

# The Interprofessional Management of Dementia-Related Behavioral and Psychological Disturbances

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## Commentary

# The Interprofessional Management of Dementia-Related Behavioral and Psychological Disturbances

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## Abstract

The comprehensive and patient-centered management of dementia patients requires the collaborative efforts of various disciplines. An emphasis can be placed on the interprofessional relationship that exists among the disciplines of psychiatry, pharmacy, and psychology as it relates to the management of the observable behavioral and psychological disturbances of the disorder. The ability to achieve a positive therapeutic outcome with dementia patients generally involves the active participation of multiple disciplines given the complex and progressive nature of dementia. The existing literature has extensively examined the relationship that exists between nurses and physicians, and the observed successes that have been identified with this collaboration can be extrapolated to other healthcare professions. This article will seek to examine the benefits that can be reaped from the involvement of psychiatry, pharmacy, and psychology in providing a focused and integrated approach to the management of patients with dementia.

## Introduction

Dementia is recognized as a predominant and progressive neurological disorder that can produce cognitive decline with the unremitting disease being associated with changes in personality, behavior, mental ability, psychiatric symptoms, and diminished capacity to function over time (Lehmann, Black, Shore, Kasper, & Rabins, 1997). The most commonly observed characteristic of dementia is the loss of memory and functional skills which can cause impairments in daily activities of living (Jellinger & Attems, 2010). Dementia affects approximately 10% of patients who are 65 years of age and more than 24% of individuals who are 85 years of age or older. The prevalence and incidence of dementia increases exponentially with age from 65 to 85 years (Lloyd, Schneider, Scales, Bailey, & Jones,

2011). One study found that dementia prevalence from all causes generally increases between the seventh and tenth decade from 0.8% to 28.5%, with Alzheimer disease (AD) prevalence (53.7% of total instances) increasing from 0.6% to 22.2% and vascular dementia (15.8%) increasing from 0.3% to 5.2% (or from 0.2% to 16% over age 80) (Lobo, 2000). The center of the healthcare practices of most institutions is founded on the basis of a collaborative practice model which has generally been synonymous with nurses and physicians (Pullon, 2008). The complex nature of dementia requires the collaborative efforts of other key healthcare professionals in order to provide individualized and optimal patient care.

There are different types of dementia, with types including Alzheimer, vascular, Lewy-body, and

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dementia due to Parkinson's disease. Alzheimer dementia is the most commonly and perhaps overdiagnosed, accounting for about 50-60% of all dementia cases. Vascular dementia accounts for 15-20% of all cases in older adults (Muangpaisan & Brayne, 2010). Lewy body dementia can account for 10-25% of all dementia cases, and can be associated with a higher prevalence of psychiatric disturbances compared to Alzheimer. Of all the types, Lewy-Body dementia is found to be more malignant and aggressive in progression when it comes to decline in cognition quality of life, and medical costs (Stubendorff, 2012).

### **Cognitive and Behavioral Symptom Management between Disciplines**

As dementia progressively worsens over time, support is needed. This need demands key healthcare disciplines such as pharmacy, psychology, and psychiatry to work collaboratively in order to promote health and maintain the wellbeing of dementia patients during the early stages of the disease; and work in partnership to promote effective person-centered care during the middle and later stages of the disease (Hogan et al., 2008; Jenkins & McKay, 2013). Each person's experience with dementia differs based on its negative effects on physical, emotional, and cognitive abilities, but being in an environment that promotes interprofessional management among disciplines can help to manage these effects (Hogan et al., 2008). Within primary care settings, there are a number of innovative collaborative models that have been designed to provide the integration of healthcare services and improve disease management. These models have not been standardized yet, but priority should be placed on treating dementia patients from a multidisciplinary approach given its multi-faceted nature (Johnson, 2008). With the development of behavioral and psychological disturbances (BPSD) in dementia patients collaboration among these three disciplines can prove to be critical in determining the progression of the disorder (Johanson, 2008). For example, daily team meeting or multidisciplinary rounds allow for the participation of these three primary disciplines, and it is during this time that an exchange of ideas, recommendations, and suggestions for treatment options can be discussed for potential implementation.

### **Examination of Interprofessional Practice**

Interprofessional collaboration is defined as collaboration between two or more professionals that work jointly towards achieving a mutual goal with shared responsibility (Stein, Watts, & Howell, 1990). The primary intent of the interprofessional collaborative approach is to foster the exchange of potential therapeutic interventions among the varying disciplines in an effort to improve healthcare outcomes. It is designed with the sole purpose of improving a patient's quality of life as a result of the interaction between the participating disciplines. Within the healthcare system, the interaction and relationships that exist between nurses and physicians have helped to foster the development of subsequent relationships among other healthcare disciplines. It has been over 40 years since Stein (1967) first wrote about the Doctor-Nurse Game (Stein, Watts, & Howell, 1990). This collaboration has been analyzed in numerous studies and has been extrapolated into the practice models for interactions among other healthcare professionals to enhance collaborative practices. (Hughes & Fitzpatrick, 2010; Lingard, 2006). The delivery of high-quality healthcare as a member of a team can be dependent on interprofessional communication. The nurse-physician communication is especially important given the interdependence of the two professionals and the primary role that they play in providing quality patient care to the dementia patient (Robinson, 2010). The interactions between physicians and nurses have fostered a collaborative process that allows the interaction of the disciplines within a flat hierarchy to make decisions that are both independent and also are a part of a team effort (Johnson & King, 2012). Given the complex healthcare environment, the collaboration of healthcare professionals that target complex healthcare issues such as the treatment of dementia is necessary to facilitate improved patient care outcomes and/or decreased patient morbidity and mortality (Head & Berrios, 1996; Stein-Parbury & Liaschenko, 2007).

### *The Role of Psychiatry*

The professionals that work within the psychiatry department are the clinicians that can perform the initial screening, assessment, and provide the

subsequent diagnosis of dementia. Once a diagnosis is confirmed based on an assessment of cognitive capacity or disturbances in executive functioning, this can lead to the development of a treatment plan (Detering et al., 2010). The formulation of a treatment plan provides the opportunity for the inclusion of psychology discipline where emphasis can be placed on the achieving a sense of control (when deemed appropriate), patient satisfaction, and improved quality of care during the length of patient care (Poppe, Burleigh, & Banerjee, 2013). The advance care planning (ACP) that occurs between the disciplines of psychology and psychiatry has the potential to improve end of life care in patients with dementia (Poppe, Burleigh, & Banerjee, 2013; van den Dungen et al., 2012). The common ACP can be completed during the early stages of the disease with preference given to earlier completion better due to the fact that problems with decision-making and ability to communicate may decrease as dementia progresses (van den Dungen et al., 2012). The ability to provide optimal care to dementia patients largely stems from the performance of a thorough initial assessment and accurate diagnosis of dementia by psychiatry which can ultimately help to guide patient care (Bishara, 2009).

### *The Role of Psychology*

The primary role of psychology aligns with its mission of ensuring that patients' rights are being met during treatment, advanced directives are being implemented, and behavioral plans are being developed and maintained based on changes in patients' conditions. The appropriate management of the behavioral and psychological symptoms of dementia (BPSD), which is defined as the group of non-cognitive symptoms that are experienced in patients with dementia, can be a focus point for psychology (Overshott & Burns, 2005). The most prominent symptoms that can represent a major challenge in over 80% of individuals with dementia are due to the development of a behavioral component at some stage of their illness. As the behavioral symptoms become progressively worse, a behavioral modification plan may be required which can focus on addressing abnormal vocalizations, aggressive, assaultive, or violent behaviors, or episodes of wandering (Mauri et al., 2006; Overshott & Burns, 2005; Spruytte, Van, & Lammertyn, 2001). It is the role of psychology to work in conjunction with psychiatry to assess the risk versus

benefit of initiating pharmacological interventions in certain cases or when they are not needed in others. The resulting BPSD can place a great amount of dependence and burden on caregivers or staff members who must address these issues either through the use of behavioral approaches or pharmacological assistance. Depending on a case-by-case basis, psychiatry and psychology must engage in a collaborative decision-making process to arrive at an intervention that is considered to be in the best interest of the demented patient (Kong, Evans, & Guevara, 2009). The use of non-pharmacological interventions has demonstrated a small to moderate effect with a short or unknown duration of action, but adjusting these interventions to individual patient preferences and needs may offer improved effects (Kolanowski, Litaker, Buettner, Moeller, & Costa, 2011; O'Connor, Ames, Gardner, & King, 2009).

### *The Role of Pharmacy*

Clinical pharmacists can prove to be instrumental when it comes to the decision to initiate pharmacological intervention in certain dementia patients. Based on patients' disease progressions and severity of behavioral and/or psychiatric disturbances, the risks versus benefit of psychotropic medications can be provided to psychiatry and psychology (Murman et al., 2002). Historically, pharmacological treatments have not demonstrated strong clinical efficacy coupled with the serious adverse reactions that can develop in this fragile patient population (Murman et al., 2002). The coordinated efforts to assess the safety and efficacy of pharmacological interventions must occur between pharmacy, psychology, and psychiatry as a means to improve quality of life for dementia patients while at the same time reducing the burden and associated high cost of managing behavioral symptoms (Duff, 2004). Pharmacists can serve as an asset to the management team based on the fact that while various studies have supported the use of risperidone, olanzapine, quetiapine and, aripiprazole in BPSD there is strong advisement against their use in elderly patients with dementia following analyses of placebo controlled trials that revealed a statistically significant increase in the risk of cerebrovascular events in this population (De Lepeleire et al., 2008). This important finding must be reiterated by clinical pharmacists during multidisciplinary team discussion when there might be the movement towards

initiating psychotropic medications. The clinical pharmacist can serve as a source of insight by providing evidence-based data on the associated risk but also possible benefits in order for the team to arrive at a final decision. In addition, the pharmacist can also have a role in discussing risks versus benefit with the patient and also family members.

## Conclusion

The management of dementia patients requires a multifaceted approach as well as multi-professional collaboration of key healthcare disciplines to ensure the quality of individualized treatment (De Lepeleire et al., 2008). The decision to initiate pharmacological and nonpharmacological interventions, depending on patient status must be based on individual patient assessment of the risks and benefits of therapy. Psychiatrists are the first to assess the status of patients and determine if a patient is best suited for a dementia diagnosis. They can then proceed to consult with a psychologist for appropriate non-pharmacological interventions for behavioral modification. They may also consult with a pharmacist to determine if psychotropic medications are necessary and preferred by the patient or the patient's family members. All three disciplines must eventually come together to arrive at a treatment plan to address both cognitive elements of the disorder and management of behavioral and psychological disturbances.

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