Alzheimer’s disease and related conditions: Management of behavioural disorders

May 2009

KEY MESSAGES

• Behavioural disorders (BDs) are of multifactorial origin. They may be determined by:
  - environmental factors, associated with the surroundings, family and friends, carers and health professionals;
  - factors relating specifically to the individual or the condition.

Priority areas for investigation are somatic and psychiatric causes, trigger factors and predisposing factors.

• Appropriate non-pharmacological methods should be used as the first-line treatment for BDs.

• Psychotropic agents are not effective in preventing the onset of BDs.

• Treatment with psychotropic agents must not be prescribed unless an assessment has been carried out in cases of refusal to cooperate, shouting and wandering.

Behavioural disorders include the following: delirious ideas, hallucinations, refusal to cooperate, agitation, aggression, abnormal motor behaviour, disinhibition, shouting, wake-sleep cycle disorders.

Behavioural disorders involve symptoms of different types, but which have common characteristics:

• they are common in these conditions;
• they often indicate a change from the patient’s previous behaviour;
• they are often of variable intensity or episodic;
• they are interdependent, often associated, and interact with each other.

I. Aetiology and approach to diagnosis

The recommended approach is as follows:

• assess the degree of urgency, danger or functional risk in the short term for the patient and for others;
• talk to and examine the patient and talk to family and friends (how long the behaviour has been going on, circumstances in which it occurs);
• investigate an environmental cause, somatic cause (urine retention, infection, acute pain, faecaloma, etc.) or psychiatric cause (severe anxiety) to be treated as a priority, together with iatrogenic factors;
• undertake a more in-depth clinical assessment of the behaviour, the extent to which it occurs and its implications;
• repeat this aetiological review at different points of the patient’s management if the problem persists.

The patient’s behaviour should be observed when he is alone and when interacting with other people, at different points of the patient’s management.

In the event of any problems persisting after several days, they should be assessed using a tool such as the neuropsychiatric inventory (NPI). The NPI is an inventory of the 12 symptoms most frequently reported in Alzheimer’s disease and related conditions, which assesses their frequency and severity, together with the
impact on the carer or health professional. An abridged version is also available which is quicker to complete: NPI-Questionnaire (NPI-Q) and a version intended for nursing home use: NPI-NH. Despite taking quite a long time to complete and the need to train carers in the use of this inventory, use of the NPI is recommended. There is no consensus on the systematic use of this tool, particularly in primary care. According to where the patient lives, the following versions of the NPI may be used:

- at home: NPI or NPI-Q, completed by the carer or a health professional;
- in a nursing home: NPI-NH, completed by the care team.

The following three principles should be applied, regardless of where the patient lives:

- a written log of the information to be recorded on forms or a file to facilitate traceability and transmission;
- it is helpful for a designated spokesperson, possibly a named contact, to collate this information in order to facilitate its transmission;
- the various health professionals involved in the care of the patient must exchange information and/or meet to discuss this information and work together to ensure the patient receives appropriate care.

II. Therapeutic management

Appropriate non-pharmacological methods should be used as the first-line treatment for BDs. These may make it possible to avoid the use of medication.

There is no evidence of the efficacy of the following non-pharmacological treatments: quality of life, speech, cognitive skills, sensory stimulation, motor activity and occupational activities. However, whether used in outpatients or in an institution, they may form part of the patient’s general care. They may be offered individually or collectively and must be provided by trained staff.

Treatment with a psychotropic agent must not begin if symptoms are of somatic or iatrogenic origin.

Psychotropic agents can be used when the care provided is not sufficiently effective, particularly when problems are severe enough to endanger the patient, affect his behaviour, pose a threat or cause serious distress to the patient’s family and friends. Such treatments should be used in synergy with management techniques. They are not effective in preventing the onset of BDs. Their use is not recommended as a first-line treatment and unless an assessment has been carried out in cases of refusal to cooperate, shouting and wandering.

III. Monitoring and preventing BDs

The prevention of BDs should be based on a strategy developed and adjusted to suit each individual patient. General preventive action includes:

- providing information and support to family carers;
- training of health professionals;
- ensuring that the patient’s environment is as well-suited as possible to his condition.