University of East Anglia

nnet neurodegeneration network

What do we know about Behavioural Crises in Dementia?

Behavioural crises in dementia

- There is little good quality evidence showing how best to manage behavioural crises in dementia
- Behavioural crises occur in people with dementia living in family homes and in long-term care institutions
- Key behaviours leading to crises are aggression and agitation
- Behavioural crises predominantly happen in the moderate and severe stages of dementia
- Behavioural crises often lead to admissions to psychiatric care or specialist dementia units, or to use of community services
- Interventions and services to help prevent and manage dementia-related behavioural crises should consider:
  - targeting people in the moderate to severe stages of dementia and their caregivers
  - targeting people living in their family homes and in care homes
  - focussing on reasons behind aggressive and agitated behaviours
  - involving a multi-faceted approach incorporating medical, non-pharmacological and pharmacological approaches

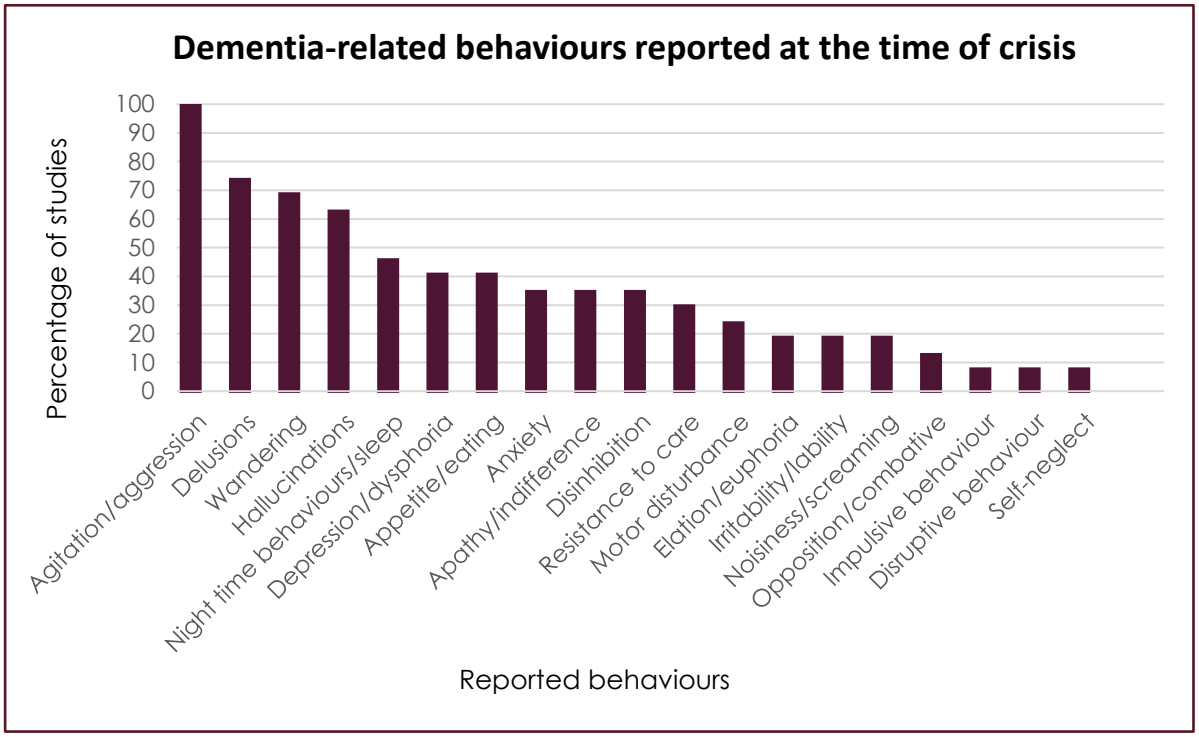
This evidence briefing has been produced by Tamara Backhouse, Julieta Camino and Eneida Mioshi (NNET) at the University of East Anglia (June, 2017) following the receipt of Research Capability Funding from the Norfolk and Waveney CCGs. Full details of methods and references are available on request from Tamara.Backhouse@uea.ac.uk

Background

Over 90% of people with dementia (PwD) will experience behavioural and psychological symptoms (BPSD) such as aggression, agitation, hallucinations, wandering, apathy, delusions and anxiety at some point in their illness, with symptoms co-occurring or increasing over time (Steinberg et al, 2008; Savva et al, 2009). These behaviours can lead to crisis points where those caring for a person feel they require urgent intervention from specialist services.

Behavioural crises

The systematic review informing this report included 18 eligible studies (24 articles – references at end of document), which covered a wide time-span (1990-2016) and took place in multiple countries from Europe, North America, South East Asia, and Australia.



Behavioural crises occurred in people living with dementia predominantly in their own homes (reported in 72% of studies) or in long-term care (67% of studies), however some PwD were in hospital at the time of the behavioural crisis. Most PwD in the studies were in the moderate or severe stages of the syndrome. Participants' mean ages ranged from 61-84, mean 78 years.

Managing behavioural crises

Crisis intervention or resolution strategies varied across the studies. Where non-pharmacological approaches were specified, they included reduction of stimuli, modifying the environment, activities, reduction of physical and pharmaceutical restraints, individualised interventions, changing staff perceptions of behaviour, counselling programmes for relatives and patients, group therapies, educating caregivers, and Occupational Health input.

Pharmacological interventions included psychotropic drugs, medication reviews or adjustments, or the use of cholinesterase inhibitors, and yi-gan-san.

Clinical or medical interventions included reducing pain, promoting nutritional intake and function, physical assessments, and multidisciplinary input.

Key findings

Key behaviours leading to crisis point

- Aggression and agitation
- Delusions
- Wandering
- Hallucinations

Behavioural crises in dementia

- Occur in family homes and long-term care institutions
- Occur in the moderate and severe stages of dementia
- Occur most frequently in females, but when in males psychiatric care is used
- Lead to admissions to psychiatric care or specialist units or to referrals to community services
- Patients can have multiple admissions over a short period of time
- Assessments of behaviours at crisis point vary widely

Treatment of crises

- Usually involves admissions to psychiatric or specialist dementia units
- Combination of pharmacological, non-pharmacological and medical interventions
  - Non-pharmacological interventions include educating caregivers, councelling, therapies and reducing stimuli
  - Pharmacological interventions include psychotropic medications and medication reviews
  - Medical interventions include reducing pain, promoting nutritional intake and function, physical assessments and multidisciplinary input

Implications

- Interventions and services to prevent and manage dementia-related behavioural crises should consider:
  - Targeting people in the moderate to severe stages of dementia and their caregivers
  - Targeting people living in their family homes and in care homes
  - Focussing on reasons behind aggressive and agitated behaviours
  - Involving a multi-faceted approach incorporating medical, non-pharmacological and pharmacological approaches

What remains unknown in the scientific literature?

- Role of dementia subtypes: are crises all the same for different dementia subtypes? For example, crises in Vascular dementia may differ from crises in Alzheimer's disease
- Models of care that may lead to fewer crises
- Whether crises are related to the individual, their caregivers or both parties not managing
- Knowledge of clear factors that could be addressed to prevent behavioral crises

References

- Savva, G. M., Zaccai, J., Matthews, F. E., Davidson, J. E., McKeith, I. & Brayne, C. (2009). Prevalence, correlates and course of behavioural and psychological symptoms of dementia in the population. *British Journal of Psychiatry,* 194(3), 212-219.
- Steinberg M, Shao H, Zandi P, et al. (2008) Point and 5-year period prevalence of neuropsychiatric symptoms in dementia: the Cache County Study. *International Journal of Geriatric Psychiatry*, 23(2):170–7.