



Top of the Cliff?

The setting up of a behavioural service for people with BPSD and subsequent audit examining its effectiveness

Dr Nigel George

**Senior Clinical Psychologist
Auckland District Health Board**

Representing the behavioural service of:

**Christina Birkin (Clinical Psychologist), Sophie Armit (CMHN), Bee Barclay (CMHN), Julie Marlow (CMHN),
& Janine Locke (ABA Intern)**

MHSOP at ADHB, NZ

- Acute mental health service for 65+
- Approx 38,000 potential clients in central Auckland
- 35 - 40 staff
- Dedicated 15 bed acute unit
- Approx 800 referrals a year
- Approx 50% are dementia related



History of the Behavioural Service

- Established with funding in 2005
- Wanted move BPSD referrals to the top of the cliff rather than bottom
- As being referred difficult to manage clients that facilities ‘*just*’ wanted to move or medicate because of ‘management’ difficulties
- Up-skill care staff about dementia and in particular the ‘*care*’ of people with BPSD



Aims of Behavioural Service

- Offer holistic, multidisciplinary assessment to people with BPSD referred to the service
- Examine holistic treatment options
- Service philosophy located within 'person centred' framework of trying to understand peoples communication
- To offer educational packages
- Direct work – ABC, role modelling
- Endeavour to maintain peoples' 'home' environment

So, did we make an impact on:

- Referral rates – NO!
- Movement of people between facilities – NO!
- Attitude of carers and their ability to manage and cope – NO!
- Use of medication – NO!
- Back to the drawing board...



Stood back from what we were doing and audit the effectiveness of these...

- So, what were we doing?
- Teaching (one off teaching sessions on particular clients)
- Consultation (hand over to trouble shoot)
- Role model (belief that people didn't have the skills to do what had been taught to them)



Audit design

Intense: ABA role modelling for a day a week for a year	12 bed Dementia unit in large facility	20 bed stand alone dementia unit
Teaching: Two one off teaching sessions	Rest home with dementia clients	Large facility with rest home and dementia unit
Consult: Monthly handover consult meetings for six months	Large retirement village	Large retirement village
Control: Treatment as normal	Rest home	

Aim of interventions

- **To understand which elements of service, if any, actually changed anything**
- **In line with original aims of Behavioural Service:**
 - **Reduce referral rates, as staff feel skilled enough to deal with clients and behavioural issues – so people stay in their ‘home’**
 - **Positive change of attitude towards caring for people with BPSD**
 - **Hope that this would move us up the cliff**

Limitations of research

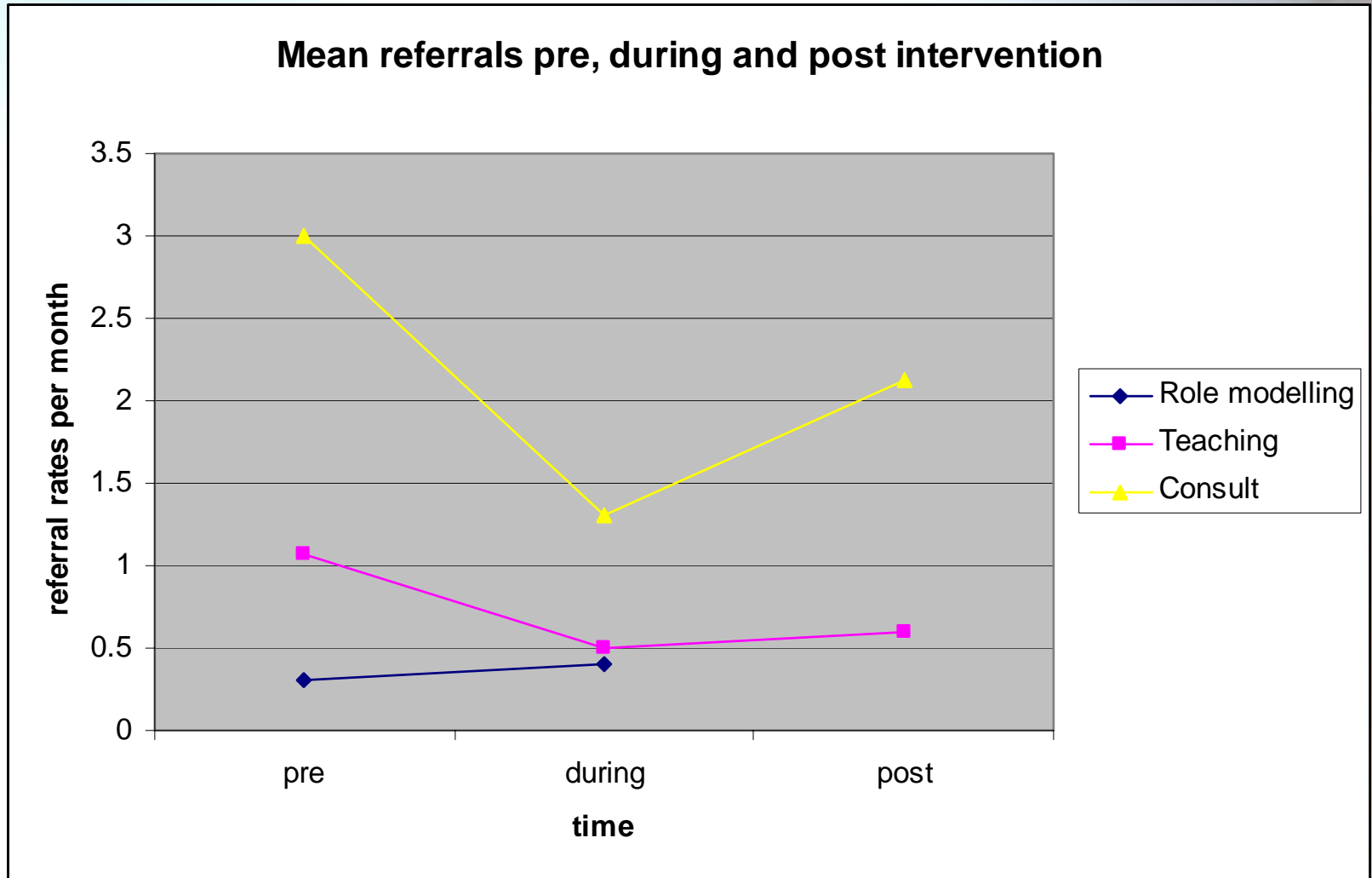
- **Applied research in ‘real’ clinical areas**
- **Confidentiality – measuring staff in units and measuring across time virtually impossible – populations unmatched**
- **Staff responding too low for statistical power – so descriptive statistics**
- **Matching of units as good as possible**

Measures used

- Referral rates for three months pre, during and three months post intervention for each of the units involved
- Attitude measure used pre and post intervention – adapted from attitude to caring for people who have had a CVA (Forster and Dowswell et al. , 1999)
- Total scores range from 12 ('negative') – 48 ('positive')
- Examples of questions:
 - I find working with residents with dementia rewarding
 - I feel confident to manage residents with dementia

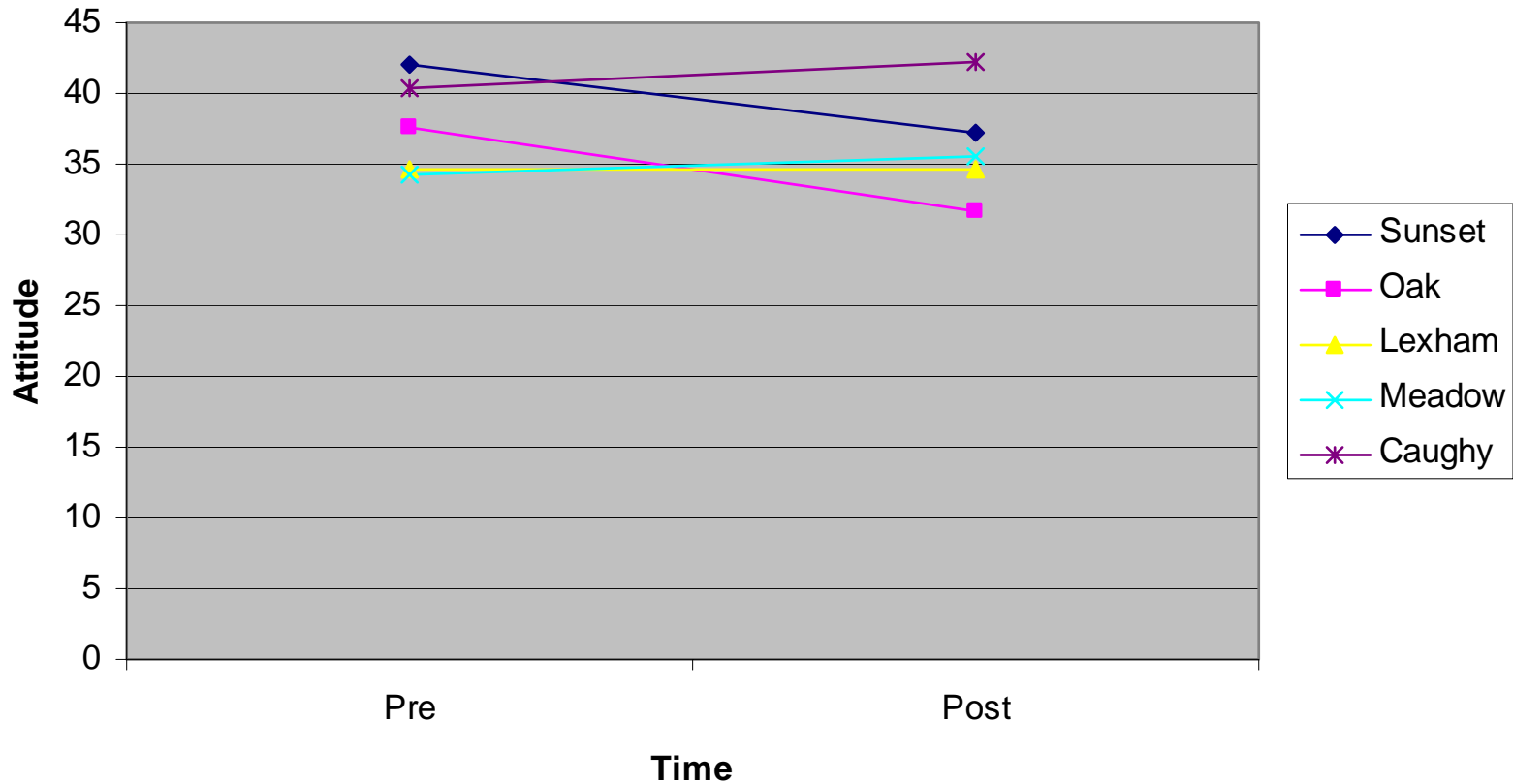
Quantitative Audit Results

- So, did we reduce referral rates?



Attitude change

Attitude change over time



Which interventions appear most important to change?

- **Consult seems to reduce referral rate and positively influence attitude**
- **Teaching appears to have a positive influence on referral but little if none on attitude**
- **Role modelling appears to have little or negative influences (but numbers small)**

Qualitative Audit Results

- **Feedback/themes from staff and facilitators of the interventions:**
 - **Management:**
 - Being used for accreditation and no desire for 'real' change
 - No buy in by some managers themselves – commitment/support of staff for learning and 'real' change
 - When management involved there appears to be 'real' culture change
 - Staff not being paid for time at handover
 - **Family/whanau:**
 - Involve in intervention as able to do and reinforce behaviour modification programme

Qualitative feedback continued

– Staff:

• Educational level/culture:

- Done ACE programme – had basic knowledge of physiology but no knowledge of different care options
- Teaching across cultures – Maori, Asian and PI and working with care givers from different cultures with different attitudes to elders

• Carers as change agents:

- Not generally thinking of themselves as the ones who could change behaviour
- Involvement of activity co-ordinator important
- Enjoyed personhood/validation/role modelling approach and life books – learnt about client as a 'person' not patient/disease

Qualitative feedback continued

- **Positive feedback to staff:**

- Interventions that improve staff life carry-on, interventions that take time with no obvious staff benefits 'fall over'
- Interventions need to be checked and then positively reinforced – no one says 'well done/thank you' - focus behavioural interventions on staff not clients!

Conclusions & Lessons Learnt

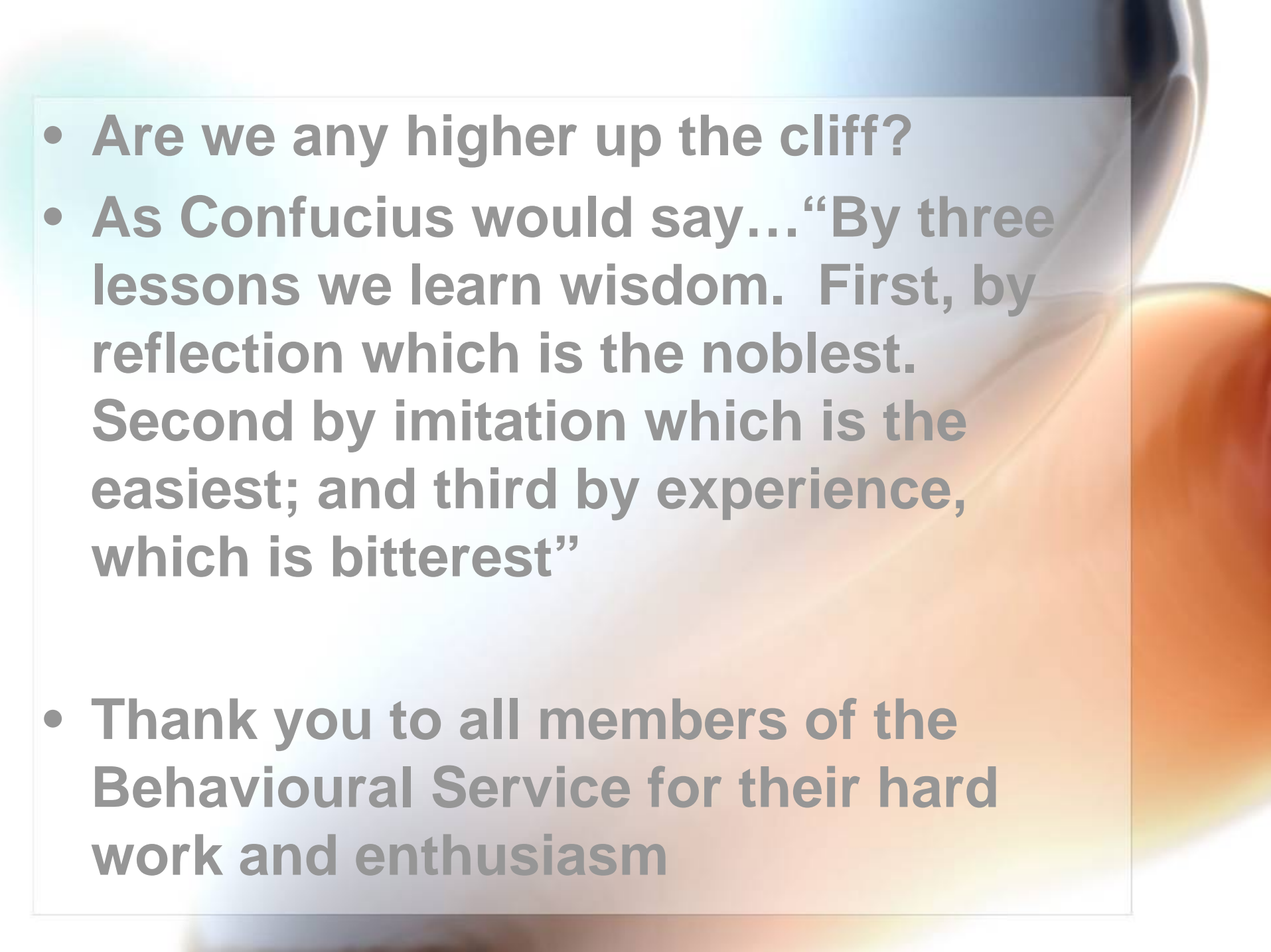
- **Audit design:**
 - Way too ambitious design
 - Needed to be smaller and cleaner
 - Matched sample and population
 - Better matching of rest homes/dementia units
 - Focus on reduction of specific referral behaviour rather than behaviour in general
 - Not to be used as an accreditation tool!

Future Directions for the Service as a result of qualitative and quantitative audit

- **Movement away from *passive* interventions (teaching, consult, and role modelling) to a more *active* intervention package.**
- **Operationalise:**
 - ‘Invite’ units to participate who want to change
 - ‘Contract’ units to change and the commitment of management and staff

Next set of work

- Combine all initiatives – teaching, modelling and consult in each unit, as all appear to contribute to ‘passive’ change and decline in referral rate
- Measure referred behaviour and its reduction on lickert scale
- Clearer initial focus on what aspect of service need to change and how to measure this outcome
- Identify and train up a member of staff and management in rest home and use as on-going resource
- Work more actively with family members
- Snowballing - try and use these services as ‘flagships’ to advertise service to others that really want change and role model what can be achieved and then use them to change others

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- **Are we any higher up the cliff?**
 - **As Confucius would say...“By three lessons we learn wisdom. First, by reflection which is the noblest. Second by imitation which is the easiest; and third by experience, which is bitterest”**
 - **Thank you to all members of the Behavioural Service for their hard work and enthusiasm**