Dealing with Challenging Behavior in the Residential Care Setting

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Common Behavioural Issues in Older People

- Agitation/Aggression
  - Verbal Agitation
    - Calling out, Screaming, Repetitive questioning, Importuning, Complaining
  - Physically Nonaggressive Agitation
    - Pacing, Disrobing, Trying to Get Somewhere Else, Motor Restlessness
- Aggressiveness
  - Verbal, Physical, Resistiveness to Care

Cohen-Mansfield 1986
Common Behavioural Issues in Older People

- Anxiety
- Apathy, Social withdrawal
- Suicidal ideation/threats/behaviour
- Tearfulness and Despair
- Suspiciousness, Paranoia
- Marked fluctuations in functional ability
- Demanding, demeaning, behavior
Role of the Physician in the Care of Behaviorally Challenging Residents

- Assist team to define target symptoms.
- Define medical & psychiatric contributions to behavior.
- Question environmental and psychosocial contributions to the behavior.
- Determine appropriateness of use of psychotropic medication.
- Know when to utilize mental health consultation.
Role of the Medical Director in Dealing with Challenging Behaviors within the Care Home

- Role model for other physicians
- Identify practices & attitudes within the care home which contribute to challenging behavior.
- Become familiar with the role of the institutional model in creating challenging behavior
- Get involved in rectifying systemic precipitants of challenging behavior – ie quality improvement/culture change.
Complexity of Clinical Presentations

- Our attitude:
  How is the challenging behavior viewed?
  1. Unmet needs which require identification and care?
  or
  2. Problems to be managed?
  (Unmet needs model – Beck et al)
Complexity of Clinical Presentations

- Thorough assessment requires a review of:
  - Here and now factors
  - Background factors
  - the needs of the individual he or she may be expressing through their behavior
Herman

I keep getting a sharp pain in my back.

You gotta expect a few aches and pains at your age. ... Are you eating plenty of fiber?

Every day.

I shouldn't worry about it.

Take a couple of these for a few days.

Thanks, Doc.
The GPEP Model

- adapted from Teri’s model
  - Antecedent
  - Behaviour
  - Consequence

- Behaviour does not occur in a vacuum
- A need to consider the context - ie.
  understanding the person with the behaviour
GPEP Model

- Psychiatric Influences
- Physiological Influences
- Psychosocial Influences
- Environmental Influences

Causes

Care Strategies

Behaviour

Consequences (Results)
Defining Target Symptoms

- Who is defining the behavior as a challenge?
- How are the symptoms being tracked?
- Is there a safety risk to others?
- What are the goals of intervention?
The Here and Now Factors

- Especially important for episodic behaviour, i.e., Aggressiveness, Agitation.
- Requires tracking over a period of time.
- Specific tools available
  - Important for monitoring efficacy of interventions.
Background Factors

- Psychiatric Issues
- Physiological Issues
- Psychosocial Issues
- Environmental Issues
- Systemic Issues
Psychiatric Issues

- Dementia –
  - Behavioral & Psychological Symptoms of Dementia (BPSD)
- Delirium
- Depression
- Psychosis
  - Delusional Disorder, Schizophrenia, Dementia, Depression
- Bipolar Disorder
- Personality Disorder (+/- any of above diagnoses)
Defining Medical and Psychiatric Contributions to Challenging Behaviour

- R/O Delirium!!!!
- Revisiting established medical and psychiatric diagnoses
- Defining new medical and psychiatric diagnoses
- Review potential medication effects
- Review causes of excessive disability - pain, sensory impairment
Physical Precipitants of Challenging Behaviors

- Common things occur commonest:
  - Infection – Pneumonia, UTI
  - Pain
  - Constipation
  - Medications (Dose, Interactions)
  - Metabolic Disturbances
    - Esp. electrolyte disturbances
  - Hypoxic states (subtle or blatant)
    - eg. CHF, COPD, Pneumonia
  - CVA
Pain and Dementia

- Untreated pain $\rightarrow$ abnormal behavior
- Language deficit $\rightarrow$ decreased verbal expression of pain.
- Later in illness, need to rely on facial expression, groaning vocalization, aggressive behavior as cues.
Medications as the Cause of Challenging Behavior

- Polypharmacy
- Anticholinergic effects of medications
  - Many cannot be avoided but try to limit use
  - Anticholinergic effects are cumulative
“Don’t take any of these red pills, and if that doesn’t work, don’t take any of the blue ones.”
Medications with Anticholinergic Effects

- Furosemide
- Digoxin
- Warfarin
- Prednisone
- Cimetidine
- Ranitidine
- Isosorbide
- Codeine
- Captopril
- Triamterene
- HCT
- Oxybutinin
- TCA’s
- Antipsychotics
Psychosocial Issues I

- Understanding the person with the behaviours
  - Life history
  - Significant Losses (recent and remote)
  - Personality/Coping Style
  - Interests, Hobbies, Strengths, Faith
Psychosocial Issues II

- Understanding the family system
- Understanding the current stresses
  - Loss
    - Health
    - Independence/Control
    - Privacy
    - Role
    - Loved Ones
Environmental Issues I

- Physical Environment
  - Space
  - Lighting
  - Levels of stimulation (over/under)
  - Distances
  - Cues of Home

- Opportunities for involvement in meaningful and pleasurable activities
  - Prevalence of loneliness, helplessness, and boredom
Environmental Issues II

- Interpersonal Environment
  - Interactions with fellow elders

- Interactions with staff
  - Communication challenges
  - Approach - What works, what doesn’t?
  - Countertransference issues
  - Consistency of Staffing
  - Staff being encouraged/empowered to get to know residents
GOD BLESS MY PERSONAL SPACE
Defining Systemic Contributions to the Behavior

- What is the care home’s philosophy of care?
  - Facility centered vs. Person Centered Care (Kitwood)
  - Institutional Model vs. Human Habitat (Thomas)
  - Behavior seen as an expression of need (Algase, Beck et al. 1996)
Implementing the Treatment Plan

- What are the barriers to implementing the treatment plan which arises from the detailed assessment?
- The easiest part to implement is the pharmacological intervention (often not the most crucial part and can potentially cause harm)
How often are we being asked to medicate a person when it is the system of care which is failing them?

Psychotropic medication is, at best, only one part of a care plan for challenging behaviour.
Psychotropic Drug Use & Dementia

- 50 - 75% of nursing home residents have at least 1 prescription for psychotropic medication.

- Concerns:
  - Lack of a documented diagnosis
  - High risk of complications
  - Lack of monitoring and follow up
Psychototropic Medications as Friends

- Depression
- Psychosis
- BPSD - Aggressiveness, Motor hyperactivity, anxiety
Antidepressant Medications – Recommendations in Dementia

- SSRI’s
  - Zoloft 25-100 mg
  - Paxil 10-30 mg
  - Luvox 25-150 mg
  - Celexa 10-30 mg
- Venlafaxine 37.5-?mg
- Nortriptyline 10 mg-60 mg (blood levels)
- Moclobemide 75-300mg
Antipsychotic Medications - Recommendations in Dementia

- **Atypicals**
  - Respiridone 0.25-2 mg/day
  - Olanzapine 2.5-10 mg/day
  - Quetiapine 12.5-300mg/day

- **Typicals**
  - Loxapine 2.5-25 mg/day
  - Nozinan 10-? mg/day (always 3rd line)
Other medications for BPSD

- **Anticonvulsants**
  - Gabapentin
    - Poor evidence base
    - Well tolerated 100mg-2000mg/day
  - Valproate
    - Some evidence in support
    - Regular bloodwork – q 4 months
    - LFT’s, CBC, level
  - Carbamazepine
    - Some evidence
    - Increased drug interactions
Psychotropic Medications as Foes - Side Effects

- Very few side effects are benign in this fragile population - ie. sedation, ataxia, anticholinergic sx - common and potentially dangerous!
- Certain side effects less common, but potentially very serious - NMS, Tardive Dyskinesia, hepatoxicity, cardiotoxicity etc.
- The potential benefits must significantly outweigh risks!
Tardive Dyskinesia

- Younger adults
  - Rate of development = 4-5%/yr

- Older adults
    - N=410 stable outpatients
    - Average age = 65
    - Rate of T.D.
      - 1 year  29%
      - 2 years 54%
      - 3 years 70%
Psychotropic Medications as Foes - Side Effects

- Very few side effects are benign in this fragile population - ie. sedation, ataxia, anticholinergic sx, orthostatic hypotension - common and potentially dangerous!

- Certain side effects less common, but potentially very serious - NMS, Tardive Dyskinesia, hepatoxicity, cardiotoxicity etc.

- The potential benefits must significantly outweigh risks!
Psychotropic Medications as Foes

- Families or Nursing staff may see psychotropic medications as “the” answer, as opposed to implementing changes in care strategies.

- Especially true in settings where no support given for individualizing care - i.e., facility centered approach to care.
Balancing Friend and Foe - The Appropriate Use of Psychotropic Medications

- Clarity of treatment goals & tracking progress.
- Start dose low enough, increase slowly enough.
- Monitor side effects - make sure family/staff know what to look for.
- Verify that other care strategies also being trialed.
- Regular reassessment of efficacy and ongoing need.
"Well, thank God we all made it out in time. ... 'Course, now we're equally screwed."
Summary

- Challenging behavior arises from unmet needs
- Our job is to identify those needs and address them in a comprehensive care plan
- Sometimes our system of care makes that a challenge
- Certain challenging behaviors may respond to psychotropic medication. This must *never* be the only approach, and only occasionally the first approach!