

Encouraging CMHT(OP) professionals to reflect on challenging behaviour in dementia referrals

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Introduction

In my role as a Clinical Psychologist working with older people, I have been struck by the vast number of referrals requesting advice about individuals with dementia who are exhibiting 'challenging behaviour'. Common 'problem behaviours' include behavioural difficulties (for example physical aggression, wandering, screaming or disinhibited behaviour) or psychological concerns (for example hallucinations, anxiety or depression). Typically, these referrals are received from residential or nursing homes who are struggling to manage such issues. Research indicates that there are high rates of 'challenging behaviour' in residential dementia settings (Berry, 2010) and such difficulties have been associated with greater caregiver burden (Bird and Moniz-Cook, 2008) as well as compromised quality of life in people with dementia (Banjaree et al., 2006).

Psychological understandings of 'challenging behaviour' argue that such issues do not occur in a vacuum (Barrick, 2006) and emphasise the consideration of multiple factors when trying to make sense of the presenting issues. For example, it is imperative that individuals' meaning making/attributions are explored during a holistic assessment since behaviours can be perceived differently by different staff/family members (Moniz-Cook et al., 2000). Given the socially constructed nature of these concerns, the phrase 'behaviour that challenges' is often utilised when describing these issues (e.g. Moniz-Cook, 2010).

Having previously observed stand-alone challenging behaviour services in a learning disability context, I was curious to find out more about how Community Mental Health Team for Older People (CMHTOP) staff respond to these referrals. During subsequent discussions with colleagues, it transpired that CMHTOP professionals often feel pressurised by referring agents to offer medication to 'treat' the behavioural difficulties despite best practice policy guidance advocating non-pharmacological approaches (Department of Health, 2009).

Following a discussion with one of the CMHTOP Team Leaders, we agreed it would be useful to organise a workshop to consider how best to negotiate this genre of referrals. With the help of a fellow Clinical Psychologist, we delivered a five-hour workshop that was attended by 17 professionals working across four CMHTOPs in the North West part of the Trust. We titled the workshop "Challenging behaviour in dementia from a CMHT perspective" and hoped the intervention would enable professionals to share skills and promote consistency across teams.

Structure of the workshop

The workshop was designed to incorporate a blend of didactic teaching and reflective discussion. Within the teaching component, we presented research and clinical examples pertaining to the following topics:

- Definitions of 'challenging behaviour' (including how to define behaviour that challenges in the context of dementia)

- Prevalence and impact of behaviour that challenges in dementia
- Models to understand behaviour that challenges (consideration of the limitations of earlier conceptualisations and discussion about psychological formulations of such difficulties. Models covered included the ABC approach, Functional Analysis and the Newcastle Model of challenging behaviour in dementia: James, 2010)
- Areas to consider when assessing behaviour that challenges (the behaviour, the person with dementia and the environment)
- Presentation of vignettes concerning behaviour that challenges in dementia (Moniz-Cook et al., 2001; 2003) which highlighted the need to 'think outside the box' when approaching such referrals.

Following the teaching session, we invited CMHTOP professionals to consider how the ideas presented might be applicable in their day-to-day practice. In a large group discussion, we encouraged staff members to reflect on the following questions:

- How do the CMHTOPs currently respond to challenging behaviour referrals?
- How consistent is our response style across and within teams?
- How often do we feel pressurised to provide a 'quick fix' using medication?
- What happens if we suggest something different to medication?
- How do we cope with the anxiety generated by these referrals?

Finally, we asked professionals to participate in small-group discussions about what could be realistically achieved during a time-limited challenging behaviour assessment. A rich debate ensued demonstrating the CMHTOP professionals' experience and knowledge about how to approach such referrals; however it was also recognised that

these interventions could at times be "stressful". During this discussion, a number of senior colleagues alluded to an internalised assessment framework that they access when negotiating 'challenging behaviour in dementia' referrals. As a group, we agreed it would be useful to operationalise this 'mental template' for the benefit of less experienced team members and also to promote consistency in terms of our response style.

Consequently, we used the remaining time in the workshop to develop a draft 'challenging behaviour in dementia' assessment form and referral pathway, which could be utilised by all four teams. Due to time constraints, we agreed that a smaller group of professionals would reconvene to finalise these documents at a later date.

Development of the challenging behaviour in dementia resource pack

Approximately one month after the workshop, a smaller group of nominated CMHTOP representatives from the North West patch met to refine the draft assessment form and referral pathway. In addition to clarifying the language used, we considered resources and leaflets that could be included in a 'challenging behaviour in dementia resource pack' for each team. The contents of this resource pack are shown in Table 1 below:

The reason for devising the resource pack was to provide professionals with a set of tools that could be used as an alternative to medication when they receive referrals from residential or nursing homes. Since finalising the aforementioned documents, the resource pack is now available in each of the team bases and copies have also been distributed to some other CMHTOPs located in different parts of the Trust.

Table 1: Items included in the challenging behaviour in dementia resource pack

Item	Function
Challenging behaviour in dementia assessment form	Provides a framework for CMHTOP staff to approach challenging behaviour in dementia referrals and useful questions to ask. Copies of the form could also be provided to residential or nursing homes so that they can complete a 'self assessment' before contacting CMHTOP services
Challenging behaviour in dementia referral pathway	Illustrates the referral process for challenging behaviour in dementia; particularly highlighting the need to exclude medical factors before completing a thorough assessment
ABC record form	A sample ABC chart to give to referring agents so that they can identify patterns in behaviour
Useful leaflets for referring agents: including information on different types of dementia, dealing with aggressive or unusual behaviour and delirium. All are available for free from either the Alzheimer's Society or the Royal College of Psychiatrists website)	To provide referring agents with psychoeducation about various dementia diagnoses or challenges associated with dementia

Reflection on the process of facilitating the workshop and ideas to improve future interventions

When providing teams with the resource pack, we were keen to stress that the documents may require further development and revision with time. Furthermore, we hoped that the sharing of materials across teams might help to promote a collegiate atmosphere whereby professionals felt able to share new resources when they became available (for example, handouts of presentations staff members have delivered on this topic to local agencies or stakeholders; more up-to-date psychoeducation materials; revised ABC charts).

Of interest, a group of Psychologists working in Dumfries and Galloway

NHS Trust have recently described their experience of developing a similar project to the one described within this article (Warwick et al., 2011). While the target audience for their intervention was slightly different (they delivered their workshop to representatives of residential or nursing homes as well as to CMHTOP professionals), they also developed a 'challenging behaviour toolkit' similar to the resource pack that we have devised locally.

Within this toolkit, Warwick et al. included a Challenging Behaviour Scale (Moniz-Cook et al., 2001b) and it may be that our resource pack would be enhanced if it also included an objective rating scale of the behaviours that challenge staff. In addition, the authors utilised a range of outcome measures (such as the Challenging Behaviour Attributions Scale: Hastings, 1997) to

evaluate how delegates' perceptions changed as a result of attending the training. If our workshop were to be repeated, it would be useful to think more carefully about how to evaluate the intervention and perhaps to develop an audit trail to formally assess whether 'challenging behaviour in dementia' referrals are negotiated differently following the training.

While this article has considered this issue from a local perspective, government-led policy initiatives (e.g. Department of Health, 2009) have also highlighted the need for non-pharmacological approaches for people with dementia exhibiting 'challenging behaviour'. This poses an exciting challenge for us locally and the older people's psychology service are currently in the process of devising more comprehensive guidelines that can be used to negotiate this genre of referrals. My hope is that we can continue to develop our skills in this important area in order to cultivate 'gold standard' person-centred services for people with dementia exhibiting behaviour that challenges.

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