A Needs-Led Approach to Understanding Challenging Behaviour

Challenging Behaviour

“Any behaviour which causes significant distress or danger to the person or others, or any expression of distress by the person.”

M.Bird(2001)

And the person does not respond to interventions

Challenging Behaviour is behaviour that is difficult for us to deal with. It leaves us feeling angry and helpless. Sometimes we feel sad and hopeless too. *But the behaviour is our challenge.*

Our challenge is to understand the message and engage with the need not being met

- What is the person trying to tell us?
- Why in this way?
- What needs are not being met?
- How can we meet this person’s needs?

Common feelings/assumptions about challenging behaviour

- It’s the dementia/stroke/LD
- They’ve always been this way
- That’s disgusting
- This is hopeless
- I am helpless to make a change here

All behaviour is understandable on some level

Fundamental Attribution Error

The tendency to be biased toward positive explanations for our own negative actions (e.g. that it was not in our control, that we were acting out of character)

*and*

the tendency to be biased towards more negative explanations for the negative behaviour of others
Why is it important to know about the fundamental attribution error?

- We should be aware of our own biases when we go in to work with CB. We tend to hold a biased view on why people behave the way they do.
- It is a human phenomenon. We can assume everybody makes this error at some time re CB (‘he knows he’s doing it’ v ‘I was drunk, I wasn’t in control’)
- The way we respond to a situation depends on how we understand the situation and how it makes us feel
- When we are working with relatives/carers who have problems with CB, we can help them by reframing the behaviour (changing their attributions)

Unmet Needs

It is increasingly recognised that challenging behaviour in dementia is often an attempt at communicating an ‘unmet need’. People with dementia and other mental health problems often lose the ability to communicate in ways that we find easy to understand. What we see as bizarre, sometimes frightening behaviour is that person’s way of telling us what their needs are.

Introducing the Newcastle (“Columbo”) Model to Understand Challenging Behaviour

- A needs led formulation based framework to make sense of behaviour
- Process to apply new knowledge

Understanding Challenging Behaviour

At some level, all behaviour can be understood

Behaviour that challenges is a poorly communicated expression of need

Clinical experience

Newcastle Model/Columbo approach

Stokes

Kitwood-PCC

Cohen Mansfield’s unmet needs

Cohen-Mansfield’s Unmet Needs Model

Lifelong habits & personality

Current condition – physical, mental

Environment – physical, psychological

Unmet need

Unmet needs

Behaviour as a means of fulfilling needs

Behaviour as a means of communicating needs

Behaviour as outcome of frustration (n.b. decreased inhibition)

Application of the Newcastle Model

- Using the Colombo approach to connect information & reach formulation of difficulties
- Identifying unmet needs of patient/client from formulation
- Developing care strategies to meet needs & manage risk
Two sources of information help us understand challenging behaviour:

- Information about the person
- Information about the behaviour

Cohen-Mansfield’s unmet needs model

Unmet need

- Lifelong habits & personality
- Current condition – physical, mental
- Environment – physical, psychological

Behaviour as a means of fulfilling needs
Behaviour as a means of communicating needs
Behaviour as outcome of frustration (n.b. decreased inhibition)

A framework to understand challenging behaviour

- Cognitive impairment
- Life history
- Mental health
- Physical health
- Medication
- Triggers
- Personality
- Social environment
- Behaviour
- Appearance
- Vocalisation

A process to develop an understanding of CB

- Assessment
  - Staff
  - Family & friends
- Formulation presentation
- Care planning and monitoring

The Behaviour

- What is happening?
- With or to whom is it happening?
- Where is it happening?
- When is it happening?
- How does the client look?
- What is the client saying?
- What effect does their behaviour have?

The Behaviour

Triggers
- When do you notice the behaviour happening?

Behaviour
- (what do you actually see them do?)
- (how do they look?)
- (what do they say?)

- Appearance
- Vocalisations

- feelings
- thoughts
Thoughts

Where's my mum? 
I need to get the kids!
Why is she trying to 
take my clothes off?

Challenging behaviour

Actions

Search for lost people
Try to leave building,
Fend off care staff

Feelings

Anxiety, fear, anger
+ 
NEED TO FEEL SAFE 
NEED FOR CONTROL

Thoughts

She's doing that on purpose!
He targets the frail ones!

Actions

‘Tell off/ reprimand’ 
‘Remove from room’
Keep away from her/him

Feelings

Angry, annoyed

Cognitive Model and Carers

Thoughts

She doesn't understand what's going on!
He thinks that person is stealing from him

Actions

Re-orientate/ redirect 
Change environment etc

Feelings

Sympathy 
Care

Cognitive Model and Carers

Thoughts

She's doing that on purpose!
He targets the frail ones!

Actions

‘Tell off/ reprimand’ 
‘Remove from room’
Keep away from her/him

Feelings

Angry, annoyed

Process of delivering the model

- Engagement with carers
- Assessment
- Formulation sessions with carers
- Developing strategies & care planning

Engagement with Carers

- Sales pitch - introductions, selling the model, clarity around mutual expectations, telling stories & citing success
- Spotting & addressing sabotage - intervention reframed as a treatment modality, assertive approach, feedback loops to referrers
- Identifying risks
- Accommodating needs of the carers
- Normalising & empathic response to distress

Assessment

Holistic assessment taking information from many sources:
- Contextual information:
  - GP records
  - Psychiatric notes
  - Families
  - Spending time in the care environment to gain understanding of their needs
  - Neuropsychological assessment
- Information about behaviour:
  - Charts completed by carers
  - Observations
- May involve referrals to other agencies e.g. continence service, palliative care
Formulation

Formulation Sessions
- Identifying the person and their experience as the main focus
- Pulling the information together to develop a story
- Challenging unhelpful stories about the person
- Creating discomfort with current position e.g. “she’s always been like that”
- Carers as experts AND information giving
- Engage carers in finding solutions

Why Conduct Formulation Sessions?
- Central to success of interventions
- Avoids ‘Chinese Whispers’ & accusations of ‘every tower’ practitioners
- Changes staff perspective on person
- Move from problem to be solved to needs to be met

Developing Care Strategies

- Needs-led
- Developed by carers, bespoke to care environment
- 3-tier approach to care planning
  1. Meeting unmet needs (avoidance)
  2. Identify and address antecedent behaviour (proactive)
  3. Manage challenging behaviour (reactive)

Case Study

- 75 year old man with longstanding dementia.
- Challenging behaviour – exposing penis in public
- Placement under threat
- Family concerns about the future

Possible Explanations
1. To meet a sexual need
2. Trouser too tight – rubbing on him, causing discomfort or a sexual response
3. Expressing a need to urinate
4. Responding to delusions/hallucinations
5. Constipated
6. Habit – some men seem to derive comfort from ‘fiddling’ with their bits

Agreed Interventions
1. Determine whether this behaviour is sexual in nature or due to some other reason.
2. Rule out the need to urinate
3. Staff feel behaviour is more frequent when Alfie is constipated – to monitor bowel habits
4. Alfie to be allowed/support to meet any sexual needs he may have in the privacy of his own room (to discuss with wife)
5. Obtain bigger trousers for Alfie (to discuss with wife)
6. When Alfie does expose his penis staff to ask him to “put it away” – he usually responds positively

Physical Health
- Generally fit and healthy
- Long-standing skin problem
- Occasional incontinence
- Requires assistance with personal care
- Needs for larger trousers
- Incontinence

Medication
- Eurax cream applied daily
- Quetiapine 25mg nocte
- Donepezil 10mg nocte
- Good diet
- Personal care.

Mental Health
- Prone to constipation
- Occasional incontinence
- Behaviour

Visual Hallucinations
- Solitary figures at the end of his fingers
- Worm like creatures ‘escaping’ through the ends of his fingers
- Visual agnosia
- Word finding difficulties
- Expressive Dysphasia
- Disorientated in time and place
- Memory problems
- Deficits in reasoning and problem solving

Cognitive Impairment
- Memory problems
- Disorientated in time and place
- Expressive Dysphasia
- Verbal findings difficulties
- Visual hallucinations
- Solitary figures
- Worm like creatures

Possible Explanations
- prude
- A practical joker with an excellent sense of humour
- Always a bit of a prude – childlike nudity jokes
- Small penis – “Victorian” attitude towards sex and nudity

Unconcerned

Matter of fact

Vocalisation
- “look at this”

Outcomes
- Staffs understanding increased
- Incidences of exposing penis stopped altogether
- Further medication avoided
- Move to EMI nursing avoided