

Mental Health in Old Age Bulletin Issue 9

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EDITORIAL

The impact of Care Trusts

Under the Health and Social Care Act 2001, it is now possible for the NHS and local government to form new Care Trusts – NHS bodies which have social care functions delegated to them and which have the potential to integrate health and social care. Care Trusts can either be based on NHS provider organisations or can adopt a Primary Care Trust model (commissioning and providing health and social care). To date there are eight such organisations – five mental health providers and three PCT-based Care Trusts. From the beginning, this was a controversial policy with a series of claims and counter claims about the merits of this new way of working (see figure 1 for a summary).

Figure 1 The Advantages and Disadvantages of Care Trusts

Possible benefits:

- An improvement in service provision and an integrated approach.
- A system which is designed around patient and users' needs.
- Better and clearer working arrangements for staff, with more and varied career opportunities.
- A single management structure, multi-disciplinary teams managed from one point, co-location of staff, as well as single or streamlined cross disciplinary assessments.
- Financial flexibility and efficiency from integration.
- A single strategic approach, with a single set of aims and targets.
- A stable organisational framework designed to improve quality of service provision through a single agency.

Possible disadvantages:

- The absence of an evidence base to justify a new model.
- Financial differences between health and social care and the complexity of merging free NHS services with means-tested social care.
- The perceived threat to social care values and to local democratic accountability.
- The focus on relationships between a narrow range of organisations (health and social care) rather than on broader partnerships (such as the voluntary sector, Local Strategic Partnerships and wider local authority services).
- The poor partnership record and limited Human Resources capacity of Primary Care Trusts.
- The impact of ongoing organisational upheaval in the NHS.
- Doubts as to whether Care Trusts offer additional advantages above and beyond existing models (such as the Health Act 1999).

Certainly, Care Trusts seem to have offered a useful way forward for some localities seeking new models to take existing partnerships between health and social care further. Often, these have been areas with a long history of joint working, stable boundaries, a coterminous health authority and local authority, and previous experience of partnership working through initiatives such as Health Action Zones. Within mental health, moreover, Care Trust status has sometimes been seen as a means of raising the profile of this user group and preventing local services from being absorbed into much larger mental health trusts. Despite this, it is far from clear how appropriate Care Trusts might be for areas without a history of partnership working, and it seems unlikely that structural change in itself could do much to eradicate existing problems in local services and relationships.

As a result, the jury is still very much out on Care Trusts – while they may be a useful model for some areas, they are not a panacea and remain one option among many for local health and social care services seeking to work in partnership.

For further details on Care Trusts, see Glasby, J. and Peck, E. (eds) (2003) *Care Trusts: partnership working in action*. Oxon, Radcliffe Medical Press.

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ARTICLE

Managing Challenging Behaviour in Nursing and Residential Homes: How can Knowledge be Shared Most Effectively?

Amongst the most challenging problems faced by staff of nursing homes are the behavioural disturbances of residents with dementia. Staff are frequently required to provide care for residents who exhibit behaviours which are difficult to manage, such as: verbal outbursts, wandering and physical aggression. This can create a stressful work environment for staff and can have a detrimental impact on the quality of life of residents.

In the past, pharmacological interventions and physical restraint have been used to manage challenging behaviour in nursing home settings. However, the use of these interventions has been criticised due to their questionable efficacy and adverse consequences (e.g. increased disorientation due to sedating medication or physical injury as a result of restraint) (Class *et al.*, 1997). Furthermore, recent advancements in theory and research of the psychological and social aspects of dementia care has provided an alternative model of how behavioural disturbance can be understood and managed (e.g. Kitwood, 1997). The evidence for non-pharmacological interventions for behavioural disturbance in dementia has grown rapidly, and there is an increasing clinical demand for professionals to provide assessment and advice regarding behavioural therapy in long term care settings.

Non-pharmacological interventions for behavioural disturbance are often based on very simple theoretical models. There are three theoretical models that have generally been applied:

- 1) “unmet needs” model;
- 2) behavioural / learning model;
- 3) an environmental vulnerability model (Cohen-Mansfield, 2001).

Unmet Needs Model

The “unmet needs” model assumes that behavioural disturbance is caused by the underlying needs of the person with dementia not being fulfilled by the caregiver. We know that significant proportions of nursing home residents suffer sensory deprivation, lack of social contact, boredom and loneliness. For example, many studies have suggested that disruptive vocalisation may result from a lack of or an excess of environmental stimulation for some individuals with dementia (Allen-Burge *et al.*, 1999). Furthermore, it can also be the case that the needs that the person with dementia is trying to communicate may not be apparent to the caregiver. Staff training programmes which aim to educate staff to be more aware of how the person with dementia communicates and how to respond appropriately have shown some success (Magai *et al.*, 2002), but the positive effects of this are often short lived.

Behavioural Model

The behavioural model assumes that a connection between antecedents, behaviour and reinforcement has been learned, and that a different learning experience is needed to change the relationship between antecedents and behaviour (the ABC model = Antecedents – Behaviour – Consequences). Many problem behaviours are learned through reinforcement by staff members who provide attention when a problem behaviour is displayed (Cohen-Mansfield, 2001). A modification of how staff reinforce a problem behaviour can usually have effective and rapid results. For example, a case study showed that positive reinforcement of calm behaviour significantly decreased noise making in an 87 year old woman during bath times (Boehm *et al.*, 1995). However, the evidence for behavioural interventions is usually based on individual case reports, and, as such, the incidence of treatment failures tends to be greatly underreported.

Environmental Vulnerability Model

The environmental vulnerability model is based on the assumption that the dementia process results in greater vulnerability to the environment and a lower threshold at which stimuli affect behaviour. According to this model, persons with dementia progressively lose their coping abilities and therefore perceive their environment as more and more stressful. At the same time, their threshold for dealing with this stress decreases, resulting in anxiety and behaviour disturbance. An environment of reduced stimulation, or stimulation that relaxes the person, such as massage, relaxing music or snoezelen facilities are supposed to limit the stress experienced and therefore reduce the level of behavioural disturbance.

These different models are not mutually exclusive and may be complementary. For example, an environmental vulnerability may produce an unmet need when normal

levels of stimulation are perceived as over-stimulation. Furthermore, different models may account for different behaviours in different people. On the whole, these different models provide the basis for interventions for the management of challenging behaviour, and the relative efficacy of these interventions can provide information about the usefulness of the theoretical models.

What is the Evidence for Behavioural Treatment Strategies?

The evidence base for behavioural treatment strategies is growing and some interventions have been shown to be transferable to care staff by a number of research studies examining the effects of training outreach programmes (e.g. Proctor *et al.*, 1999; Burgio *et al.*, 2002). The findings of research studies suggest that staff training is most effective when it is accompanied by ongoing support and supervision of staff (Moniz-Cook., 1998; Proctor *et al.*, 1999). Studies which have combined education with advice and consultation that is resident-specific have shown significant improvements in displays of challenging behaviour. However, there is little evidence to suggest that there is a long term benefit of intensive training programmes for care staff, as many studies do not include long term follow-up assessments, and those that do, show that there is a need for ongoing managerial support for care staff to implement behavioural management strategies (Burgio *et al.*, 2002).

How Can the Positive Effects of Training be Maintained?

There are many factors which may contribute to poor longevity of improvements in the management of challenging behaviour in the format of current training outreach models.

Nursing homes notoriously have a high turnover of staff. Despite the stressful nature of the job and the skills required, nursing assistants are poorly paid and largely undervalued. Furthermore, in reality, attendance at training programmes that are offered by community mental health teams generally does not have any direct benefit to the career progression of nursing assistants, so there is poor motivation in the first instance. Staff motivational programmes whereby managers are trained to formally supervise and monitor the progress of interventions have been shown to be effective in maintaining the skills learned in formal training sessions (Burgio *et al.*, 2002). However, the results that can be achieved by a well resourced research team cannot always be replicated in standard clinical practice. Furthermore, the implementation of new management strategies in a nursing home environment would take a considerable amount of time, skill and effort which many clinical teams would not be able to resource.

Future Research Directions

While many of the behavioural interventions suggested are simple and easily applied, there is a clear need for guidance for staff, so that they feel confident in suggesting a care routine or type of interaction that is out of keeping with the usual busy and pressured routine of the home. In view of this, two key questions for future research in this area must be:

1) What type of support is most effective in helping staff to maintain the skills necessary to manage challenging behaviour in residents in nursing homes?

2) How much of this support is needed to maintain these skills in the long term?

With new developments in technology increasingly becoming a part of health care practice, there are many possibilities to explore. For example, there could be a future for online support in this context.

In order for there to be meaningful changes in the quality of care that nursing homes can offer, there needs to be a fundamental change in how the role of care staff is perceived and valued. At the present time, a high expectation of care is placed on a group of extremely hard working staff who receive little training, recognition or support. This places a high risk for increased stress and staff burn-out, which, in turn, has implications for the incidence of emotional and physical abuse in long term care settings. While there is a clear need to examine how training can be delivered in these settings, there is also a need to find ways in which staff can feel valued and recognised for the work that they do. In this way, incentives are provided for staff to engage in further training and development.

There is clearly a need for further research to identify innovative and effective ways of sharing knowledge about dementia care in nursing and residential homes. While the theoretical models of challenging behaviour are simple, the process of sharing and applying this knowledge in a way that will have a long term impact on the quality of care in nursing homes is an area which needs careful consideration.

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CURRENT KEY ISSUES

The National Service Framework for Older People

The National Service Framework for Older People suggests that the introduction of the Single Assessment Process across health and social care for older people will promote:

- a more standardised assessment process across all agencies and areas;
- raised standards of assessment practice; and
- a greater likelihood that older people’s needs will be assessed in the round.

To achieve this will require the development locally of a framework which promotes good assessment practice and assists information sharing between all those participating in the process. The guidance which has accompanied the introduction of the Single Assessment Process suggests that old age psychiatrists are most likely to be involved in the comprehensive assessment process conducted in respect of older people with complex health and social care needs as a precursor to admission to a care home or the provision of a substantial package of care to enable them to continue to live in their own homes. As such old age psychiatrists will be contributing a specialist assessment. The four articles reviewed explore two issues of particular relevance to old age psychiatrists in this context: first, the dilemmas inherent in the introduction of this new approach to assessment and second, their evolving role within it.

McNally, D., Cornes, M. & Clough, R. (2003) Implementing the single assessment process: driving change or expecting the impossible? *Journal of Integrated Care* 11 (2), pp. 18-29.

This article reviews progress in the introduction of the Single Assessment Process from three perspectives: its potential to address shortcomings in assessment within care management arrangements, initial progress in implementation in one strategic health authority and next steps in the implementation process. As such it illustrates the complexities of the requisite changes and indicates that the implementation

process will be a long one. The article highlights the fact that localities are required to implement these changes with little or no new resources thereby illustrating challenges facing those with responsibility for the introduction of the Single Assessment Process of initiating major changes in practice within existing resources – both in terms of funding and personnel. Furthermore, the discretion in the guidance is detailed thus providing a rationale for differences between localities in the way in which the changed assessment processes are being implemented. The value of this article, therefore, is that it provides an explanation and a context for the current arrangements in which professional staff are routinely undertaking the assessment of vulnerable older people.

Cornes, M. & Clough, R. (2004) Inside multi-disciplinary practice: challenges for single assessment. *Journal of Integrated Care* 12 (2), pp. 3 - 13.

This article is based on research conducted in three localities with a sample size of 39 cases referred for community care assessment. An ethnographic approach was applied in which the researcher interviewed all those who had participated in the assessment and care management process. This included users and carers and professionals with both a health and social care background including general practitioners and consultants. In addition, care pathways were recorded based on case files. Whilst this article was completed prior to the introduction of the Single Assessment Process the authors seek to extrapolate from the findings some of the challenges inherent in the implementation of this changed approach to multidisciplinary assessment. First, they highlight the amount of time it takes to co-ordinate a multidisciplinary assessment and query who is best placed to undertake this task. Second, the authors warn against an over investment in the quest to develop an IT system which will facilitate the introduction of the Single Assessment Process suggesting that different perspectives and documentation need not necessarily militate against an effective multidisciplinary assessment. Finally, they provide a timely reminder of the danger of an excessive focus on assessment to the neglect of the monitoring and review of the subsequent care plan.

Reilly, S., Challis, D., Burns, A. and Hughes, J. (2004) The use of assessment scales in old age psychiatry services in England and Northern Ireland. *Aging and Mental Health* 8 (3), pp. 249-55.

This article is based on a cross-sectional survey of old age psychiatrists with a 73 per cent response rate. Respondents were asked to complete a structured questionnaire which included a section relating to the use of standardised scales as part of the assessment process. Findings relate to both the range and scope of questionnaires used and factors associated with their use. Sixty two separate instruments were identified and almost two-thirds of respondents reported that their service used three or more standardised assessment scales. A number of factors were associated with the greater use of certain standardised assessment scales. For example, shared documentation, along with other indicators of integration between health and social care were associated with the greater use of standardised scales. In the context of the introduction of the Single Assessment Process this article provides useful information to assist old age psychiatrists as they contribute to the development of practice at a local level. For example, it highlights the importance of standardised scales in the assessment process as a means of facilitating the sharing

of information with colleagues in multidisciplinary teams. It also provides evidence to assist old age psychiatrists in determining the content of their contribution to the process and, more generally, in the remit given them in the guidance to the Single Assessment Process to assist in the selection of assessment tools locally.

Pomeroy, I., Clark, C. and Philp, I. (2001) The effectiveness of very short scales for depression screening in elderly medical patients. *International Journal of Geriatric Psychiatry* 16, pp. 321-26.

The objective of the research described in this paper was to compare very short scales for screening in depression with longer, widely used scales. A sample of 87 elderly patients admitted to rehabilitation wards or attending a day rehabilitation facility were screened for depression using the 1-item mental health inventory and 4-item, 15-item and 30-item geriatric depression scales. The results showed that all the scales had comparative sensitivity, specificity and positive predictive values. Hence it was concluded that very short scales performed as well as longer screening tools in this population. For old age psychiatrists involved in the implementation of the Single Assessment Process this research is of particular interest for two reasons. First, as the authors note, the utility of these scales should be explored further because of their brevity and their ease of use in assessing frail patients often undergoing multiple social, physical and psychological assessment. Second, and as the authors acknowledge, the utility of these brief scales is only proven within a defined sample, excluding for example, patients with significant communication problems, suggesting that this is an area of further enquiry.

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BOOK REVIEW

The experience of Alzheimer's Disease : life through a tangled veil

Steven Sabat (2001) *The experience of Alzheimer's Disease : life through a tangled veil*. Blackwell. ISBN 0631216669. Price: £17.99.

This is a substantial text that details, through the presentation of narratives and case studies, the social experience of what it may be like to have dementia. It is divided into 8 chapters each of which addresses the effects of having the condition on different areas of individual's lives. Areas covered include, a discussion of the problems in diagnosing the dementia from a physiological and cognitive testing perspective, communication and the abilities of people with dementia to compensate for the effects of their cognitive impairment, excess disability and how the social environment can act to disable a person with dementia, making links with Kitwood's

malignant social psychology and self-esteem and how this can be assaulted in various ways. Also discussed is the person with dementia as a semiotic subject, the predicament of people with dementia in relation to Critical Personalism, and selfhood and the person with dementia. In the final chapter Sabat draws upon the work of Laing and the evidence from previous chapters to highlight the ways in which the relationships that surround a person with dementia impact on their lives in positive and negative ways. He points out that the world of the person with dementia is our mirror – we too will one day be old and may have dementia. Sabat leaves the reader with a powerful message that we must take responsibility for the some of the ill-being and losses experienced by people with dementia, it cannot all simply be attributed to cognitive decline. He argues that we must therefore remove the ‘us’ and ‘them’ from dementia care if not because we feel it is our moral and ethical obligation to improve the lives of people with dementia, then simply because one day we may be ‘them’ and there will be another generation of ‘us’. How will we want them to care for us?

Overall this book is a rich source of the experience of having the condition from people with dementia, described using many examples of their own words and conversations. It has foundations in many areas of social theory, giving brief and accessible introductions to these theories and then providing evidence for them from the narratives of people with dementia. It is written in an accessible style and the summary sections at the end of each chapter are particularly useful as reminders of the key content. However, the use of terms such as ‘sufferer’ and ‘afflicted’ throughout the book continues to suggest the notion of the helpless victim of the condition, when in fact the text demonstrates the contrary.

After reading it one is also left with the feeling that many of the people with dementia who appear in this book, such as Dr M and Dr B the academics and Mrs F the music teacher, all of whom are described as highly articulate and creative people, are not particularly representative of the people with dementia we might meet in an average day centre. One must ask whether the experience of having dementia is represented, or whether the book reflects only a white, middle class perspective. Despite this though, this text provides a useful insight into what it might feel like to have dementia, and challenges us to reflect on how we interact with people with the condition. It is thus a useful text for psychiatrists and students alike who want a basic grounding in social theories as applicable to dementia and an evidence base for person-centred approaches to dementia care, and is a rich source of data for those who already ascribe to this philosophy.

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WEBSITE REVIEW

Free journals on the web (3)

Advances in Psychiatric Treatment

Published by RCPsych.

Free full-text available after 12 months at: <http://apt.rcpsych.org/>

Brain

Published by Oxford Journals

Brain provides researchers and clinicians with the finest original contributions in neurology. Leading studies in neurological science are balanced with practical clinical articles. Its citation rating is one of the highest for neurology journals, and it consistently publishes papers that become classics in the field.

Free full-text available after 24 months at: <http://brain.oxfordjournals.org/>

Evidence-based Mental Health

Published by BMJ Publishing Group

A quarterly digest of the most important clinical research of relevance to clinicians in mental health

Free full-text available after 12 months at: <http://ebmh.bmjournals.com/>

Journal of Psychiatry and Neuroscience

The official journal of the [Canadian College of Neuropsychopharmacology](#). All articles published in *JPN* are available free at the time of publication, both through the journal Web site and PubMed Central.

JPN has an impact factor of 2.3 (2004 ISI data), making it the highest-ranking free-access journal in both the psychiatry and neuroscience categories.

Free full-text available at: http://www.cma.ca/index.cfm/ci_id/12267/la_id/1.htm

Psychiatric Bulletin

Published by RCPsych

Free full-text available after 12 months at: <http://pb.rcpsych.org/>

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