Improving Outcomes for People Living with Complex Behaviour

The ACSA IAHSA Joint International Conference

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Improving Outcomes for People Living with Complex Behaviour

Presentation Overview

- Wintringham Aged Care
- Physical, social, psychological and financial outcomes of complex behaviour for the elderly
- Introducing Margaret’s Case Study
- The psychological drivers of behavioural change
- Prioritising behaviours of concern
- The ABCD of behaviour management
- The Wicking Project: Residential care for older people living with an Alcohol Related Brain Injury
Wintringham is a specialised not for profit welfare company working with elderly homeless men and women in Melbourne Australia.

Established in 1989 as a response to closure of night shelters and inability of aged homeless people to gain access to mainstream aged care services.

In recognition of the high incidence of premature aging among our client population Wintringham provides the full spectrum of aged care services to people aged 50 years and older.
Wintringham Services - Overview

- **Residential Aged Care** - 236 beds located at five different sites around Metropolitan Melbourne

- **Home Care** – 546 Home Care Packages managed from six offices in Melbourne and three regional locations

- **Housing Support & Outreach** - 452 predominantly one-bedroom units located both in Melbourne and in country Victoria.

- **Support services** - Food Services, Research, Clinical Care, Recreation, Maintenance, Finance, IT, Human Resources and OH&S.
Wintringham is driven by a simple and overwhelming conviction: we believe in social justice
Multiple Pathologies Impacting Behaviour & Cognition

- Dementia eg. age-related, progressive disorders
- Alcohol Related Brain Injury & Frontal Lobe damage
  - Disinhibition and poor impulse control
  - Poor insight and decision making
- Acquired Brain Injuries eg. accidents, fights, falls, motor car accidents, loss of consciousness
- Intellectual Disabilities
- Mental Illness eg. anxiety, mood, impulse control
- Personality Disorders – difficult to define/treat
- Physical Illness/Premature Ageing eg. pain, fatigue, disability
- Ongoing episodes of intoxication or drug affects
- Past life experiences / lifestyles; eg. homelessness, prison, violence, hardship, trauma
Common Types of Complex Behaviour

- Perseveration (repetitive or cyclic behaviours)
- Verbal Aggression
- Physical Aggression
- Lack of motivation
- Withdrawal & Social Isolation
- Confusion & Confabulation
- Suspicion & Paranoia
- Provocation & Antagonistic
- Sexually Inappropriate
- Hording & Neglect
- Criminal Activity
- Ongoing Drug & Alcohol Abuse
# Ageing, Homelessness & Cognitive Impairment

<table>
<thead>
<tr>
<th>Neuro cognitive Disorder</th>
<th>Estimated Prevalence</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Severe Cognitive Impairment</td>
<td>10 - 25%</td>
<td>Buhrich et al, 2000</td>
</tr>
<tr>
<td>General Cognitive Impairment</td>
<td>67%</td>
<td>Rogos et al, 2008</td>
</tr>
<tr>
<td>Dementia (incl ABI/ARBI)</td>
<td>82%</td>
<td>Gilchrist &amp; Morrison 2007</td>
</tr>
<tr>
<td>Alcohol Related Brain Injury</td>
<td>21%</td>
<td>“</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>45%</td>
<td>Topolovec-Vranic et al, 2014</td>
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At present the most frequent drug of abuse among the elderly is alcohol\(^1\)

- In a recent study in Melbourne, 43% of an elderly (50+YO) homeless population reported having issues with alcohol\(^2\).
- 75% of older Salvation Army Service clients in Melbourne, were reported to have a cognitive impairment; the majority being alcohol related brain injury\(^3\).
- The problem is much more wide spread than among the older homeless population\(^4\).

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Alcohol & the Body

* Toxic effect on central nervous system
* Changes to metabolism and blood flow
* Affects the body's use of thiamine (Vit B1)
* Is associated with poor diet
* Causes dehydration
* Leads to falls, fights and other medical conditions that may injure the brain

(Ref: www.betterhealth.vic.gov.au)
Alcohol Related Brain Injury (ARBI)

Cerebellar atrophy & Peripheral neuropathy – poor mobility, dexterity, balance & gait

Frontal lobe injury – Thought to be due to alcohol toxicity. Impaired information processing and behavioural changes;

Hepatic encephalopathy – chronic liver disease toxins leading to progressive brain disease

Thiamine Deficiency - Amnestic Syndrome due to haemorrhage in midline structures in the brain

Confusing Terminology
Wernicke’s- Korsakoff’s Syndrome, Alcohol Induced Dementia, Alcoholic Dementia, Korsakoff psychosis Alcohol Related Brain Disease, Substance Abuse Related Brain Injury

(Ref: www.betterhealth.vic.gov.au)
Executive Dysfunction in ARBI

Long-term drinkers experience difficulties with:

• Attention and concentration
• Planning, organisation, problem solving
• Complex, abstract and flexible thinking
• Initiative and motivation
• Emotional and behavioural changes
• Self awareness and insight
• Short/Mid-term memory

www.minddisorders.com
Possible Long-term Consequences of Complex Behaviour

- Premature ageing
- Financial Hardship
- Estrangement from family & friends
- Isolation, self-neglect & malnutrition
- Traumatic injuries & assaults
- Reluctant to seek appropriate, timely medical care & poor compliance
- Addictions – alcohol, other drugs, gambling
- Impaired sense of safety or trust
- Imprisonment & Institutionalisation
- Guardianship & Administration Orders
Barriers to Effective Engagement

Vulnerable older people need tailored approach that must take into account the needs of the whole person. This includes:

- understanding the individual’s physiological, psychological and sociological health and well being;
- poor historians;
- low motivation levels;
- slow to build relationships, rapport & trust;
- low self care practices;
- limited living skills and life skills;
- low income;
- impact of ongoing drug and alcohol use;
- exposure hardship, trauma, violence & discrimination;
- short-term, crisis-driven interactions with services.
Attributions and Stigma

• Perceptions that the person should be ‘Older and Wiser’
• Receive less empathy and often attract more judgemental attitudes in the public view than other older people
• Often driven by fear, others tend to ostracize the person
• Can be judged by others as being ‘unworthy’ or ‘underserving’
• Many people view behaviour as a ‘personal choice’ without understanding that the person is no longer able to regulate their behaviour
• Discrimination against: Alcoholism, Mental Illness, Social class, Racism etc
Margaret

Earlier photo of Margaret – Now Aged 75
Referral

• Margaret has been referred to residential aged care
• Referred by McAuley House (formerly Regina Coeli) which supports women who are homeless or at risk of homelessness
• McAuley House staff reported concerns regarding Margaret’s behaviour during her 9 week stay there.
Clinical history — High Blood Pressure, Chronic Open Airway Disease, Severe Rheumatoid Arthritis, Old hip injury, Short term memory loss, Acquired Brain Injury following a traumatic head injury (2001), Alcohol Related Brain Injury


Addictions — Smoker, Abuse of prescribed medicine (doctor shopping), Drinking 6 – 8 standard drinks of sherry daily.

Social history — Finished Year 10 secondary and then worked as a secretary in a fashion company until she married in her mid 20s. Widowed to her first husband. Divorced from her second husband. 2 children (John 38YO estranged, Mike 42YO minimal contact), 2 Grandchildren to John. Currently has a boyfriend who visits fortnightly (Suspected abusive relationship – violent & demands money).
Housing history — After leaving rehabilitation following a violent assault resulting in an acquired brain injury, Margaret moved to a women’s refuge. She then lived with her son Mike in his OOH unit 2004 – 2011 until their relationship broke down. Margaret moved out and then bunked in with friends for several years prior to moving to McAuley House.

Supporting Agencies — Administration through State Trustees (2004). Occasional contact with the regional mental health service and Salvation Army crisis services.

Current needs — Margaret is independent with most ADLs occasionally requiring prompting for personal care. She is seeking long-term housing with support.
Margaret’s Behaviours of Concern

• Continues to have regular contact with boyfriend – despite suspected physical and financial abuse
• Regularly shoplifts cosmetics and fashion accessories
• Engages in circular repeated conversations and requests
• Intrusive behaviour noted – taking co-resident’s cigarettes from bedrooms etc
• Suspicious of others – accusations
• Verbal aggression (insults) on perceiving that others are telling her what to do
• Demanding staff to promptly respond to her needs and requests
• Sleeping disorder – wakeful at night
• Misuse of alcohol & prescription medication
Unravelling the Complexity

Picasso Weeping Woman, 1937
The Wicking I & II Projects

Older People with Acquired Brain Injury and Associated Complex Behaviours: A Psychosocial Model of Care

In October 2006 Wintringham was awarded a $900,000 J.O and J.R Wicking Trust Research grant administered by ANZ Trustees to develop and trial a specialised model of residential care to support older people living with an alcohol related brain injury (ARBI), in particular older homeless people living with highly complex behaviour.

In January 2012 the Wicking Trust funded a second Wicking II Project to the value of $1.1M which is currently underway in Dandenong, Victoria.
Wicking Project Participants

Phase 1 – living in an independent 4-bedroom home in Flemington (2002 – 2006)

Phase 2 – incorporation within a 60-bed Wintringham residential aged care facility in Dandenong (2012 – 2015)

Men and Women aged 50 years or older

Participants were selectively recruited for:

- a history of homelessness
- unsuccessful tenancies arising from complex behaviours
- the presence of an ARBI
- 28 volunteer participants (7 control participants)
In Response to:

- A distinct lack in statutory provision for the older homeless population in Australia;

- A significant shortage of higher level supportive accommodation for older people with complex behavioural needs (which is not specific-age related dementia);

- Shortage of services with the skills-base and expertise to manage the complexity of need associated with complex neuro-cognitive disability.
Super Specialist Aged Care?

- **Super Specialist Residential Care** (eg Wicking)
- **Specialist Residential Aged Care** (eg Wintringham)
- **Mainstream Residential Aged Care**

Increasing Behaviour Support Needs
Wicking Project Outcome Measures

- Wechsler Adult Intelligence Scale (WAIS-III).
- Wechsler Memory Scale (WMS-III).
- Hopkins Verbal Learning Test (HVLT).
- Rey Complex Figure Test (RCFT).
- Controlled Oral Word Association Test (COWAT).
- Color Word Interference Task (DKEFS).
- Colour Trails.
- Wechsler test of adult reading (WTAR).
- The Hospital Anxiety and Depression Scale (HADS).
- Satisfaction with Life Scale (SWLS).
- Life Role Checklist.
- The Neuropsychiatric Inventory Questionnaire (NPI-Q).
- The Alcohol Use Disorders Identification Test (AUDIT).
- The Overt Behaviour Scale (OBS).
- The Health of the Nation Outcome Scales (HoNOS).
- Community Integration Questionnaire (CIQ).
Psychosocial Model of Specialised Care: The Wicking Projects I & II

• Individualised & specialised care, support, behaviour management strategies
• 25 hours per week of 1:1 structured activity program & structured activity program
• 24-hour specialist residential aged care
• Encouragement and support to maximally utilise structured activity programs focussed on community integration
• Highly trained & skilled personnel
• Neuropsychological support, training & case management
• Harm minimisation model e.g. alcohol and cigarette programs
Outcomes of The Wicking I Project

Specialised Intensive Transition Support

• Cost Benefit
  Economic modelling has demonstrated a cost to government saving of $30 per day for The Wicking Model relative to a crisis driven service interventions.

• Quality of Life Outcomes
  In addition to positive changes in psychological health and general health, all indicators of life quality and wellbeing underwent significant positive change for Wicking Model participants.
Wicking Outcomes
Anxiety & Depression

Anxiety: $F = 9.083, p = 0.013$

Depression: $F = 7.875, p = 0.019$
Wicking Outcomes - Drinking

AUDIT scores * F= 6.11, p=0.03

No of Drinks/Day * F= 8.03, p=0.02
Behaviours of Concern?

It is important to keep in mind that people do not generally set out to intentionally disrupt or challenge others or to be judged negatively. The behaviours that are exhibited can be their way (albeit inappropriate) of endeavouring to have their perceived needs met.

BEHAVIOUR = COMMUNICATION

“Behaviour of Unmet Need”

The key question therefore becomes

“How else can this person’s needs be met?”
Most Common Causes of Complex Behaviour

1. Loss of control and choice and independence
2. Poor impulse control and reduced levels of insight
3. Difficulty comprehending due to slow thought processing, impaired logic and reasoning
4. Not being heard, noticed or understood – stigma
5. Inability to express/articulate needs or emotions
6. Fear and frustration
7. Inability to recall or put together the pieces due to memory loss
8. Memories of abusive, threatening or emotional experiences situations
9. Loss of Life Role
Alcohol and Cigarette Program

Harm Minimisation Strategy

Involves the provision of alcohol and cigarettes in accordance with a prescribed administration regimen

Due to the client’s inability to self regulate their consumption – **Inability to Rehabilitate**

**Requires 100 % consistency**

Inconsistent implementation by staff may avoid immediate challenges but will eventually lead to an escalation in the frequency and severity of behaviours.

Structured Activities
Prioritising Behaviours of Concern

• Get to know the person as best you can
• List the main behaviours avoiding repetition or duplication
• Ensure that non judgemental language is used
• Identify with the client which behaviour they find the most concerning
• Identify associations between behaviours eg. Two different behaviours that occur in response to the one trigger => Management of one behaviour can flow on to the other
• Prioritise the risks associated with each behaviour
• Identify a priority order for developing behaviour plans
The ABCD Approach

Behaviour Management & Planning

A = Antecedents or Causes – What were the background factors and triggers leading up to an incident or behaviour?

B = Behaviour – Precisely what happens? How does the behaviour play out?

C = Consequences & Impact – What happens as a result of the behaviour? Short-term & Longer term.

D = Discuss and Debrief – Brain storm all aspects of the behaviour and consider future actions. Consider the whole person: their strengths and their weaknesses.
# Developing Behaviour Plans

## Behaviour Plan

<table>
<thead>
<tr>
<th>TIME/DATE</th>
<th>SITUATION/TRIGGER</th>
<th>WHAT HAPPENED?</th>
<th>WHO WAS AFFECTED/INVOLVED?</th>
<th>WHAT ARE THE RISKS?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Antecedents</td>
<td>Behaviour</td>
<td>Consequences</td>
<td>Discuss</td>
</tr>
</tbody>
</table>

- **Antecedents**: What triggered/lead to the behaviour or what occurred before the incident?
- **Behaviour**: Describe in detail the incident/behaviour.
- **Consequences**: Who was affected/involved? What was their response? What was the impact?
- **Discuss**: What are the risks? What needs to change? What did or didn't work? What can we try next time?
The need for Routine, Repetition and Consistency

Neuro-psycho-social Approach

• Change the world to fit the person
• Creating an environment in which demands are within the capabilities of the person and the person can function well
Older Homeless Person Living with A Dementia

- Prevention: New Vs Long-Term Homeless
- Policy: Recognition, Support & Funding
- Coordinated Service Delivery
- Establish Specialised Care Services
- Education & Training
- Research: Prevention Service Improvement Cultural
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