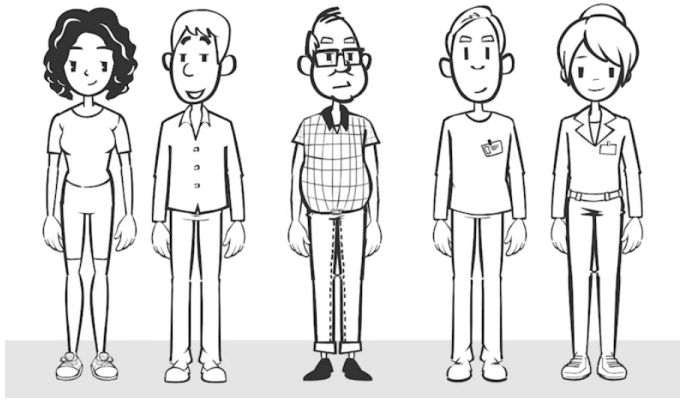

ASSESS AND UNDERSTAND
THESE BEHAVIOURS AND
OFFER A RANGE OF MANAGEMENT OPTIONS

DTA animated video: Responsive Behaviour in Dementia

CURRENTLY THE BEST EVIDENCE FOR
PEOPLE WITH DEMENTIA DISPLAYING
AGITATION IS FOR CITALOPRAM

RISPERIDONE

TREATING PSYCHOSIS

RISPERIDONE OR OLANZAPINE

AGITATION OR AGGRESSION

Anna

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Anna

- 86-year-old
- Lives with daughter in granny flat
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Strategies – non-pharmacological

- **Communication** - distraction
- **Activity -** Daily exercise has been shown to improve quality of life
- **Unmet/unwell -** pain – poor fitting dentures
- **Story -** Person centred therapy – massage, photos, music, social interaction
- **Environment -** Noxious stimulation from noise, smells
- **Dementia – apathy as a feature of dementia**

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Who can you involve in your approach?

Multi-disciplinary approach

- Carer
- OT
- Physio
- Pharmacist
- Dementia Support worker
- Nurses
- DBMAS (DSA)
- Dementia Australia
- Charity/outreach services
- Environmental design experts

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Safety/ Risk Assessment

- What is the immediate risk to the person and those around them
- Can a period of assessment and observation be conducted

- If immediate risk
  - Make the environment as safe as possible for person living with dementia and staff
  - Ask for help
  - Consider instituting immediately necessary non-pharmacological interventions
  - Consider pharmacological interventions

How to approach low/intermediate risk behaviours

What is the specific behavior to be reduced?
Who is the behavior an issue to?
How often is the behavior occurring?
Start a behavior chart/record triggers/aggravating factors/improving factors
What is the impact on? carer stress/QOL/Safety

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Pharmacological Intervention – Cochrane review[6] – weak evidence for most

Safest options to try least adverse to most adverse effects

- Analgesia
- Melatonin
- SSRI
- Anticholinesterase Inhibitors – Donepezil and Memantine
  - Nausea, dizziness, vomiting, headaches
- Anti-psychotics
  - Drowsiness, extra-pyramidal side effects, stroke, UTI, gait abnormlaties, falls and death

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References

1. Algase, D., Beck, C., Kolanowski, A., Whall, A., Berent, S., Richards, K., & Beattie, E. (1996). Need-driven dementia compromised behavior: an alternate view of disruptive behavior. *American Journal of Alzheimer's Disease*., 11, 10–19.
2. Stokes, G. (2017). Behavioural, ecobehavioural and functional analysis. In G. Stokes & F. Goudie (Eds.), *The essential dementia care handbook* (pp. 79 – 89). Oxon: Routledge.
3. Smith, M., Gerdner, L., Hall, G., & Buckwalter, K. (2004). History, development, & future of the progressively lowered stress threshold: a conceptual model for dementia care. *Journal of American Geriatrics Society*, 52(10), 1755-1760.
4. O'Toole, G. (2017) CAUSEd: effective problem solving to support well-being, *Australia Journal of Dementia Care* 6(1)
5. Maslow, A. H. (1987). *Motivation and Personality* (3rd ed.). New York: Harper and Row.
6. Dyer, SM., Harrison, SL., Laver, K., Whitehead, C., Crotty, M. (2018). An overview of systematic reviews of pharmacological and non-pharmacological interventions for the treatment of behavioral and psychological symptoms of dementia. *International Psychogeriatrics* 30 (3) 295–309

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Questions

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Resources

- DTA resources:
  - Animated video: Responsive Behaviours in dementia
  - Developing Behavioural Interventions Toolkit: Developing Behavioural Interventions| Dementia Resource | DTA
  - Responsive Behaviours Quick Reference Cards: Responsive Behaviours Cards | Dementia Resource | DTA
  - Responsive Behaviours App: Responsive Behaviours App | Dementia Resource | DTA
- Dementia Support Australia: www.dementia.com.au
- Dementia Australia: www.dementia.org.au
- Department of Health Victoria Standardised Care Process: Responsive Behaviours
- Delirium Action Plan