Aggressive behaviours in-service

Behaviour Management
A Guide to Good Practice

Working with people with dementia who present with aggressive behaviours

A presentation for residential aged care staff and community care staff prepared by the Dementia Collaborative Research Centres (DCRC-ABC) with the assistance of Sharon Wall for the Dementia Behaviour Management Advisory Services (DBMAS)

Acknowledgment of Country

We acknowledge the traditional custodians of this land
We also pay respect to the elders past and present and extend that respect to other Aboriginal people present

Objectives

At the end of this presentation participants will have an increased understanding of:
• How aggressive behaviours present in people with dementia
• Diagnostic criteria & potential causes of aggressive behaviours in dementia
• Strategies & considerations to assist in the care of people with aggressive behaviours in dementia

What are aggressive behaviours in dementia?

Presentation is not always consistent but these are characterised by:
• physically &/or verbally
• threatening behaviours directed at people, objects or self

What do aggressive behaviours look like in a person with dementia?

• Verbal insults
• Shouting, screaming
• Sexual aggression
• Hitting, kicking, pushing,
• Throwing objects

Aggressive behaviours are typically perceived as a threat to:
• the person with dementia
• family carers
• care staff &/or
• others in the care environment

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Pathology of aggression
Not well understood but the following are implicated:
• Frontal lobe/ executive dysfunction
• Reduced serotonergic activity
• Reduced cholinergic transmission
+ • Interaction between the individual & the environment

Many potential areas may contribute to aggression in dementia
Fatigue
Physical discomfort
Loss of control
Impaired vision or hearing
Hallucinations
Sleep deprivation
Need for attention
Misunderstanding
Pain

Possible causes of aggressive behaviours in dementia
May be a complex interaction of:
• underlying depression
• psychotic symptoms
• environmental stressors
• unmet needs
• response to a violation of personal space or perceived threat
particularly during personal care tasks involving close carer/staff-resident contact

Rates of aggression reportedly higher in those with:
▶ dementia severity
▶ rate of cognitive decline
▶ performance in activities of daily living (ADLs)
▶ language abilities

Diagnostic Considerations
Using a person-centred approach, gather ALL potentially important information
▼ Is the aggressive behaviour due to pain/discomfort, physical illness/injury or other physical causes?
▼ Could this be a symptom of depression, agitation, psychosis or delirium?
If YES, respond & treat accordingly FIRST

If NO, consider management options
▼ Develop individually tailored psychosocial/environmental strategies & interventions
▼ Only where necessary individually targeted medication to address safety concerns
▼ Review!
Differential diagnosis for aggressive behaviours in dementia

- Differentiate between aggression &
  - psychiatric disorder
  - medical condition
  - delirium
- Treat underlying causes

Measuring aggression in dementia

Instruments to assist:
- The Rating scale for Aggressive behaviour in the Elderly (RAGE)
- The Overt Aggression Scale (OAS)
- Cohen-Mansfield Agitation Inventory (CMAI)
- Neuropsychiatric Inventory (NPI)

Prevalence of aggressive behaviours in dementia

- 20% - 30% of those with dementia living in the community
- 6% - 95% of those in RACFs
- Equal prevalence in AD & VaD
- Higher incidence of physical aggression in those with FTD than AD
- Rates vary according to definition & tools used to measure aggression

Effects of aggression

- Decline in cognition
- Carer burden
- Quality of life
- Physical health
- Potential harm to the person &/or others in the care environment
  + premature placement in RACF

What might it be like to feel aggressive when you have dementia?

Why might it be more difficult for a person with dementia to control their emotions?
Before you move on have you:

• ensured that the person & all those in their environment are not at risk?
• provided a full person-centred assessment of the behaviours presented?
• excluded &/or treated any potentially reversible factors?

Caring approaches & interventions

First line response:
Psychosocial &/or Environmental e.g.
• Montessori activities
• Light massage
• Touch therapies
• Bright light therapy
• Individual behavioural therapy

Principles of psychosocial responses

Engagement
Reassurance
Safety
Clear communication
Simplify environment
Targeted & Individualised
Distraction
Gentle approach
Empathy
Reduce fear
Acceptance
Reduce

Caring approaches & interventions

2nd line approach - biological

• May be necessary for safety when symptoms are severe
• Attempting to restrain the person can exacerbate the behaviour
• Informed consent prior to prescribing
• Consider short term use of atypical antipsychotics
• Consider memantine as alternative - may provide safer option

2nd line approach – biological cont.

Where pharma is prescribed:

• Use with caution - short term only
• Use in combination with psychosocial interventions
• Be aware of risks
• Reduce, discontinue when indicated
• Monitor closely & REVIEW!
A clinical scenario - Mr B

Mr B - presentation
- 89 years, Italian migrant
- Admitted to RACF 3 years after wife’s death
- Unable to read/write English, reverting to 1st language
- Becomes frustrated when unable to communicate with staff & others
- Results in episodes of verbal aggression
- At times, escalate to physical aggression
- Resists care & direction from staff

Mr B - presentation cont.
- When displeased, uses his walking stick as machine gun attempting to ‘shoot’ at others
- At times appears threatening as though he might hit out
- Staff & residents are frightened
- Staff response is reactive
- Mr B frustrated further by their attempts to reason with him
- At risk of losing his accommodation

Mr B - potentially contributing factors
- Overstimulation (noise, people, activities)
- Lack of attention to culturally-relevant needs
- Overextending his capabilities, expecting too much of him

Potentially contributing factors cont.
- Unfamiliar/altered/deprived physical environment
- Reduced threshold to cope with stress due to dementia
- Underlying depressive &/or psychotic symptoms
Mr B
With the potentially contributing factors in mind, what aspects of Mr B’s situation could be important in your assessment?

Mr B - assessing the situation
• Encourage Mr B to express his needs as far as he is able
• Directly observe what may trigger the behaviour
• Involve staff who know Mr B in identifying his unmet needs or possible reasons for his aggression
• Consult his personal history

Mr B - assessing the situation cont.
• Assess immediate environment for possible triggers
• Consult close family members to identify possible triggers
• These may be unknown to staff &/or undocumented

Mr B – some outcomes

Aggression in dementia - conclusions
• Multidisciplinary, individualised, multifaceted approach ALWAYS!
• Reduce &/or treat possible causes e.g. pain
• Some support for massage, individual therapy & Montessori-based activities
• Short-term pharma only where necessary for safety
• Some evidence for atypical antipsychotics & memantine – be aware of risks
• Support carers!

‘Success’
• Typically not about eliminating BPSD
• Has BPSD ↓?
• Has person with dementia’s distress ↓?
• Has carers’ understanding of potential causes ↑?
• Has carers’ skills/coping ↑?
• Do carers feel supported?
• Be realistic about goals/outcomes
• BPSD are SYMPTOMS of dementia!
Reflection & review

How can you use this information to make a difference in the lives of people with dementia who present with aggressive behaviours?

Thank you for your attention & your participation in DCRC research

See DCRC website for further resources
http://www.dementiaresearch.org.au

Resources

Alzheimer’s Australia - Aggressive behaviours

Translating what we know about pain recognition & management in people with dementia

Better Health - State Government of Victoria:

Dementia Outcomes Measurement Suite

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