And We All Thought He Had Brain Damage

By Susan Saldibar

The following is a true story from Susan Almon-Matangos, Speech-Language Pathologist and National Clinical Director for Aegis, a Senior Housing Forum Partner:

"I worked with a man who would just sit in his chair, head down. He was new to this community and they didn't have a lot of history on him. He was sleeping most of the day, not interacting. From what testing I was able to do, he appeared to have a very low cognitive level and, despite working with him, he just wouldn't interact. The consensus was that there was 'nothing we can do'. I believe he was on Ativan. At some point the decision was made to wean him off. It was a complete transformation. He could talk, was alert, looked at everyone. And we all thought he had brain damage!"

Susan is the first to say she was not privy to every detail on the case but, even so, talk about an area ripe for changes. And the good news is that there have been some recent initiatives geared towards getting residents off of antipsychotic drugs.

No one said it was going to be easy. But it can be done.

Susan, along with Angela Edney, Occupational Therapist and National Clinical Director for Aegis are working to help senior care providers understand the role therapists can play in moving residents off of antipsychotics and other drugs.

Here are steps therapists can take to assist the team in implementing nonpharmacological approaches to replace antipsychotic drugs*:

- Know all the medications he or she is taking, from aspirin to antipsychotics.
- Ensure that the individual is not a danger to him or herself or those around them.
- Use the Allen Cognitive scale to assess the cognitive level and to determine strengths of the individual.
- Determine target behaviors as a team.
- Target each behavior specifically. Don't generalize.

Customize the therapy to modify the individual's behavior considering the patient's values, interests and past occupation.

Develop alternative ADL, leisure, and wellness activities based upon the person's cognitive level of function, strengths, interests and values.

These activities can be implemented by team members, including family members, volunteers, etc.

Monitor responses and make changes as needed.

Implement needed changes as an interdisciplinary team across the community.

No more bracing for the "sundown effect".

According to Angela and Susan the trouble times are those when shifts are changing and caregivers and other staff are coming and going. "It is called the 'sundown effect' because there tends to be more commotion at that time which, in turn, can make residents more anxious and prone to wandering," says Susan.

But, by using targeted therapies, shift changes don't necessarily have to be a time of stress.

Each individual can become agitated due to different trigger points. Part of the answer lies in mapping the behavior patterns of residents. Aegis recommends assessing the following:

Time: When did the behavior occurs?

Antecedent: What happened before the behavior occurred? (Note the persons present, location, environmental factors, etc.)

Behavior: What was the observed behavior? (Note the specifics)

Consequence: What happened after the behavior occurred (Note the consequences, which include ignoring, injuring self/others, etc.)

She was a typist. She was a seamstress. Make it your business to find out.

"You have to take the time to meet with the families," says Angela. "They can provide so much insight into an individual's history that can be used to make the therapy and cognitive programming more meaningful," she adds.

Case in point: A woman an occupational therapist worked with who exhibited a great deal of anxiety and restlessness during certain times of the day. "We found out, through her family, that she had made a living as a professional typist," says Angela. "We asked the family to bring in her old typewriter, which they did. Now every day at a time when she feels restless, she is given some space, her typewriter, and some paper and she types away." And, she was taken off her antipsychotic drugs with no side effects.

In another instance, it was discovered that a resident had been a seamstress in her youth. Providing her with fabric and sewing supplies, brought in by her husband, enabled her to calm herself during stressful times, medication free. While she was no longer able to sew, she was happy simply manipulating the materials. Eager to be involved, her husband received training in strategies to reduce her behavioral issues. The result was that she was able to go home.

Give your patients a fighting chance before you resort to medications.

Angela and Susan are passionate about believing that no one is a lost cause. They regularly work with individuals who are semi-comatose, giving them small sensory activities to help calm them without the need for medication.

"Before you put anyone on antipsychotic drugs, refer them to a therapist," says Angela. "Take that extra step to see if there is a way to address issues without medicating the resident. If you can do it, do it. It's worth the effort to give that person and his or her family a measure of their lives back."

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