Understanding Behavioral Issues in Long Term Care Patients.


Sosunmolu Shoyinka, M.D.
Medical Director for Behavioral Health,
Sunflower Health Plan.
Adjunct Professor of Clinical Psychiatry,
University of Missouri, Columbia.
Disclosure

Medical Director for Envolve People Care, a for-profit, publicly traded company.
Objectives

At the end of this talk, participants will

1. Understand the manifestations of common mental health conditions in Long Term Care patients, including addictions.

2. Understand how to communicate with individuals with mental health conditions in Long Term Care.

3. Understand how to manage common behavioral issues in individuals with mental illness who live in Long Term Care facilities.
Behavioral Health Conditions in Nursing Home Patients
Psychiatric Conditions in Long Term Care (LTC) Facility Patients.

- Increasingly, LTC facilities are being used for long term care of individuals with severe mental illness, intellectual disability or a combination of both, in addition to dementia.

- A 2005 study showed that the proportion of those being admitted to LTC facilities for mental illness + dementia is greater than dementia alone.

- Prevalence of mental illness in LTC facility patients range from 65-91%.

- Increases with age.

- Dementia
  - commonly comorbid with other psychiatric conditions (30% to 90% of patients)
Psychiatric Conditions in LTC facility Patients.

Depressive Disorder

- X 3 to 5 times more prevalent than in the community.
- Major depressive disorder [6-26%]
- 11-50% had depressive symptoms

Other conditions commonly comorbid with dementia include

- Anxiety
- Psychosis,
- Agitation
- Aggression
- Disinhibition
- Sleep disturbances.
Psychiatric Conditions in LTC facility Patients.

- Schizophrenia (2.7 - 7%)
- Intellectual disability.
- Delirium
- Increasingly, SUD.
Why is this important?

- Mental illness is one, and sometimes the decisive, factor contributing to placement in a LTC facility.
- Predicts longer stays.
- Mental illness in LTC facility patients predicts the use of restraints and psychotropic medications.
- Both are linked to higher morbidity and mortality, for patients.
- Consumes more nursing time.
- Higher rates of staff turnover and injury.
- Higher overall costs to system, including more frequent admissions.

  – LTC facility residents with dementia complicated by mixed agitation and depression have the highest rate of acute hospitalization compared with other groups (15.6% over 3 months), compared with only 9.4% for residents without a diagnosis of dementia (Bartels, Horn, et al., 2003).
Depression

- Among the commonest of medical conditions worldwide
Depression: A Global Crisis

- A spectrum of disorders, ranging from mild-severe.
- Affects over 350 million people worldwide.
- The leading cause of disability worldwide in terms of total years lost due to disability (DALY).
- Burden of disease is 50% higher for females than males (WHO, 2008).
- Leading cause of disease burden for women in both high-income and low- and middle-income countries (WHO, 2008).
- Maternal depression may be a risk factor for developmental delays in young children (Rahman et al, 2008).
- 12 month prevalence in the US is 7%
5 or more of the following present daily/nearly daily for > 2 weeks.

- Depressed mood (core symptom)
- Anhedonia (core symptom)
- Significant weight loss or gain (>5%) in a month)
- Insomnia or hypersomnia nearly daily
- Psychomotor agitation or retardation
- Fatigue nearly daily
- Feelings of worthlessness/excessive or inappropriate grief
- Inability to concentrate, indecisiveness
- Recurrent thoughts of death/suicidal ideation or plan.

- In many cultures (US included) primary complaints are be somatic (e.g. pain) or may manifest as anxiety or irritability.
Medical Complications of Depression

- Worsens outcomes for virtually all co-morbid conditions.
- Chronic pain
- A predictor of worse outcomes post-MI, post-stroke.
- Worse outcomes in nursing home patients
- Leads to poor adherence to treatment recommendations and poor outcomes (diabetes, HTN, post-MI)
- Strongly associated with alcohol abuse/dependence and other SUDs.
“Secondary” Depression

- May be due to the direct pathophysiological effects the associated medical condition (common with neurologic and endocrine disorders)
- May be due to medication/substance administration/intoxication or withdrawal
- Psychological stress associated with medial illnesses may induce or exacerbate anxiety.
Medications Associated with Depressive Symptoms

- Anti HTN drugs: calcium channel blockers, Alpha methyl dopa, guanethidine, reserpine, clonidine)
- Retinoic acid derivatives
- Antidepressants,
- Anticonvulsants
- Anti migraine
- Hormonal preparations
- Tamoxifen

- Propanolol
- Steroids
- IF alpha
- GnRh
- IL2
- L Dopa
- Chemotherapeutic drugs
- Steroids
Anxiety Disorders

• A group of disorders that share the features of

  - excessive fear
  - anxiety
  - related behavioral disturbances

• Differ from normative fear by being

  – Excessive
  – Persisting beyond developmentally appropriate periods
  – > 6 months.
Prevalence

- 18% of the general population suffers from an anxiety disorder at any given point in time.

- Frequently co-morbid with medical illness: e.g. > 1/3rd of individuals with chest pain and normal coronary arteries have a panic disorder.

- Commoner in females (2:1)
DSM V Anxiety Symptoms

Various specifiers for GAD, Panic disorder, Social anxiety, OCD, specific phobia.

Common symptoms include:

- Muscle tension.
- restlessness/feeling keyed up/fidgetiness.
- Inability to concentrate.
- Insomnia.
- Irritability.
- Fatigue.
- Symptoms cause clinically significant impairment or distress.
Anxiety Disorders

- Separation Anxiety.
- Specific Phobia (e.g. needles, blood)
- Social Phobia.
- Panic Disorder.
- Panic attacks.
- Agoraphobia.
- GAD.
- Selective mutism
- OCD
- Delirium
- Dementia
- Somatoform disorder (e.g. hypochondriasis)
- PTSD
- Mood disorders
- Psychotic disorders
## Secondary Causes of Anxiety

### Medical Causes
- Thyrotoxicosis
- Hypothyroidism
- Phaeochromocytoma.
- Carcinoid syndrome.
- Hyperparathyroidism
- Vestibular dysfunction
- Seizure disorders
- Cardiopulmonary disease; arrhythmias, SVT, COPD, asthma.
- Parkinson’s disease
- Post stroke

### Medications
- Anesthetics
- Analgesics
- Sympathomimetics
- Bronchodilators
- Anticholinergics
- Insulin
- Thyroid meds
- OCPs
- Antihistamines
- Antiparkinson meds
- Corticosteroids
Schizophrenia

- Severe Persistent Mental Illness.
- Often preceded for years by a prodrome, with attenuated symptoms.
- Characterized by delusions, hallucinations, disorganized speech and behavior.
- Associated with neurocognitive deficits, apathy, amotivation, impaired executive function ➔ disabling.
- Social or occupational dysfunction.
- Symptoms must have been present for six months and include at least one month of active symptoms.
- Outcomes are highly variable.
- Some evidence of heritability.
Substance Use Disorders: DSM V

• Taking the drug in larger amounts and for longer than intended.
• Wanting to cut down or quit but not being able to do it
• Spending a lot of time obtaining the drug
• Craving or a strong desire to use (drug)
• Repeatedly unable to carry out major obligations at work, school, or home due to drug use
• Continued use despite persistent or recurring social or interpersonal problems caused or made worse by drug use
• Stopping or reducing important social, occupational, or recreational activities due to drug use
• Recurrent use of drug in physically hazardous situations
• Consistent use of drug despite acknowledgment of persistent or recurrent physical or psychological difficulties from using drug
• Tolerance
  – as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or
  – markedly diminished effect with continued use of the same amount.
• Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)
Behavioral Issues

A behavior becomes a problem when it is associated with:

- Distress (*subjective experience of the resident*)
- Disability (*observable functional impairment*)
- Disruption (*interference with delivery of care, or disturbance of the living environment*)
- Danger (*to self or others*)

Making Sense of Behavioral Symptoms in Nursing Home Residents: Alternatives to Antipsychotic Drug Use. Quality Insights Webinar 2.20.13 Joel E. Streim, M.D.
Common Behavioral Issues

- Restlessness
- Yelling or verbal hostility
- Rejection of care
- Apathy/lethargy
- Physical combativeness

Making Sense of Behavioral Symptoms in Nursing Home Residents: Alternatives to Antipsychotic Drug Use. Quality Insights Webinar 2.20.13 Joel E. Streim, M.D.
Understanding Behavioral Issues

• Not all behavioral symptoms are problems.

• Most ongoing problematic behaviors among nursing home residents are not likely to respond to medication in the long term.
  • Most behaviors are not caused by psychotic illnesses.
  • Only a small proportion of residents have conditions that can be appropriately treated with antipsychotic medication.
  • Medications may exacerbate problems (e.g. akathisia, confusion) or lead to harm.

• Behavior problems are often triggered by an approach to care that fails to incorporate the resident’s own experience.
  • E.g. care that is based solely on facility routines and caregivers’ perceptions often causes the resident to become anxious, fearful, irritable, or angry.
Understanding Resident Behavior

• All behavior makes sense / has meaning

• Applies to residents with and without dementia

• Looking for reasons behind behaviors by “stepping into the resident’s world”

• This focuses on the problem-solving to meet the member’s needs and allows teams to identify person-centered solutions.
  – Are responsive to resident needs
  – May avoid the use of medications
Common misattributions for behaviors

Caregiver may assume resident is:
• Angry / Belligerent
• Lazy / Dependent
• Manipulative

Often, a behavior that is interpreted as “uncooperative” is actually better explained by cognitive disability
Causal and Contributing Factors

- Cognitive deficits
- Unmet needs *(physical and psychological)*
- Environmental / social irritants
- Medical illness / physical discomfort
- Psychiatric conditions
- Adverse drug effects

Making Sense of Behavioral Symptoms in Nursing Home Residents: Alternatives to Antipsychotic Drug Use. Quality Insights Webinar 2.20.13 Joel E. Streim, M.D.
Cognitive Domains Impaired in Dementia

• Memory loss (*amnesia*)

• Decline in other cognitive functions.

  ➢ Language (*aphasia*)

  ➢ Visual-spatial function

  ➢ Recognition (*agnosia*)

  ➢ Performing motor activities (*apraxia*)

  ➢ Initiating/executing sequential tasks (*apathy, abulia, executive dysfunction*)
Unmet Needs Can Lead to Behavioral Disturbances

• Spiritual Needs

• Emotional Needs
  – Human interaction, emotional connection, recreation, agency, self-direction, meaning.

• Physical needs
  – Nutrition, hydration, toileting, exercise, rest
Environmental irritants that can lead to behavioral disturbances

• Physical
  – Noise
  – Confusing visual stimuli
  – Physical barriers
  – Uncomfortable temperature
  – Unfamiliar surroundings

• Social
  – Changes in routines
  – Caregiver interactions
Medical conditions and physical discomfort that can lead to behavioral disturbances

Physical discomfort
- Pain
- Constipation
- Urinary urgency
- Shortness of breath
- Dizziness
- Fatigue
Psychiatric conditions that can cause behavioral disturbances

- Depression
- Delirium
- Psychosis
  - delusions
  - hallucinations
- Anxiety
- Sleep disturbance
Adverse drug effects that can cause behavioral disturbances

- Nuisance symptoms
- Anticholinergic effects
- Antihistaminic effects
- Paradoxical excitation / disinhibition
- Intoxication or withdrawal states
- Akathisia (syndrome of motor restlessness)
Identification of any of these modifiable causes—
✓ unmet needs
✓ environmental and social irritants
✓ medical illness and physical discomfort
✓ psychiatric conditions
✓ adverse drug effects—

points the way to specific interventions
Person-centered Care: HOW?

• Look for meaning in verbal and non-verbal communication

• Ask, “what do you want? “how can I help?”

• Listen for clues to sources of distress or unmet needs

• Avoid saying “no”, arguing or disagreeing

• Offer to help in ways that reduce distress or meet needs, without compromising safety
Remember: There’s no one-size-fits-all response to behaviors

- Different residents have different situations and needs.

- Residents change over time; needs and behaviors change, too.

- Some responses work one day, not the next.

- Some responses work for one caregiver, but not another.

- Responses must be tailored to the individual and modified over time.
Institutional Approaches

- Consistent staff assignments

- Assignment of staff across disciplines to supervise everyday leisure activities
  - Group
  - Individual / solitary
  - Beyond structured recreation therapy

- Space for exercise, outdoor activities
Aggression

• Often the result of a medical condition such as infections or endocrine conditions

• Common in dementia.

• Can be due to underlying/untreated mental health conditions such as schizophrenia, PTSD, Anxiety, Depression

• Sundowning.

• Medications (may confuse/disinhibit)

• Interpersonal discord with peers and staff.
Aggression Management

Prevention/De-escalation

- Active listening
- Verbal responding
- Redirection
- “Fiblets”
- Stance
- Positioning
- “Tincture" of time
- Not jumping to conclusions
- Controlling the environment
- Teamwork
Strategies for Communicating with Residents with Mental Illness

**DO**
- Minimize distractions
- Use active listening.
- Mind non-verbals. Understand that eye-contact may be threatening.
- Simplify and be straightforward.
- Acknowledge what the other person says and how they feel, even if you don’t agree.
- Engage by asking for opinions and suggestions.
- Look for common ground. Avoid unnecessary confrontation.
- Stick to present issues.
- Use humor in easy situations.
- Ask permission before physical contact.

**DON’T**
- Don’t take things personally.
- Don’t criticize, accuse or blame.
- Don’t make assumptions. Clarify by asking questions.
- Don’t raise your voice or attempt to intimidate or “discipline” the person.
- Don’t use sarcasm and avoid humor in difficult situations
- Avoid sounding patronizing or condescending.
Treatment: a Bio-Psycho-Social approach

- A thorough, careful review to rule out underlying causes.
- ALWAYS rule out delirium.
- Investigate personal and family history.
- Review medications, especially if new-onset and temporally related to addition/discontinuation of medication.
- Review drug/addiction history.
- Physical examination: look for stigmata of ETOH/opioid/other drug use.
- Investigate for potential underlying etiologies: ABGs, EKG, ECHO, Holter, serum PTH, TSH, CMP, CBC, MRI, catecholamines.
- Check serum markers for ETOH addiction, such as MCV, GGT, LFTs, CDT.
Medication Use in LTC facility Residents

• Appropriate use of psychiatric medications in LTC facilities is a long-standing quality of care issue.

• Inappropriate prescribing includes that aimed at addressing behavioral symptoms by using sedating medications, partly to compensate for poor staffing levels (Hughes & Lapane, 2005).

• Concerns about the possible misuse of antipsychotic medications in LTC facilities led to the development of a special section of the OBRA regulations in order to restrict their use.

• Stevenson et al. (in press) found that 40% of LTC facility residents using an antipsychotic medication had no appropriate indication for such use, while 42% of residents who took benzodiazepines had no appropriate indication.

• Despite widespread use, clinical trials research studies show modest effectiveness at best and underscore significant potential side effect
  
  – Antipsychotics are somewhat effective but overall effectiveness was offset by adverse events resulting in physicians discontinuing the medication (Karlawish, 2006; Schneider, Dagerman, & Insel, 2005)
Medication Use in NH Residents

- In one study, 27.6% of Medicare beneficiaries in LTC facilities received an antipsychotic prescription during the study period (Briesacher et al., 2005).
  - Only 41.8% received antipsychotic therapy in accordance with nursing home prescribing guidelines;
  - 23.4% of residents had no appropriate indication,
  - 17.2% had daily doses exceeding recommended levels,
  - 17.6% had both inappropriate indications and high dosing (Briesacher et al., 2005).
Psychotherapy

• Generally underutilized

• Fewer side effects compared with psychiatric drug regimens (Bharucha, Dew, Miller, Borson, & Reynolds, 2006).

• Reminiscence group therapies (Goldwasser, Auerbach, & Harkins, 1987)
  – Significantly decrease depression scores, as measured by the GDS and the Beck Depression Inventory (Cook, 1991; Haight, Michel, & Hendrix, 1998; E. D. Jones, 2003).

• Other nonpharmacological therapeutic modalities include
  – Improve/give a sense of control
  – Problem solving
  – Cognitive behavioral therapies
    • Shown to decrease depression symptoms and improve the quality of life for residents in the nursing home (Zerhusen, Boyle, & Wilson, 1991)
Social Treatments

• Appropriately involving family, friends whom the patient identifies as being supportive with their permission.

• Help pt. with realistic planning: imparts a sense of control and direction.

• Pastoral care/involving religious community.

• Social work: can be helpful in identifying additional resources.
Kenneth "Bubba" Levesque died of a Fentanyl overdose two days after he was discharged from Braemoor Health Center. State investigators found that the home failed to provide him with substance abuse counseling.
Addiction in LTC facilities.

- A growing problem in the elderly population
  - Up to 15%.
- Often unrecognized.
- Easily missed/not screened for routinely.
- Mostly alcohol, OTC and prescription meds (opioids, benzodiazepines, muscle relaxants, sedatives).
- Some patients have a lifetime history of drug use.
  - May have significant mental health and medical problems arising from drug use.
- May be lethal given changes in body’s handling of medication with age.
- May involve an accomplice.
Recognizing Addiction in LTC facilities.

- Mood changes: depression, anxiety, and irritability.
- Memory problems.
- Fatigue
- Sleep problems
- Confusion
- Sudden/new/recent onset cognitive problems
  - Difficulty with concentration, loss of short-term memory, and general loss of interest.
- May involve problem behaviors
  - Asking to go outside at unusual times
  - Withdrawal symptoms for some drugs
  - Notable change in cognition, mood or behavior following outings/visits by certain persons.
  - Clear change from baseline.
- May be administered in unusual ways (iv lines/ports, feeding tubes).
  - Can lead to medical complications (central line infections, endocarditis)
Treating Addiction in LTC facilities.

- Recommend proactively planning for and developing policy in this regard.

- May require referral to treatment facility/program if sufficiently severe.

- Consider medication-assisted treatment.
Questions