Behavioural and Psychological Symptoms of Dementia (BPSD)

Tier 7: Dementia with extreme BPSD (eg, physical violence) Prevalence: Rare
Management: In intensive specialist care unit

Tier 6: Dementia with very severe BPSD (eg, physical aggression, severe depression, suicidal tendencies) Prevalence: <1%
Management: In psychogeriatric or neurobehavioural units

Tier 5: Dementia with severe BPSD (eg, severe depression, psychosis, screaming, severe agitation) Prevalence: 10%
Management: In dementia-specific nursing homes, or by case management under a specialist team

Tier 4: Dementia with moderate BPSD (eg, major depression, verbal aggression, psychosis, sexual disinhibition, wandering) Prevalence: 20%
Management: By specialist consultation in primary care

Tier 3: Dementia with mild BPSD (eg, night-time disturbance, wandering, mild depression, apathy, repetitive questioning, shadowing) Prevalence: 30%
Management: By primary care workers

Tier 2: Dementia with no BPSD Prevalence: 49%
Management: By selected prevention, through preventive or delaying interventions (not widely researched)

Tier 1: No dementia
Management: Universal prevention, although specific strategies to prevent dementia remain unproven

*Prevalence is expressed as estimated percentage of people with dementia who currently fall into this category.
† Estimate based on clinical observations. ‡ Estimate based on Lyle et al.³

Dr Victoria Hill, Consultant Clinical Psychologist
Sutton & Merton Challenging Behaviour Service
Dementia is much more than forgetting...

The risk of BPSD in dementia patients approaches 90%.

Behavioral and psychological symptoms (BPSD)

- Agitation
- Social withdrawal
- Anxiety
- Depression
- Psychosis

Cognitive decline

BPSD Symptom Clusters

- **Aggression**
  - Physical aggression
  - Verbal Aggression
  - Aggressive resistance to care

- **Pacing**
  - Repetitive actions
  - Dressing/undressing
  - Restless/anxious

- **Agitation**
  - Hallucinations
  - Delusions
  - Misidentification
  - Suspicious

- **Depression**
  - Sad
  - Tearful
  - Hopeless
  - Guilty
  - Anxious
  - Irritable/screaming
  - Suicidal

- **Apathy**
  - Withdrawn
  - Lacks interest/motivation

- **Mania**
  - Euphoria
  - Pressured speech
  - Irritable

- **Psychosis**
  - Hallucinations
  - Delusions
  - Misidentification
  - Suspicious
Managing BPSD

• Is everyone's business....
• Needs a pathway/systems approach
**Step 1: Recognition**
Identification of difficulties, physical health & initial monitoring
(GP & carers/care staff)

**Step 2: Assessment and treatment of contextual issues: Low Intensity**
Thorough assessment and general good practice in care environment
(GP & carers/care staff)

**Step 3: Protocol-led interventions: high intensity**
Interventions tailored to specific presentations and needs
(Experienced practitioners and carers/care staff)

**Step 4: Idiographic formulation-led intervention: Specialist**
Individualised assessment, formulation and intervention
(Specialist practitioners and carers/care staff)
Primary Care Interventions

- Screening and dealing with physical health difficulties which might impact on behaviour:
  - Delirium (Infections), Managing Pain, Dental, Constipation, Sensory problems
- Screening for depression & previous psychiatric history
- Encourage behavioural monitoring
- Advice and support to staff for mild/moderate behavioural difficulties eg: sleep hygiene, social inclusion, environmental changes, life story work
- Refer for assessment and advice for moderate/severe difficulties
- Medication for severe behavioural problems if really necessary (whilst resisting the pressure for the “quick fix”)

South West London and St George’s Mental Health NHS Trust
Specialist Services for BPSD

• Memory clinics
• Multi-professional community mental health teams
• Specialist teams for care homes (eg: Newcastle, Sutton and Merton, Wandsworth, Lewisham)
• Specialist care home placements
• Acute mental health wards
• Neurology & Neuropsychiatry
• Geriatricians
Good Practice Guidance

- National Dementia Strategy
- National Institute for Health & Care Excellence
- Royal College of Psychiatry
- 2013 briefing paper by the Faculty of the Psychology of Older People - Stepped Care Approach to managing BPSD
- Royal College of Physicians guidelines on delirium
Good Practice in Management of BPSD

• **Non-pharmacological approaches as first line treatment for mild/moderate BPSD**
• Medication for only severe challenging behaviour and/or when other approaches have been tried.
• Implementing behavioural interventions instead of antipsychotic medication could lead to savings of £54.9 million above the cost of the therapy in England alone, resulting in a reduction in side effects such as the occurrence of incidence of stroke and falls (NHS Institute of Innovation and Improvement, 2011), which would result in an increase in the quality of life of people living with dementia.
The “Newcastle” Approach

- Carer-centred, person-focused interventions
- Biopsychosocial model (not anti-medication)
- Needs led rather than problem focused
- Try to manage in the current setting
- Work collaboratively, with resources available
- Prevent unnecessary admissions
I need to feel safe in my environment
I need to feel loved and appreciated
I need to feel respected and valued
I need to achieve self-fulfillment and have purpose and meaning
I need to eat, sleep, drink, toilet

Maslow's hierarchy of need

self-actualization
morality, creativity, spontaneity, acceptance

self-esteem
confidence, achievement, respect of others

love and belonging
friendship, family, intimacy, sense of connection

safety and security
health, employment, property, family and social stability

physiological needs
breathing, food, water, shelter, clothing, sleep

South West London and St George's
Mental Health NHS Trust
DICE Model/Pathway

• D: Describe - Asking the caregiver, and the patient if possible, to describe the “who, what, when and where” of situations where problem behaviors occur and the physical and social context for them. Caregivers could take notes about the situations that led to behavior issues, to share with health professionals during visits.

• I: Investigate – Having the health provider look into all the aspects of the patient’s health, dementia symptoms, current medications and sleep habits, that might be combining with physical, social and caregiver-related factors to produce the behavior.

• C: Create – Working together, the patient’s caregiver and health providers develop a plan to prevent and respond to behavioral issues in the patient, including everything from changing the patient’s activities and environment, to educating and supporting the caregiver.

• E: Evaluate – Giving the provider responsibility for assessing how well the plan is being followed and how it’s working, or what might need to be changed.

Kales et al 2014
Understanding the Reasons for BPSD

The importance of considering physical (biological), psychological and social factors.
South West London and St George’s
Mental Health NHS Trust

**Physical Health**
- Pain, infection, constipation, dehydration, hypoxia, mobility problems, eyesight/hearing problems, problems with communication, medication side effects etc.

**Dementia**
- Specific problems caused by neurological damage e.g. dysphasia, dyspraxia, perceptual problems, disinhibition, impaired information processing, loss of mental flexibility etc.

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**Behavioural and Psychological Symptoms of Dementia (BPSD)**

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**Personal History**
- Personality, attachment style, coping mechanisms, previous experiences, likes/dislikes, routines, important relationships, hobbies, routines etc.

**Psychological Health**
- Presence of depression, anxiety, psychosis etc.

**Environment**
- Physical environment (space, overcrowding, noise), availability of appropriate activity, staff, carer approach, knowledge and training, contact with family and friends, etc.
Sutton & Merton Formulation Structure

Cognitive and functional abilities

Physical Health and medication

Personality, social history, relationships/attachments

Environment (physical and social), activities

Mental Health and psychotropic medication

Behavioural and emotional Expression

Carers Vocalisations

Carers Behaviour/Appearance

Persons Vocalisations

Persons Behaviour/Appearance

Need/Consequence for Carer

Carers Thoughts/Beliefs (Cognitive Triad)

Need/Consequence for person

Persons Thoughts/Beliefs (Cognitive Triad)
Types of Non Pharmacological Approaches

• Standard Preventative/Wellbeing Interventions
  – reality orientation, reminiscence and validation
  – cognitive stimulation,
  – Music, dance, aromatherapy, art
  – Multi-sensory, tool box, doll therapy, pet therapy.

• Social contact/simulated presence

• Staff training/communication and care techniques

• Activity based interventions

• Environmental interventions

• Individualised treatment programmes/Person centred care
Communication

- Words: 7%
- Non-verbal: 55%
- How you say it:
  - Visual, Auditory, Kineesthetic
  - Pitch
  - Pace
  - Volume
  - Emotion
  - Detail/High level
- 38%
Reminiscence

Validation

“... a rare book written with empathy for the caregiver.”
—Naomi Perl-MtS, ACSW, LSW, BCD, founder of The Validation method

Validation Techniques for Dementia Care
The Family Guide to Improving Communication

Vicki de Klerk-Rubin

Reality Orientation
Reality Orientation

- Widely used strategy for managing people with dementia
- Reminds person of facts about the themselves and their environment
- Uses memory aids such as signposts, menu’s, notice boards
- Fact based rather than emotion focussed
Reminiscence

- Involves the discussion of past activities, events and experiences
- Can use materials like old photos, newspapers, books, music to help
- Seen as a way of improving well-being, cognitive stimulation, social interaction
- Has been found to have beneficial effects on depression
Validation

• The founder of Validation therapy Naomi Feil suggested that some features of dementia such as repetition and retreat into the past, were an active attempt by the person to avoid stress, boredom and loneliness.

• It is about accepting the persons, values, beliefs and reality.

• The idea is to “agree” but to use conversation to get the person to do something else or think about other things without them realising they are being redirected.

• The key is empathy, genuine interest and focusing on the person’s emotions.

• Techniques are used to explore that persons reality – using who what where when and how questions.
Simulated Presence Therapy

- Aims to make the environment as familiar as possible for the person with dementia.
- Usually involves family members recording their voices or videoing themselves, giving messages of affection, current news and memories from past events.
- A meta-analysis found that SPT had significant benefits of agitation and depression.
- Other studies have shown an increase in behavioural disturbance!
My Life Films

• http://mylifefilms.org/
Doll and Animal Therapies
Doll Therapy

- Doll therapy, may bring back some happy memories of early parenthood and help make the person feel useful and needed.
- Dolls can promote positive changes in behaviour, reducing aggression and agitation (Moore, 2001). They also increase interactions between staff and residents who can talk about the doll and carry out activities relating to it together such as folding its clothes.
- Not everyone will respond positively to a doll. Like any other intervention it needs to be provided as part of a person-centred care plan.
Animal Assisted Therapy

- Positive physiological effects
- Mental Stimulation
- Outward focused
- Empathy and nurturing
- Increased motivation
- Socialisation and entertainment

- Small studies suggest animals can reduce levels of agitation
- More studies indicating robotic animals can also reduce agitation
Sensory Stimulation and Activity
Music Therapy

- People with dementia appear to retain the ability to sing old songs.
- Music seems to reach parts of the damaged brain in ways other forms of communication cannot.
- Structured music activity appears to enhance communication and interaction, recall of memories and emotions.
- Music therapy may consist of singing, listening to music, playing an instrument.
- Music therapy can significantly reduce agitation in dementia (systematic meta reviews).
Environmental Interventions

- Stimulation
- Lighting
- Secure grounds
- Personalised space
- Use of colour
- Signage/orientation
- Homely
- Space
- Resident mix
Environmental Adaptations Examples
Staff Interventions

- Liaison, Staff Training, Consultation Model
- Aimed at improving staff understanding of BPSD and skills in managing/responding to need
- Multiple components to intervention
- Communication training often primary
Evidence for Non Pharmacological Approaches

- **Difficult area for research; poor research designs; not many RCT’s; varying outcome/symptoms measures.** Heterogeneous interventions.

- Recent RCT meta-analysis by Livingston etc al; only 33 studies out of almost 2000 could be included based on design criteria.

- There are still conflicting results when comparing good RCT’s for certain interventions.
Livingston et al (2014) – Meta-analysis of RCT’s for agitation

- Person-centred care, communication skills training and adapted dementia care mapping decreased symptomatic and severe agitation in care homes immediately and for up to 6 months afterwards.

- Sensory interventions (touch/massage, multi-sensory interventions) significantly improved agitation of all severities while in place.

- Activities and protocol led music therapy reduce overall and symptomatic agitation in care homes while in place.

- Aromatherapy and light therapy did not demonstrate efficacy.
Implementing non pharmacological interventions

• Conditions for success
  – Tackle carer scepticism first
  – Collaborative
  – Respect carer perspectives
  – Organisational support – ongoing
  – Carer training – roleplays, videos, case studies useful
  – Encourage reflective carer dialogue
  – Modelling and supervision
Any Questions