2013 WEBINAR SERIES

STATE OF THE SCIENCE:
DEMENTIA EVALUATION AND MANAGEMENT
AMONG DIVERSE OLDER ADULTS AND THEIR FAMILIES

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Please mute your Headset!!
NON-PHARMACOLOGICAL INTERVENTIONS FOR PERSONS WITH DEMENTIA & BEHAVIOR PROBLEMS

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Q & A after the presentation

• We will reserve time at the end of the presentation for questions. If you have any questions, please use the “Chat” feature located on the right side of your screen. Please send your chat to everyone if possible.

• After the Q and A, We would like to ask each of the participants to answer the short evaluation questionnaire.

Please complete our short survey, We appreciate your feedback.
NOTE: Continuing Education Participants must complete a final survey in order to receive CEU/CME credit.

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“Non-pharmacological interventions for persons with dementia & behavior problems”

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Suzann Ogland-Hand: I have the following financial relationships to disclose: Honoraria from: Stanford Geriatric Education Center Employee of: Pine Rest Christian Mental Health Services
Kim Curyto: I have the following financial relationships: Employee of: VA Western New York Healthcare System

About the Presenters

Kim Curyto, PhD, received her PhD in clinical psychology from Wayne State University, Detroit, MI, in 2000. She completed internships at Temple University Hospital and the University of Pennsylvania, and did post-doctoral work at Polisher Research Institute at the Philadelphia Geriatric Center. Currently, she practices at the VA Western New York Healthcare System, in the Community Living Center. Clinical and research interests focus on interventions to increase positive affect and behavior and overall quality of life in persons with dementia.

Suzann Ogland-Hand, PhD, received her PhD in clinical psychology from Fuller Graduate School of Psychology at Fuller Seminary, Pasadena, CA, in 1993. She completed her internship and post-doctoral training in geropsychology at the Palo Alto VA. Currently, she practices at Pine Rest Christian Mental Health Services, a non-profit free-standing behavioral health facility in Grand Rapids, MI. She also holds an adjunct assistant professor appointment in the department of psychiatry at Michigan State University, and is active with the Geriatric Education Center of Michigan.

Co-authors partnered in creating a residential treatment program for persons with dementia and significant behavioral problems.
Overview

- Mood & behavioral problems associated with dementia
  - Depression, anxiety, behavior problems
- Behavior Assessment
- Non-Pharmacologic Interventions for problem behaviors
  - Theoretical models
    - Learning Behavior Model
    - Person Environment Fit
    - Unmet Needs Model
  - Evidence-based treatments (EBT’s)
- Positive Behavior Approach: Implementation
  - Barriers to implementation
  - Process of implementing

Mood & Behavioral Problems Associated with Dementia

- 50 - 70% in LTC have Alzheimer’s disease or other dementias
- Prevalence Rates
  - Depression
    - 1.5% – 25%; these rates are likely low  (Rosenberg, et al, 2005)
    - 50% LTC residents  (Jongenelis et al, 2004)
  - Anxiety
    - 12 – 50%  (Herbert et al, 2003; Shankar, et al, 1999)
  - Behavior Problems
Mood Problems

- Difficult to assess in dementia
- Self-report suspect, over time
  - Memory loss
- Language problems
- Reliability of informants

Depression in Dementia

Cornell Scale for Depression in Dementia (CSDD)
- 19-item
- Rated 0 (absent) to 2 (severe)
- Clinician-administered, based on observation or informant-based questions (e.g., caregivers)
- Clinical judgment is critical aspect of CSDD
- Cut-off varies; 8 is often used

(Alexopoulos, et al, 1988)
Anxiety in Dementia

Rating Anxiety in Dementia (RAID)
- 18-item
- Rated 0 (absent) to 3 (severe)
- Designed to be based on caregiver or staff report, patient interview, and clinical notes
- Scores range 0 – 54, with >11 indicating significant clinical anxiety

(Shankar, et al, 1999)

Mental & Behavioral Health Needs in LTC: Impact

Caregivers in LTC: not always trained or equipped to deal with these needs

Impact of unmet behavioral health needs
- Poor quality of care and quality of life
- Caregiver burden and turnover
- Increased cost of care
  - psychiatric hospitalization, ER visits
  - frequent transitions
  - higher level of care, institutionalization

(Connelly, Campbell, 1991; Brotons, Pickett-Cooper, 1996; Daniel, 2000)
Behavior Assessment

• Before decreasing problem behaviors, we must be able to describe them
  ◦ Be specific
  ◦ Break complex behaviors down into simple components i.e., “aggressive”
    • What does the person do? “hits”
    • Toward who or what? “self”
    • How often? “everyday”

Behavior Assessment

• Identify the Activators and Consequences, ask the ‘W’ questions
  ◦ What
  ◦ Why
  ◦ When
  ◦ Where
  ◦ Who
Observation is How We Find Patterns

• Are there days that behavior does *not* occur?
• Does it only happen around certain people?
• Does it have a cyclic pattern?
• Is it more likely under certain conditions?

Behaviors Rated by Dimension

(Cohen-Mansfield, 2000)
### Assessment: Problem Behaviors We Don't Want

<table>
<thead>
<tr>
<th>Verbally Nonaggressive</th>
<th>Verbally Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal/Vocal</td>
<td></td>
</tr>
<tr>
<td>- complaining</td>
<td>- cursing and verbal aggression</td>
</tr>
<tr>
<td>- negativism</td>
<td>- making strange noises</td>
</tr>
<tr>
<td>- repetitive sentences or questions</td>
<td>- verbal sexual advances</td>
</tr>
<tr>
<td>- constant, unwarranted requests for attention</td>
<td>- screaming</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nonaggressive</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically Nonaggressive</td>
<td>Physically Aggressive</td>
</tr>
<tr>
<td>Physical</td>
<td>Physical</td>
</tr>
<tr>
<td>- performing repetitious mannerisms</td>
<td>- physical sexual advances</td>
</tr>
<tr>
<td>- inappropriate robbing and disrobing</td>
<td>- hurting self or others</td>
</tr>
<tr>
<td>- eating inappropriate substances</td>
<td>- throwing things</td>
</tr>
<tr>
<td>- handling things inappropriately</td>
<td>- tearing things</td>
</tr>
<tr>
<td>- trying to get to a different place</td>
<td>- scratching</td>
</tr>
<tr>
<td>- pacing, aimless wandering</td>
<td>- grabbing</td>
</tr>
<tr>
<td>- intentional falling</td>
<td>- pushing</td>
</tr>
<tr>
<td>- general restlessness</td>
<td>- spitting</td>
</tr>
<tr>
<td>- hoarding things</td>
<td>- kicking</td>
</tr>
<tr>
<td>- hiding things</td>
<td>- biting</td>
</tr>
<tr>
<td></td>
<td>- hitting</td>
</tr>
</tbody>
</table>

(Cohen-Mansfield, 2000)

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### Behavior Assessment: Excess Disability & Behavioral Deficits

- Behaviors we expect/want to see and don’t
  - Decreased social engagement
  - Apathy/decreased display of emotion
  - Physical dependency/ADL limitations greater than expected because of illness/disease
  - Not engaged with surroundings
- Assess depression, anxiety, sensory deficits, poor environment, pain, psychosis
- Problem behaviors easily fill the void
Good news . . .
Problem behaviors can DECREASE!

Theoretical Model of
Non-Pharmacologic Intervention
For Problem Behaviors
**Theoretical Models of Behavior Intervention**

- **Locus of change:** Environment
- **Need to assess the reason/cause**
  - Need to understand behavior before you act
  - Focus on the person
  - Maintain or rely on person’s ability
- **Focus on psychosocial interventions, & avoids drawbacks of medication**
  - Side effects
  - Drug interactions
  - Limited value (increase positive behavior)
Evidence Based Interventions for Problem Behavior

- Evidence-Based Behavior Interventions
  - Show that improvement would not have happened without intervention (comparison group, ABA design)
  - At least 2 separate studies, at least 30 participants studied
- Treatments based on psychological theory

Evidence Based Treatment (EBT) for Problem Behavior

- Learning Behavior Model:
  - ABC Intervention
  - Pleasant Events Scheduling
- Person Environment Fit (PEF) Model
  - Environment Interventions
  - Simulated Presence Therapy
  - Activity Programming
- Unmet Needs Model
  - Treatment Routes for Evaluating Agitation (TREA)
Learning Behavior Model

- Connection occurs between activators, behavior, & consequences
- Problem behavior learned through reinforcement from others
- Goal:
  - reinforce positive, appropriate behavior through associations and reinforcement (& not problem behavior)

ABC Intervention: Caregiver Training

- Teach caregivers to identify activators, behavior, and consequences (ABCs) to identify predictors and change reinforcers
- Manualized
- Intervention Logistics:
  - 2 half-day workshops, 4 individual sessions
  - 8-9 60-90 minutes sessions, peer support

(Procter et al, 1999; Teri et al, 2003; Teri et al, 2005)
Behavior Assessment: ABC Intervention

“A” Activators
- What happened just before “B”?
  - People (+ or –)
  - Places
  - Things
  - Events
  - Time of Day
- Describe:
  - Looks like
  - Frequency
  - Duration
  - Intensity

“B” Behavior
- What happened just after “B”?
  - What happened
  - Reaction from others
  - Get something
  - Avoid something
  - Other changes

“C” Consequences
- Change the “A”s
- Change the “B”
- Change the “C”s

Behavior Plan: ABC Intervention

Change the “A”s
- How will you change your approach?
- How will you change the environment?

Change the “B”
- What is the desired GOAL behavior?

Change the “C”s
- What will you do when the goal behavior happens?
- What will you do if it does not?
Changing Activators

Identifying and changing activators can prevent a behavior from happening and lead to more positive behavior

Source: Teri

Modifying Consequences

Changing the response to behaviors can reduce their duration, severity, and probability of occurring in the future

Source: Teri
Case Example: ABC Intervention

- Ms. Smith is incontinent of urine, and you need to clean her up. You dread doing it because you know you’re going to be in for a fight. As you transfer her to the toilet, you brace yourself to be cursed and pinched and kicked. As you expected, it happens. After being pinched and kicked a couple of times, you leave and Ms. Smith calms down.

Case Example: ABC Intervention

- Activators = help predict & prevent behaviors
  - Ms. Smith is incontinent
  - Caregiver transfers her
  - Caregiver braces her/himself with approach
- Behaviors
  - Pinching and kicking the caregiver
- Consequences = maintain the behavior
  - Caregiver leaves and Ms. Smith calms down
Case Example: ABC Intervention

- The caregiver has Ms. Smith use a toileting schedule to avoid the trigger of incontinence. The next time she is incontinent, you ask another caregiver to help. She holds Ms. Smith’s hands, lets her know what is going to happen before you provide care and talks with her about an enjoyed topic (i.e. grandkids).

- Intervention:
  - Toileting schedule (avoid trigger of being wet)
  - Two caregivers approach (they are more relaxed)
  - Announcements to help Ms. Smith understand what is happening
  - Distract her with conversation (she is engaged and calm)

ABC Intervention Caregiver Training: Outcomes with Facility Staff

<table>
<thead>
<tr>
<th>STUDY</th>
<th>SETTING</th>
<th>N</th>
<th>DESIGN</th>
<th>OUTCOME p&lt;.05</th>
</tr>
</thead>
</table>
| Teri et al (2005)   | Assisted Living  | 31  | Treatment vs. control | < Behavior symptoms frequency  
                             < Depression & anxiety                                                |
                             < Depression                                                      |
### ABC Intervention Caregiver Training: Outcomes with Community Cgs

<table>
<thead>
<tr>
<th>STUDY</th>
<th>SETTING</th>
<th>N</th>
<th>DESIGN</th>
<th>OUTCOME p&lt;.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teri et al. (2003)</td>
<td>Research staff train cgs in home</td>
<td>153</td>
<td>Treatment vs. control</td>
<td>&lt; Institutionalized due to behavior symptoms &lt; depression</td>
</tr>
<tr>
<td>Teri et al. (2005)</td>
<td>Trained consultants train cgs in home</td>
<td>95</td>
<td>Treatment vs. control</td>
<td>&lt; Cg rated behavior frequency &amp; severity</td>
</tr>
</tbody>
</table>

### Pleasant Events Scheduling

- **Pleasant Events Schedule**
  - Identify individual pleasant events
- **Pleasant Events delivered 1:1, 3x/week for 20-30 minutes for 3 months**
  - Increase positive behavior, replace potential problem behaviors
- **Manualized training**
  - 5 hours training
  - weekly supervision
  - monthly conference calls

(Gittin et al, 2008; Lichtenberg et al, 2005; Teri et al, 2005)
Case Example: Pleasant Events Scheduling

Mr. Brook has difficulty finding things to do and starting activities because of dementia. He has poor eyesight and hearing. He usually spends his time looking down with his head in his hand in the dining room. He makes constant noises and requests during downtime. This noise bothers others around him and places him in danger of retaliation.

Case Example: Pleasant Events Scheduling

- **Activators** = help predict & prevent behaviors
  - Mr. Brooks is not engaged
  - He gets less stimulation due to poor hearing and eyesight
- **Behaviors**
  - Repeated noises, constant requests
- **Consequences** = maintain the behavior
  - Mr. Brooks likely gets interaction and/or stimulation
- **Intervention**
  - Assess activities that he would enjoy (used to like reading western novels)
  - Adapt to sensory impairment (listen to audio books of Western stories using headphones)
  - Few times/week during downtimes
### Pleasant Events Schedule

**30-items**

(Logsdon & Teri, 1991)

<table>
<thead>
<tr>
<th>Activity examples</th>
<th>Pleasant Now 0=no 1=yes</th>
<th>Available past mo 0=no 1=yes</th>
<th>Frequency past week 0=none 1=1-6/wk 2=7+/wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting, walking, wheelchair outside</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading, listening to books on tape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crossword, jigsaw, word game puzzle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to sounds of nature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting or sending cards, letters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having coffee, tea, cocoa with others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercising (walking, stretching, PT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grooming (shave, nail care, hair care)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Recalling or discussing past events</td>
<td></td>
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</tbody>
</table>

### Pleasant Events Scheduling: Outcomes

<table>
<thead>
<tr>
<th>STUDY</th>
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<th>N</th>
<th>DESIGN</th>
<th>OUTCOME p&lt;.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teri et al. (1997)</td>
<td>Community caregivers</td>
<td>72</td>
<td>Treatment vs. control</td>
<td>&lt; % with behavior symptoms &lt; Depression</td>
</tr>
<tr>
<td>Gitlin et al. (2008)</td>
<td>Community caregivers</td>
<td>60</td>
<td>Treatment vs. control</td>
<td>&lt; # &amp; frequency of behaviors &gt; Engagement</td>
</tr>
<tr>
<td>Lichtenberg et al. (2005)</td>
<td>Nursing Home</td>
<td>20</td>
<td>Treatment vs. usual care</td>
<td>= Behavior frequency decrease &lt; Behavior severity</td>
</tr>
</tbody>
</table>
**Person Environment Fit Model**

- As mental abilities decline, person relies more on surroundings.
- Disruptive behavior = poor fit between abilities of person and demands of surroundings leads to more disability than expected by their condition.
- Using physical and social surroundings as mental prosthesis.
- Goal:
  - Match demands of surroundings to abilities of person.

(Lawton & Nahemow, 1973)

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**Environment Interventions**

- Match/adjust the demands and design of environment to level of ability of person.
- Not manualized.
- Intervention Logistics
  - Ranged from one 4-hour or two 3-hour in home caregiver counseling/training sessions.
  - Some followed with 2/week 15-minute phone sessions.

(Gerdner et al, 2002; Huang et al, 2003)
Examples of Environment Adjusted to Ability

- **Meaningful stimulation**
  - Different textures, objects to manipulate (i.e. tackle box and lures with no hooks), aroma therapy, music
  - Change environment to allow activities (i.e. kitchen counter at wheelchair height, closet bars adjustable)

- **Familiar cues** – where to go, what to expect
  - High-contrast labels, cues, props, personal memorabilia
  - Increase natural lighting
  - Contrast between objects & background – toilet, steps

- **Decrease over-stimulation**
  - Simplify (reduce clutter, smaller groups of people)
  - Regulate stimulation from TVs, alarms, etc.


Case Example: Environmental Intervention

- Mr. Johnson has dementia. He likes to wander from room to room in the afternoon. He looks into all the rooms to see what is happening. You need him to stay close because he has been unsteady, and you are afraid he will fall and hurt himself. He will often become incontinent following his search.
Case Example: Environmental Intervention

- Assessment
  - Behavior: Wandering unsafely
  - Environment: Halls, activity not visible, afternoon. Bathroom is hard to see.
  - Ability: Poor balance. Loss of memory.

- Intervention:
  - Help Mr. Johnson engage in favorite activities that don’t require balance or memory in afternoons
    - Set out items to manipulate, such as a deck of large print cards to sort and lures without the hooks to put away in a tackle box
  - Help Mr. Johnson find bathroom when needed
    - Keep bathroom door open, paint around the toilet to make it more visible, post signs with picture of a toilet

Environment Interventions: Outcomes in Community Caregivers

<table>
<thead>
<tr>
<th>STUDY</th>
<th>N</th>
<th>DESIGN</th>
<th>OUTCOME p&lt;.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerdner et al. (2002)</td>
<td>132</td>
<td>Treatment vs. comparison</td>
<td>&lt; Behavior frequency based on non-spousal caregivers only</td>
</tr>
<tr>
<td>Huang et al. (2003)</td>
<td>48</td>
<td>Treatment vs. control</td>
<td>&lt; Behavior frequency</td>
</tr>
</tbody>
</table>
Simulated Presence Therapy

- 15 minute audiotape of only family member’s part of a conversation with the person about positive past events and most cherished memories to allow response/interaction

- Logistics
  - Played with headphones during problem behavior episodes or at high risk times.
  - Played strategically 15 minutes/day, 3 days/week

(Camberg et al, 1999; Garland et al, 2007)

Simulated Presence Therapy: Outcomes in the Nursing Home

<table>
<thead>
<tr>
<th>STUDY</th>
<th>N</th>
<th>DESIGN</th>
<th>OUTCOME p&lt;.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camberg et al. (1999)</td>
<td>54</td>
<td>Random sequencing of tx vs. usual care vs. placebo with washout</td>
<td>&lt; Staff observed behavior sxs in tx phase up to 15 minutes after</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt; Observed interest up to 15 minutes after</td>
</tr>
<tr>
<td>Garland et al. (2007)</td>
<td>30</td>
<td>Same as above</td>
<td>&lt; Physical and verbal agitation frequency in tx phase + 15 minutes</td>
</tr>
</tbody>
</table>
Planned Activity Programming

- Planned activities
  - Meaningful, small group activities
  - Adjusted to mental ability, avoid over-stimulation
  - Alternated with times of rest and downtime
- Logistics
  - Delivered by recreation therapist or taught to caregivers in eight 1-hour sessions
  - During high need times (e.g., 10am-3pm; 2:30-4:30pm)
  - Adjusted to individually preferred times

(Rovner et al, 1996; Putnam & Wang 2007; Volicer et al 2006)

Planned Activities Adjusted to Ability: Examples

- Reminiscing
- Memory books
- Meaningful life activities (hobbies, chores)
- Care of plants/animals
- Appropriate music
- Aroma therapy
- Different textures, objects to manipulate

(E.g. Allen-Burge Stevens, & Burgio, 1999; Cohen-Mansfield, 2001; Day, Carreon, & Stump, 2000; McCabe, Davison, & George, 2007; Logsdon, McCurry, and Terri, 2007; Opie, Rosewarne, & O’Connor, 1999)
Planned Activity Scheduling: Outcomes in the Nursing Home

<table>
<thead>
<tr>
<th>STUDY</th>
<th>N</th>
<th>DESIGN</th>
<th>OUTCOME p&lt;.05</th>
</tr>
</thead>
</table>
| Rovner et al. (1996)| 81 | Treatment vs. control | < Met criteria for a behavior disorder  
< Restraints & antipsychotic meds  
> Activity participation |
| Volicer et al (2005)| 28 | Pre-post      | < Use of psychotropic medications  
< Social isolation |
| Putnam et al (2007) | 13 | Pre-post      | < Behavior symptoms, screaming & complaining especially |

Unmet Needs Model

- Need-Driven, Dementia-Compromised Behavior
- Unmet needs are causing problem behavior
- Problem behaviors = due to interaction among habits & personality, current physical and mental abilities and difficulties, and unfavorable surroundings
- Goal:
  - Prevent reaching the point of unmet need

Treatment Routes for Exploring Agitation (TREA) strategy

- Decision trees use correlates of behavior subtypes to guide:
  - 1) Exploration of associated needs
  - 2) Identifying personally meaningful interventions, adjusted to ability, that meet the person-specific need
- Detailed in publications, Not (yet) manualized
- Intervention Logistics
  - 10-14 days during 4 hours of most frequent problem behaviors
  - Target most problematic behavior subtype
  - Implemented by research assistant, interdisciplinary team


Verbal/Vocal Behavior

- Physical pain or discomfort?
- Need for social contact?
- Need for stimulation? Boredom?
- Need for control?
- Insufficient daylight
- Misinterpretation of the situation?
- Hallucinations?

- Medical treatment or Nursing intervention
- Social interaction: Real or taped
- Identify meaningful activities/ Physical exercise
- Offer choices/Provide tasks that allow for control
- Take outside or use bright light therapy
- Improve communication
- Check vision/hearing or try using familiar objects or people

(Cohen-Mansfield, 2000)
Case Example: TREA Strategy

- Mrs. Kane has significant difficulty with memory for instructions and understanding what others are saying to her due to dementia. She has always enjoyed baths once a week in the evening. She just moved to a new residence. She is scheduled for a shower three times a week in the morning, and consistently refuses. She makes threats to hurt caregivers and will hit and scratch during showering.
Aggressive Behavior (physical & verbal)

- Trying to communicate discomfort?
  - Change environment to be more comfortable

- Delusions or hallucinations?
  - Check vision, hearing, or other causes of misinterpretation

- Person feels you invaded his/her personal space?
  - Try new approaches for getting closer to the person

- Refusing an ADL?
  - Perform ADL at different time or by a different method

- Bothered by another resident?
  - Try to separate the people who may trigger negative responses

Cohen-Mansfield, 2000

TREA Model: Outcomes

<table>
<thead>
<tr>
<th>STUDY</th>
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<th>OUTCOME p&lt;.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohen-Mansfield et al. (2007)</td>
<td>Nursing home</td>
<td>89</td>
<td>Treatment vs. control unit</td>
<td>&lt; Behavior frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt; Pleasure &amp; interest</td>
</tr>
<tr>
<td>Cohen-Mansfield et al. (2007)</td>
<td>Nursing home</td>
<td>167</td>
<td>Treatment vs. control facility</td>
<td>&lt; Behavior frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt; Pleasure &amp; interest</td>
</tr>
<tr>
<td>Curyto et al. (In progress)</td>
<td>Assisted living</td>
<td>24</td>
<td>Pre-post, 4 month follow up</td>
<td>&lt; Behavior frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt; Active participation</td>
</tr>
</tbody>
</table>
Implementing EBTs

• THE QUESTION:
  why aren’t they used more?

Implementing EBTs: Barriers

• Therapeutic nihilism
  ◦ “nothing can be done” or “nothing will work”
• Turf battles
  ◦ lack of agreement between cgs, disciplines & shifts about priorities & goals
• Lack of or poor communication
  ◦ about behavior problems, intervention plan, goals, & outcomes
• Lack of information
  ◦ knowledge or training about dementia, problem behaviors, and EBTs
  ◦ detail about how to implement the intervention, key components
• Caregiver time constraints
  ◦ lack of time, coverage, and commitment to training and ongoing supervision
• Return to the norm
  ◦ no support, feedback, incentives, or boosters to maintain EBTs

(Curyto et al, 2012)
Implementing EBTs: Process

- Caregiver training
  - Informational training, offered to all caregivers, interactive
  - On-the-job support and consultation/booster sessions
- Comprehensive assessment
  - Medical, physical, mood, behavior, cognition, & psychosocial function
  - Person-centered & recovery focused

(Curyto et al, 2012)

Implementing EBTs: Process

- Developing person-centered behavior plans
  - Assessment based
  - Guided by EBTs
  - Comprehensive interdisciplinary goals
- Standardized measures for tracking behavior symptoms
  - Identify patterns of behavior
  - Identify successful and unsuccessful interventions
  - Track outcomes

(Curyto et al, 2012)
Implementing EBTs: Process

Caregiver-Report Behavior Measures

- BEHAVE-AD = Behavioral Pathology in Alzheimer’s Disease Rating Scale (Riesberg et al, 1987)
- DBS = Disruptive Behavior Scale (Beck, Frank, Chumbler et al, 1998)
- NPI = Neuro-Psychiatric Inventory (Cummings et al, 1994)
- RMBPC = Revised Memory and Behavior Problem Checklist (Teri, Truax, Logsdon, et al, 1992)

Implementing EBTs: Team Process

- Set realistic expectations – improvement, not a quick fix
- Be open to new ideas, try new approaches
- Collaborative effort – agree on the problem, plan, and goals
- Monitor your own response (emotions, behavior)
Implementing EBT: Resource Recommendations

- Collaborative effort
  - Expect that all disciplines and services need to adjust in support of EBT implementation (nursing, medicine, recreation, food service, housekeeping, facilities)
- Enhance social and physical environment to support EBT implementation. E.g.,
  - Flexible services (meals, bathing, wake and sleep schedules)
  - Outdoor access
  - Change signs, improve lighting
- Ongoing support and incentive/rewards for caregivers

Conclusions

- Many mental health & behavioral health needs exist
- Non-pharmacologic treatments work
  - although treatments are at “quite early stages of intervention development” (Niederehe, 2005)
- EBTs can successfully decrease frequency and severity of disruptive behaviors
- Implementing EBTs require
  - a plan for needed resources and
  - change in process and
  - collaboration among all caregivers, disciplines, and shifts

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Q & A

- We now have some time to answer your questions. If you have any questions, please use the “Chat” feature located on the right side of your screen. **Please send your chat to everyone if possible.**
- After the Q and A, we would like to ask each of the participants to answer the short evaluation questionnaire.

Please complete our short survey. We appreciate your feedback.  
**NOTE:** Continuing Education Participants must complete a final survey in order to receive CEU/CME credit.

Final Question
Thank You for Participating!

Reminder: Please complete our short survey.  
We appreciate your feedback.  
**NOTE:** Continuing Education Participants must complete a final survey in order to receive CEU/CME credit.
References


References

References


References


*reference not included in presentation, but topically relevant