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Psychology Specialists Working With Older People

AIMS

- ◆ to promote opportunities for the exchange of knowledge and expertise between members;
- ◆ to promote a greater appreciation of psychological factors in ageing;
- ◆ to advise and participate in matters of teaching and training;
- ◆ to stimulate research and disseminate research findings;
- ◆ to act in an advisory capacity on issues relating to the well-being and provision for care for older people;
- ◆ to foster an exchange of information and ideas with other professional and voluntary groups.

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Letter from the Editor

Louisa Shirley

WELCOME to the 110th edition of the *PSIGE Newsletter*. This edition features articles from members of the Welsh geographical groups, many of which would have been presented as papers at the cancelled conference last year. Also, as there are a number of other articles that have been waiting during the editor handover, the group from Wales kindly agreed to host these papers in their edition.

As always, contributions reflect a number of areas of interest to PSIGE members nationally. Morris and Morris's paper describes feedback from a small group of service users regarding a stroke support group. It is often difficult to articulate the psychological benefits of running groups like these and this article helpfully reveals practical as well as social and psychological value attributed by participants to the group. It gives others considering running such a group a head start in its finding that there may be differences between participants in their appreciation of some aspects of the group that should be taken into account when service planning. In another service audit, Ekin-Wood, Morgan and Rachel-Adams report in detail the complexity of people's needs who attend their Satellite Club day provision, a strong argument for the continuation of the service and the inclusion of well trained professionals who can work with complex mental and physical health issues.

Moss and Barker's article on the discrepancy of scoring the Mini Mental State Examination reflects other studies' findings and demonstrates how training can increase inter-rater reliability. Crucially, they also find that training leads to more conservative scoring which would potentially have an impact on the prescription of cognitive enhancers.

It is encouraging to receive reports of positive service developments; I was particularly interested in Rooke and Morgan's description of their shared-care service where there has been a successful effort to acknowledge and meet the needs of a group of people with complex mental and physical health needs. The impact of this service on admissions into care homes needs to be taken seriously by commissioners and providers both in terms of human and financial cost. Also, Wilcox, describes a systematic drive to meet the objectives of the National Service Framework for Stroke with optimistic signs for increasing psychological input into services in the future.

Dow provides food for thought in her paper on working with Welsh-speaking clients. The problems described must resonate with many PSIGE members working in multicultural environments.

Finally, we have included three papers from out with Wales: Robson and Higgon add to the evidence of under representation of older people in psychological services in Dumfries and Galloway, echoing the position articulated by the Royal College of Psychiatrists amongst others that we need to be careful that, in the drive to develop 'ageless' services, we don't passively discriminate against older people.

We have contributions from Lewis et al. looking at links between occupation and health and life satisfaction in retirement, suggesting that dissatisfaction with work should be addressed previous to retirement as it can linger on even in a group who have been retired for some time. Finally, Stewart et al. describe an audit of a measurement tool to look at sexually aggressive behaviour in older people. While I was hoping that one of the 'themed' newsletter editions might be on the subject of sex and sexuality, you may have noted recently this is being proposed as

a topic for a special edition of the *Clinical Psychology Forum*, and so we will leave this subject for a later date. While the paper generally looks at a proposed measurement tool which might be helpful in looking at prevalence of this type of behaviour, I am sure it will also raise some interesting questions about sexual behaviour as ‘challenging behaviour.’

Also appearing in this edition, you will find the names and contact details of all the National Committee members and Geographical Group Convenors. Please contact us if your information is not correct.

Finally, I would like to propose that our first ‘themed’ editions of the *Newsletter* are on the topics of: (1) ‘personality disorder’ in

later life; and (2) teaching, training, and formulation development with staff and carers. I am happy to receive contributions describing research, audit, service development, literature reviews and case studies. If you are thinking of submitting a reflective article, please have a look at the guidelines which are also included in this edition.

Louisa

P.S: Many thanks to Dr Lorna Livingston for noticing the absence of Lincoln, Bauman and Radford’s article on assessing the utility of one cognitive test battery which was alluded to in my last editorial. It now appears in this edition of the Newsletter. Apologies to the authors.



Letter from the Guest Editor

Becci Dow

Croeso i'r gyfres Cymraeg – welcome to the Welsh edition of the *PSIGE Newsletter*.

IN WALES we are fortunate to have two PSIGE groups: North and South, both groups representing large rural and urban, geographically diverse populations and both groups linking with, supporting and supported by two clinical psychology training courses. Here in South Wales our members comprise psychologists working alone in the rural, agricultural West, those working with ex-mining, industrial heartlands in the valleys and those working in the capital and on the borders. This offers a real opportunity to share ideas and practices, recognise, value and learn about the differences and seek as a larger body to promote working psychologically with older people in Wales.

Health care in Wales is a devolved issue; that is under the governance of the Welsh Assembly Government (WAG – Y Cynulliad). We are party to the national standards but have significant differences across plans strategies and direction. Health care is now split across seven health boards, signifying considerable change for clinical psychologists – with mergers, changing jobs and even greater challenges with finance. Not to mention the problems remembering the name of your own service; Hywel Dda, Betsi Cadwallder, Aneurin Bevan, etc.

Wales was the first to introduce an older person's commissioner, Ruth Marks. Her aim is to champion the cause of older people in Wales, promoting and safeguarding interests. The WAG has developed the older persons' strategy (living longer, living better) committing to the themes of valuing, well-being and independence. Wales however does not have a National Dementia Strategy, but a National Dementia Action Plan, currently in post consultation stage. For many this represents a 'catch up' position – seeing developments elsewhere and waiting

for them to reach Wales. Others see opportunities to learn from the English strategy, introduce differences and tailor to our needs. Regardless of perspective, Wales faces significant challenges in dementia care and practitioners and services are awaiting clear direction.

The approach to Improving Access to Psychological Therapies (IAPT) in Wales is also substantially different. There is no legislative introduction; no extra moneys and we are very much in the 'early days'. Services provided are guided by a clinician led reference group and there is patchy, idiosyncratic provision across the health boards.

Clinical psychologists, however, are able to maintain close links to the WAG and the APHSAG (Applied Psychologists in Health-care Special Advisory Group) can liaise directly across issues and services. We are fortunate that older adult psychologists are involved at all levels of government, highlighting need.

2009 did represent a major disappointment for PSIGE in Wales – the necessary cancellation of the Conference. Both North and South Wales groups collaborated to create a potentially successful event, with individuals committing significant time and effort to generate interest, enthusiasm and support. But on this occasion we were thwarted. In the fall out of the cancellation, we have all reflected greatly on significant factors: lack of CPD money, employer focus on current 'hot topics', availability of alternative events, academic topics, workload etc. But also were reminded that maybe these difficult times represent a greater need for a supportive organisation, an opportunity to meet, consider new ideas and gain strength in number. I certainly hope PSIGE events re-gain a priority this year and next.

Hopefully, the diverse topics from Wales, presented in this *Newsletter* offer a glimpse of the work we do and generate interest.

On behalf of the South Wales PSIGE group we would also wish Jean Board best of luck in her move to a Huntington's disease role and retirement from head of service in Gwent and to Chris Morley on her retirement from head of service in Carmarthen/Hywel Dda. Both are well known, influential clinicians whose role in developing,

sustaining and promoting older adult clinical psychology in Wales cannot be over emphasised and who are both irreplaceable.

Diolch.

Becci Dow

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Letter from the Chair

Don Brechin

WELCOME to the first *Newsletter* of 2010 and many thanks to Louisa to all her hard work pulling this together. After the delays to publication from last summer and the backlog of work this generated, it has been a busy induction for her. It is great to have the *Newsletters* coming through the letter boxes again!

On the administrative front, our membership database has now been successfully transferred over to the British Psychological Society's system. All the membership data has been updated as a result and one big advantage of being on the Society's system is that this will now happen automatically whenever there are any changes to our Society membership (e.g. when people qualify, when people retire, etc.). Alice Campbell has also been liaising with the finance department to arrange the transfer of our accounts and will be liaising with Geographical Group treasurers in due course to let them know how the new system works. It appears that the new finance system at the Society will make it substantially easier for treasurers to access up-to-date information about their funds, so again this looks to be a positive development.

We have also had an opportunity to discuss how we focus our activities at a national level, and how we work with local groups to deliver our core activities. We are planning to meet with the Geographical Group co-ordinators in May to discuss these proposals and agree a number of options to put forward to the AGM in July. More detail will emerge prior to the AGM, but we are looking at: (i) how we can deliver accessible and cost-effective national and local CPD; and (ii) how we align our strategic activities

around needs pathways (in line with national policy developments) and build on our unique clinical and research expertise as psychologists working with older people.

Once we flesh out these proposals in more detail we will need to look at how the National Committee and Geographical Groups work to deliver these activities, and how you as individuals can contribute. We believe that a proactive Faculty can be a strong advocate for psychological developments within the DH's new well-being agenda, and there are many psychological, social and economic benefits to be gained. However, this will not happen without an active membership, and we will be calling on you to have an active role in this whether it is to contribute your time and expertise to project work, supporting Geographical Groups, or working on the National Committee. We have at least four people moving on from the National Committee this year so we will need people coming forward to support. In the past we have had to proactively reach out to recruit people, but it would be good to have volunteers come forward. In this vein, if anyone would like to talk to me about the National Committee and what is involved, please drop me an e-mail.

Finally, a reminder that the Annual Conference this year is a one-day event at the Society's London offices. The programme is looking good, and the final tweaks are being made before the publicity information goes out. There are only 70 places available, so please book quickly if you want to attend.

Best wishes.

Don

Forthcoming Regional Newsletter Editions

Region	Date	Submit by
South & North Wales	January/April 2010	
South Thames	July 2010	April 2010
Conference/Themed Edition	October 2010	July 2010
Oxford	January 2011	October 2010
General/themed edition	April 2011	January 2011
Wessex	July 2011	April 2011
Conference/themed edition	October 2011	July 2011
Scotland	January 2012	October 2011
General/themed edition	April 2012	January 2012
North East	July 2012	April 2012
Conference/themed edition	October 2012	July 2012
East Anglia	January 2013	October 2012
General/themed edition	April 2013	January 2013
North West	July 2013	January 2013
Conference/themed edition	October 2013	July 2013
Yorkshire & Humberside	January 2014	October 2013
General/themed edition	April 2014	January 2014
Trent	July 2014	April 2014

Each region needs to nominate a Guest Editor to liaise with the Newsletter Editor(s). Copy needs to be ready for first proofs two months in advance of the publication month.

A hospital-based peer support group for stroke survivors and their carers

Reg Morris & Paula Morris

Objective: *The aim was to examine stroke survivors' and carers' experiences of peer support groups during hospital-based rehabilitation.*

Design: *Retrospective assessment using qualitative methodology; Inductive Thematic Analysis supplemented by questionnaire ratings.*

Setting: *A hospital stroke rehabilitation unit.*

Participants: *Seven stroke survivors and three carers who had attended at least two open group sessions.*

Method: *Semi-structured interviews were recorded and analysed by inductive thematic analysis to obtain 'in-depth' information. Participants also answered questions taken from a standardised therapeutic factors questionnaire.*

Results: *Five main themes emerged. Three were related to group processes; practical issues (three sub-themes), staff presence, similarity-difference, comparison to other group members. The fourth, value of peers (five sub-themes), was mainly concerned with beneficial outcomes. In the main participants were positive about processes and outcomes. Only the similarity-difference theme and four sub-themes of 'value of peers' were related to items from the therapeutic factors questionnaire. The therapeutic factors questionnaire revealed a consensus about several statements that did not emerge as themes; feeling secure in the group, being able to express emotions, helping others and increased independence.*

Conclusions: *Participation in the group brought a number of benefits including helpful information, advice, new connections and increased awareness of stroke. Informants identified a number of important group processes, and distinguished between helpful and unhelpful aspects in a way that permitted recommendations for change to be formulated. Responses to the therapeutic factors inventory suggested that attendance brought some therapeutic benefits, but the emergence of themes unrelated to therapeutic factors indicated that it had a broad impact.*

PEEER SUPPORT improves the social environment and positively affects the psychological adjustment and recovery of people with chronic health conditions (Cohen et al., 2000; Doull et al., 2008; Helgesson & Gottlieb, 2000; Stewart, 1993). Peers share similarities with service users and possess knowledge 'derived from personal experience rather than formal training' which differs from professional knowledge in being pragmatic rather than theoretical, here-and-now rather than long-term, holistic rather than segmental (Borkman, 1976). Peer groups pool large amounts of such knowledge and provide practical, informational, emotional and affirmational support (Dennis, 2003). Studies of peer support with head-injury patients found that it provided opportunities for socialising, discovering

others' perspectives, expressing feelings and sharing experiences, receiving advice and information, gaining understanding acceptance, increasing hopefulness and helping others (Schulz, 1994; Schwartzberg, 1994). Dale et al. (2008) reviewed six randomised controlled studies of telephone peer support and concluded that these interventions were frequently beneficial.

Peer support may provide role models who enable survivors and carers to learn skills that increase their self-efficacy (Bandura, 1986), it may also engender social comparison process which influence coping and emotions (Taylor et al., 1990). Benefit may be direct, through practical help and support provided (e.g. Streobe et al., 2005). Alternatively, it may occur through 'stress-buffering' that operates only when individ-

uals face stress, for example, by promoting the perception of additional resources and means of coping. Finally, it may exert its influence by 'mediating' responses to stress, for example, by inhibiting maladaptive responses to perceived stressors (Thoits, 1986). Cohen and Willis (1985) found evidence for direct and buffering effects in health care settings, but Stroebe et al. (2005) concluded that only direct effects are present in bereavement. Evidence suggests that the *perception* of social support is crucial and is linked to coping effectiveness (Bennett, 1993; Stewart, 1993; Hartke & King, 2003).

Stroke survivors want peer support (Morris et al., 2007; Stone, 2007) and peer support is included in the National Stroke Strategy for England's 10-point improvement plan (Department of Health, 2007) and in four of its quality markers. But research into peer support in stroke is limited to investigations of carers. Stewart et al. (1998) found that stroke carers considered home visits from peer supporters to be a useful means of gaining valuable information and led to reductions in burden and increased coping, self-esteem and confidence. A randomised controlled trial to evaluate the effectiveness of telephone contact between peer supporter and carer (Hartke & King, 2003), suggested that, despite a lack of improvement in participants' self-ratings of depression and loneliness, those who received this support had significantly better outcomes for perceived burden and competence when compared to the control group.

Effective peer support requires a supportive mission and culture as well as dedicated staff time to provide training, mentoring and supervision. Roy and Atcherson (1983) found that training in communication skills and dealing with frequently asked questions is important. Visitor volunteers were also given guidelines about self-presentation, confidentiality, listening, dealing with emotions and respecting professional boundaries.

The aim of the present study was to assess the feasibility of starting an on-ward peer support group, and to investigate stroke survivors' and carers' experiences of the group, with a particular emphasis on any therapeutic processes that might occur.

Method

Ethical approval

Ethical permission was obtained from management and the local audit committee.

Group sessions

Former patients and carers were recruited to a volunteer pool of nine former patients (two female, seven male, four under 50) and four carers (all female, all over 60). Three of the volunteers in the pool were wheelchair users, all had experienced some communication difficulties at some time, but only two had continuing difficulties. One male volunteer died over the course of the meetings and his carer withdrew.

Sessions were approximately bi-weekly, and open to all patients and carers currently in the ward. They were invited via posters, word of mouth, and information in an information pack. Sessions lasted 90 minutes with a 'rolling' set of topics set by group members at each session. These included: cognitive impairments, mood, recovery, speech and communication, driving, community support, etc. Some topics re-occurred across sessions since the group was open and had different membership each week. Sessions followed the format: introductions, whole group discussion, refreshments, small group discussion (separate survivor and carer groups), whole group discussion. There were five sessions scheduled in each phase with a training session for the peer volunteers between each phase and before the first phase. (One session in the second phase and one in the third phase were cancelled due to ward closure.) Table 1 shows the composition of sessions. In addition, at least two staff attended each session.

Table1: Attendance at sessions.

Session	1	2	3	4	5	6	7	8	9	10	11	12	13*
Carer Volunteers	1	2	1	1	1	1	1	1	1	2	1	3	3
Survivor Volunteers	1	4	3	3	2	4	5	4	5	4	4	4	7
Current Carers	5	3	5	4	2	2	0	0	0	2	0	2	2
Current Patients	4	4	9	8	8	10	6	6	2	7	3	5	0*
Totals	11	13	18	16	13	17	12	11	8	15	8	14	12

* Ward closed due to infection. Group held in another venue.

At each meeting there were approximately the same number of men and women. All sessions included wheelchair users as well as ambulatory survivors; all but two of the sessions included patients with communication difficulties, and all include at least one patient under 60.

Research design and measures

Semi-structured interviews with open-ended questions and closed, Likert-type questions were used to focus on particular topics whilst being flexible enough to allow individuals to provide detailed information (Ryan & Bernard, 2003; Willig, 2008). Open-ended questions were adapted from the Wiltshire Expert Patient Programme and the Likert-type statements from the Therapeutic Factors Inventory (Lese & MacNair-Semands, 2000). Demographic information was also collected.

Participants

The participants were stroke rehabilitation in-patients or their carers, had attended at least two group sessions, and were able to recall and communicate their views. They included seven survivors (five males, two females, mean age 68.14 – range 44 to 95) and three carers (two females, one male, mean age 65.3 – range 53 to 77) respectively. The majority of informants were White British. Wheelchair users and participants with expressive communication difficulties were included in the sample. All but one of the participants were interviewed after discharge from hospital.

Procedure and analysis

Interviews were about 30 minutes long, by telephone or face-to-face and all participants gave consent in advance. Interviews were digitally recorded and transcribed verbatim. Responses to the open-ended questions were analysed using inductive thematic analysis (Braun & Clarke, 2006; Ryan & Bernard, 2003). Themes from each transcript were noted and sorted under potential headings. Information that occurred several times during the interviews was categorised into final themes. Unique viewpoints were also noted. Participants’ ratings on the closed Therapeutic Inventory Statements were used to supplement the themes. Several of the transcripts were read by another member of the research team. This enabled the themes to be discussed, verified and modified and provided an assessment of inter-coder reliability (Ryan & Bernard, 2003). One theme was merged into another and one re-labelled as a result.

Results

Five themes (and several sub-themes) emerged from interviews (Figure 1).

The themes are illustrated with quotations and relevant questionnaire responses to the Therapeutic Factors Inventory items are presented at the end of each.

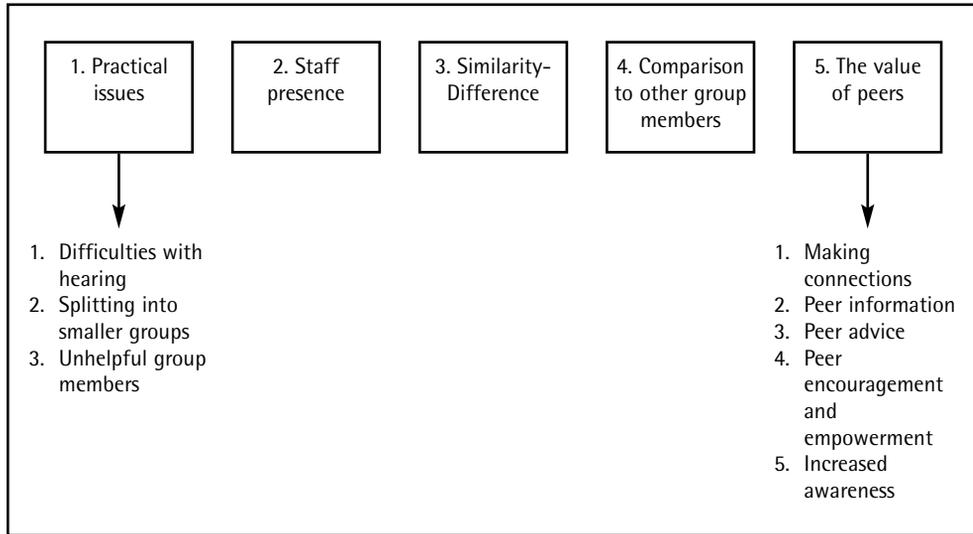
Theme 1: Practical issues

1.1 Difficulties with hearing

Several informants commented.

‘...you tend to lose interest, if you can’t hear, don’t you?...’ (Survivor)

Figure 1: Participant interview themes.



1.2 Splitting into smaller groups

There was mixed opinion on dividing into survivor and carer sub-groups.

‘...the carer can come out with some advice for the patient, and if they were split up, you know, you’re only talking to another carer...’
(Survivor)

Others felt that smaller groups encouraged people to become involved.

‘...too many people, you don’t want to talk you know... when you got five or six people it’s usually okay.’ (Survivor)

Some would have preferred smaller, mixed survivor and carer discussion groups,

‘splitting into smaller groups, that might help...especially if you kept carers and patients together.’ (Carer)

1.3 Unhelpful group members

Some commented negatively about other members.

‘...some people who like standing on a soap box, and once they start talking, they never stop.’ (Carer)

‘...he [another patient] was in a different world to us’ ... ‘he just talked nonsense.’
(Survivor)

Theme 1: Therapeutic Factors Inventory

No items related to this theme.

Theme 2: Staff presence

Informants valued ward staff involvement during the peer group sessions.

‘He [facilitator] was good at trying to get the facts from the meeting.’ (Survivor)

‘...staff presence was important to me as they can put in a professional viewpoint... being there and hearing carer’s concerns helps the staff to understand the difficulties that carers and families have.’ (Carer)

Theme 2: Therapeutic Factors Inventory

No items related to this theme.

Theme 3: Similarity-Difference

Similarity was helpful.

‘You don’t feel quite so much out on a limb. When you’ve heard other people have gone through the same procedures you had.’
(Survivor)

Differences in circumstances reduced the relevance of information and the connection.

‘I wanted to know more about the effect on younger children when their parent has a stroke.’ (Survivor, with young children)

'...people who were in a closer situation than I am ... partners mainly, had a much more direct responsibility, and they themselves can have a bigger influence than I could possibly have ...' (Carer)

Theme 3: Therapeutic Factors Inventory

Most informants agreed with the following statements from the Therapeutic Factors Inventory.

'In the group I've learnt that I have more similarities with others who have had a stroke or have been affected by stroke than I would have guessed.'

'This group helped me to recognise how much I have in common with other people who have had strokes or who have been affected by strokes.'

Theme 4: Comparison to other group members

Comparison with others in the group had both positive and negative effects.

'It [the group] gave me a sense of not feeling quite so ill really...I found that a lot of people were worse than I was, and they were trying with it as well.' (Survivor)

'To see others who were in a more difficult situation. I feel that was unhelpful... it lowers your spirits a little bit.' (Care)

Theme 4: Therapeutic Factors Inventory

No items related to this theme.

Theme 5: The value of peers

5.1 Making connections

'The group has changed my life as I have made friends with other people who have had a stroke.' (Survivor)

'...well almost extended another group of friends I suppose ... we've got things in common ... there's another contact.' (Carer)

5.2 Peer information

Several participants felt that peers provided valuable information.

'I've learnt what help you can get when you come home ... and how to get it.' (Survivor)

'People came up with their experiences of different organisations that were available, which you may not have heard about...'
(Carer)

5.3 Peer advice

Participants also discussed how valuable they found peer advice.

'...feeling that you have got someone out there that is in the same position, or you know that in the group you can ask for ideas and help.'
(Carer)

'That was the ones that I probably got the most benefit from. The ones that had come in that had had strokes probably a year earlier than I had that were further up the road...'
(Survivor)

5.4 Peer encouragement and empowerment

'I've learnt to stay positive by seeing people who were in similar situations who are now a lot better...' (Survivor)

'...determination I think, that's what comes through mostly from the ones [peers] that I talked to, you've just got to keep going, and be determined.' (Survivor)

'The group definitely gave me a boost in confidence, you know, for coping.' (Survivor)

5.5 Increased awareness

Participants found that the group increased their awareness of difficulties after stroke.

'I've learnt how to be more understanding of [the survivor's] needs, hearing about other stroke patients' frustrations and challenges and what it is like for the patient has helped me to be more tolerant.' (Carer)

Theme 5: Therapeutic Factors Inventory **Making connections**

Most participants agreed with:

'I feel a sense of belonging to the group.'

Peer information

Half of the participants agreed strongly agreed with:

'When I hear how other people are coping with their problems in the group, I often learn new ways to cope with my difficulties.'

Peer advice

Five participants agreed with:

'I pay attention to how others handle difficult situations in my group so I can apply these strategies in my own life.'

'In the group, other members advise me what I should do about difficult situations and life decisions.'

These ratings were supported by participant disagreement or neutrality with:

'Nobody gives much advice in the group.'

Surprisingly only four participants agreed with the statement:

'In the group I get 'how-to's' on improving my life.'

Three rated this statement as neutral and three disagreed.

Peer encouragement and empowerment

Most participants agreed with the statements:

'It touches me that people in the group are caring of each other.'

'Things seem more hopeful since joining the group.'

'The group helps me feel more positive about my future.'

'This group inspires me about the future.'

Therapeutic Factors Inventory, specific findings

Several of the Therapeutic Factors Inventory items did not map directly onto the emergent themes, but were endorsed by most participants and identified salient aspects:

- Group security (*'Even though we have our differences, our group felt secure to me.'*)
- Opportunity to express emotions (*'It's okay for me to show anger in the group'; 'I feel able to vent my feelings in the group.'*)
- Increase independence (*'It's been surprising, but despite needing support from my group, I've also learned to be more self-sufficient'; 'I believe that the group helps me to be more independent.'*)
- A sense of helping others (*'Helping others in the group makes me feel better about myself'; 'When I share experiences I often help other group members.'*)

Discussion

Stroke survivors and carers perceived benefit from participation in peer support groups, and this finding is congruent with their expressed need for such groups (Stone, 2007; Morris et al., 2007) and the findings of outcome research (Dennis, 2003; Doull et al., 2008). Two themes (practical issues and staff presence) related to the organisation and delivery of the groups. It is perhaps self-evident that sessions should be audible, and members able to interact harmoniously. The size of the groups seems to bear upon informants' feelings of comfort and anxiety about contributing. The salience of splitting into sub-groups of carers and survivors was surprising and appears to stem from concerns about missing information and perspectives. The value accorded to having staff present demonstrated that the positive effects outweighed negative feelings such as feeling inhibited, exposed or 'under scrutiny'.

The theme of similarity-difference was also process-related and was identified as an important aspect of the value of the peer interaction: those with similar circumstances were perceived being the most valuable. This is congruent with the findings of Stewart et al. (1998) with dyads, and is what we would expect if either access to experiential knowledge (Borkman, 1976) is a factor in peer support or social learning based on role models occurs (Perry & Furukawa, 1986).

Comparison with others referred to significant processes that occurred during the group, and reflect aspects of social comparison that are known to influence emotions and coping (e.g. Taylor et al., 1990). Both upwards and downwards comparisons occurred; but the process is complex and downwards comparisons in particular could be variously uplifting or demoralising. The potential for bi-directional affects of both types of comparison was noted by Taylor et al., and was found in the accounts of cancer survivors (Bellizzi et al., 2006). Downward comparison may make an individual feel 'fortunate', but at the same time provide information that their

situation could become worse, it is not currently evident what factors determine the direction of the outcome.

The cluster of sub-themes subsumed under 'the value of peers' described benefits that were congruent with the types of benefit identified by Dennis (2003); emotional, information and affirmational (i.e. promoting positive appraisals and self-evaluations). Two of these themes closely resemble findings of Schultz (1994) and Schwartzberg (1994) with head injury survivors; social support, making contacts and the practical value of discussing topics with peers emerged strongly in both studies. These themes demonstrate participants' appreciation for practical information and advice about health conditions, reflecting the conclusion of Doull et al. (2008) with regard to a range of health conditions and the finding of Hartke and King (2003) and Stewart et al. (1998) for carers of stroke survivors.

The themes were concordant with the items from the Therapeutic Factors Inventory, suggesting that therapeutic processes may be important in peer support. In particular, the themes of 'making connections', 'similarity-difference', and the first four sub-themes of the 'value of peers' all echoed the content of the Inventory. Items from the Inventory also revealed a consensus about a number of aspects of informants' experience that did not emerge strongly as themes; group security, opportunity to express feelings, increased independence and a sense of being helpful to others. These items indicate that the groups provided participants with an avenue to share their experiences and express emotions in a secure environment and improved their sense of self-efficacy and self-esteem through helping others. Several of these factors accord with those found in Schultz's (1994) study of head injured people (sharing experiences and feelings, helping others), but the finding of increased self-efficacy and self-esteem for current patients and their carers through peer interaction is novel.

Limitations

The sample was small and those who opted to attend groups may not have been typical of all patients or carers. There may have been a reluctance to express negative views. The majority of participants in this study were White British. The study did not consider the experiences of the peer supporters themselves.

Recommendations

- The peer support groups have value as a means for stroke survivors and carers to gain support.
- Staff members should be present at the peer group sessions in order to provide facilitative and information.
- Peer supporters should be screened to assess if they are at an appropriate stage in their recovery to provide effective support.
- Audibility should be improved, possibly by installing a hearing loop.
- The structure of the group session (i.e. whether to split into groups, etc.) should be agreed collaboratively by those who attend.

Acknowledgments

We gratefully acknowledge all the stroke survivors and their carers who participated in the groups and the audits of the groups, and the volunteers who gave so freely of their time and shared their valuable experiences.

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An audit of a 'Satellite Club Service' for people experiencing mild to moderate dementia

Abi Ekin-Wood, Sarah Morgan & Dawn Rachel-Adams

This paper describes a small-scale audit carried out by a trainee clinical psychologist whilst on placement. The audit aimed to evaluate the characteristics of individuals attending a secondary mental health care 'Satellite Club Service' designed to meet the needs of clients experiencing 'mild to moderate' dementia. The audit was conducted to establish whether these individuals' needs could be better met, outside secondary mental health care services. Ninety clients' files were examined, 67 were female and 23 male, ages ranged from 54 to 95 years of age. Psychiatric and physical health diagnoses, factors affecting engagement with the community and services and professional involvement were considered to be important variables to examine.

Results revealed that satellite club attendees had complex needs and experienced a combination of serious mental health problems (e.g. Alzheimer's disease) combined with chronic medical health conditions (e.g. cardiac problems). They also experienced a low level of social support in the community. Most of them were living alone and experienced a number of debilitating conditions that inhibited their ability to successfully engage with the wider community, outside mental health services. It was difficult to see how current community facilities could meet and sustain the needs of these individuals; consequently it was concluded that the satellite club service was an effective means of meeting the needs of a considerable number of isolated individuals living in the community with mild/moderate dementia diagnoses, both in terms of prevention and managing an exacerbation of mental health problems experienced by attendees.

THIS AUDIT aimed to encapsulate the characteristics and presenting difficulties of clients attending 'Satellite Clubs' which were part of day care provision in a secondary community mental health service for older people with dementia. The clubs aimed towards assessing, monitoring and engaging clients experiencing 'mild to moderate' dementia or cognitive impairment. The audit was conducted in order to establish whether their needs could be better met elsewhere in the community, outside of secondary mental health care services or whether the satellite service was an effective use of secondary mental health care resources.

The Satellite Club Service

Community nursing and occupational therapy manage the service and plan the care of clients attending the satellite clubs. In theory satellite club attendees do not

warrant the medical and nursing input of a day hospital but do require physical and psychological stimulation, assessment, monitoring, prevention of additional mental health complications and the club also provides respite for carers. The day hospital (DH) is aimed towards more severely affected patients with more advanced dementia and challenging behaviour. Day care provision is recommended in the NICE guidance for caring for people with dementia (2006) in terms of the need to provide meaningful activity and stimulation for patients.

There are eight satellite clubs in the locality in which the study was conducted. Referrals could be made by anyone within the locality MDT. The service consists of 10 half-day groups that are located within different areas of the locality, within the client's community, hence the term 'satellite'. Each club has transport that will collect clients from

their homes if needed. Within the clubs, clients are offered psychosocial interventions in the form of activities, social contact with staff and other clients. The ongoing monitoring of clients' health (both psychiatric and physical) effectively allows clients to continue living in the community for longer, prevents additional psychosocial problems from developing and respite for carers.

If appropriate, satellite clubs are also in a position to facilitate individuals' access to additional community support, but quite often, attendees are experiencing chronic difficulties which may disable them from accessing this community/social support successfully. Access to psychological therapies is also available via attendance and assessment at these clubs, and as the demand for psychological therapies is increasing (Department of Health, 2005) it is important for people vulnerable to depression to be in an environment, which enables them to seek help or be offered it appropriately.

Rationale for the audit

There was a query from the local health board and health trust management team that the clients attending the satellite clubs could be cared for elsewhere within the community, thus freeing the skills and resources of the professionals involved in the clubs to be utilised for clients elsewhere in the service. It was, therefore, timely, to evaluate the needs of the clientele already in attendance of the clubs. This audit formed part of a longer-term day service review project carried out by the local health board. The proposed evaluation being in line with recommendations that NHS services should be modernised and re configured (Welsh Assembly Government, 2005)

Information was, therefore, collected regarding the client's social situation, psychiatric and physical health, and their reliance on satellite clubs at the time and the amount of professional involvement required by clients. It was hoped that the collection of this information would reflect the clients' needs and help to inform wider develop-

ments in terms of service and community provision for this client group.

Method

Design

The design incorporated a quantitative method, to extract and describe the necessary information from client's files.

Participants

Ninety client's files were examined (at the time of the study 107 individuals attended satellite club), 67 of these were female and 23 male. All clients attended at least one and a maximum of three of the Satellite clubs. Ages ranged from 54 to 95 years the average being 82 years of age.

Materials/Measures

A data collection form was devised with a clinical psychologist, three clinical nurse managers and an occupational therapist, to record essential information from the client's medical file, summarised in Table 1.

Procedure

Before conducting the audit, a proposal form was completed and sent in to register the audit within the trust. The satellite club co-ordinator and lead occupational therapist was then contacted for an up-to-date list of all attendees. The lead clinical psychologist, trainee psychologist (lead researcher) and volunteer assistant psychologist conducted the vast majority of data collection.

The psychologists then contacted all of the relevant key workers regarding their clients and located each file by requesting them from key workers and medical records. When it wasn't possible to access the notes directly, key workers filled out the record form. The data was collected over a period of 12 months, and only current attendees were evaluated. If, in this period participants had stopped attending or had died, that particular data was not included in the audit. Although in total 107 people attended the clubs, due to time constraints a cut-off date for data collection was agreed.

Table 1: Variables of interest from client's files.

Age	Mental Health Presenting Problems
Gender	Factors affecting engagement in society
Satellite Clubs attended	Mini Mental State Examination Score (MMSE)
Other organisations attended	Social Situation—lives alone, spouse etc
Mental Health difficulties	Medical Diagnoses/Physical Health Factors

Data analysis

The data was analysed using descriptive statistics, including means for age, gender, number of clubs attended and frequencies of primary and secondary mental health and physical health diagnoses for each client. The data was input into SSPS for windows for easy comparison of means and the data was then presented in charts.

Results**Mini Mental State Examination scores (MMSE)**

The average most recent MMSE score out of 70 attendees was 20.8 out of 30. The MMSE is a widely used broad measure of current cognitive ability used to track cognition over time and is recommended by NICE. Using a cut-off score of below 24, the MMSE is 87 percent sensitive and 82 specific in detecting dementia (Anthony et al., 1982).

Mental health diagnoses/presenting problems

Client notes revealed that individuals attending satellite club were experiencing a combination of mental health diagnoses/presenting problems. In order to simplify the data concerned the data is presented in terms of primary, secondary and tertiary diagnoses/presenting problems (Table 2).

71.1 per cent of the attendees had a primary diagnosis of dementia. The most common mental health diagnosis after dementia was depression. Furthermore, 36 clients experience depression as a secondary or tertiary mental health diagnosis (Table 3). The data also showed that 85.6 per cent of attendees had at least a combination of two mental health diagnoses interacting, for example, Alzheimer's disease and depression in combination.

Table 2: Primary mental health diagnosis/presenting problems.

Primary diagnoses/problem	Frequency (N)	Per cent
Alzheimer's disease	28	31.1
Mixed: Alzheimer's disease and Vascular dementia	19	21.1
Vascular dementia	17	18.9
Depression	12	13.3
Cognitive impairment (unspecified)	7	7.8
Anxiety	3	3.3
Brain injury	3	3.3
Other	1	1.1
Total	90	100.0

Table 3: Secondary mental health diagnosis/presenting problems.

Secondary diagnoses/problem	Frequency (N)	Per cent
Depression	34	37.8
Other	13	14.4
None	13	14.4
Anxiety	10	11.1
Challenging behaviour	6	6.7
Bipolar	4	4.4
Cognitive impairment (unspecified)	3	4.4
Psychosis	3	3.3
Social isolation	2	2.2
Brain injury	1	1.1
Total	90	100.0

Table 3 shows that the most common secondary mental health diagnosis was depression in 37.8 per cent of cases.

Table 4 indicates that 70 per cent of individuals had three mental health diagnoses/problems interacting, the most common tertiary diagnosis being anxiety in 20 per cent of cases.

Medical diagnoses

It was evident from the notes that 85 clients experienced at least one medical problem, 68 of those 85 experienced at least two medical problems and 46 clients of these 68 experienced at least three separate medical problems as cited in their notes.

Table 4: Tertiary mental health diagnosis/presenting problems.

Tertiary diagnosis/problem	Frequency (N)	Per cent
None	27	30.0
Anxiety	18	20.0
Other	13	14.4
Psychosis	9	10.0
Social isolation	8	8.9
Challenging behaviour	8	8.9
Self neglect	3	3.3
Depression	2	2.2
Cognitive impairment (unspecified)	1	1.1
Insomnia	1	1.1
Total	90	100.0

Table 5: Frequency and type of medical problem experienced by attendees.

Medical problem	Frequency	Per cent (N=159)
Other (inc visual problems)	39	24.5
Blood pressure problems	39	24.5
Cardiac problems	27	17.0
Arthritis	17	10.8
Thyroid problems	15	9.4
Diabetes	12	7.5
Previous CVA	6	3.8
None	5	5.5 of N=90
Asthma	4	2.5

Table 6: Level of social support to satellite club attendees.

Level of social support	Frequency	Percentage
Alone	53	58.9
With spouse	20	22.2
With family	15	16.7
Total	88	97.8

Only 5.5 per cent of attendees did not have medical problems cited in their notes as an issue. The most common medical issue documented in client notes was blood pressure problems (N=39). Table 5 shows the number of clients experiencing each difficulty.

The percentage of attendees living alone in the community was 58.9.

The data also indicated that 27 clients were described as being socially isolated.

The data shows that 66.6 of 81 clients do not attend any other community group/organisation. Sixteen per cent of clients regularly access their local church as a source of support.

Out of a total of 69 participants, 53.5 per cent of attendees demonstrate a poor to medium engagement ability in satellite club; one could assume from this that these individuals would find it even more difficult to

engage in community services outside secondary care.

Discussion

Study implications

The results demonstrate that the clients attending these groups have a variety of complex characteristics and presenting difficulties, which could have a significant impact on their ability to engage and participate in activities in the wider community. It can be inferred from the results that these clients would also have a complex range of needs that would not be adequately met by groups already established in the community (e.g. church groups).

Seventy-one per cent of clients had a primary diagnosis of dementia, a serious mental illness, degenerative in its progression and is associated with a decline in mental functioning and significantly

Table 7: Additional factors affecting engagement in the community outside secondary mental health services.

	Frequency	Per cent (N=84)
Deafness	15	17.8
Self neglect	15	17.8
None	14	15.5 of N=90
Falls	13	15.5
Other	13	15.5
Poor eye sight	10	12.0
Poor mobility	8	9.5
Suicidal ideation	4	4.7
Challenging behaviour	3	3.6
Language problems	3	3.6
Total	84 issues for 76 cases	100.00

Table 8: Evidence of engagement in society (outside mental health services).

Service	Frequency	Per cent
None	54	66.6
Other	9	11.1
Church	13	16
'Old Age' club	4	4.9
Bingo	1	1.2
Total	81	100.0

Table 9: Level of engagement at Satellite Club.

Engagement	Frequency	Per cent
Good	32	46.3
Medium	18	26.0
Poor	19	27.5
Total	69	99.8

impaired functioning. The MMSE scores revealed that the average score was 20 out of 30. The results suggest clients are experiencing significant cognitive impairment, which is likely to have an effect on their ability to engage, and access community groups effectively (NICE, 2006).

The most common mental health difficulty following dementia was depression, which is likely to significantly impair people's ability to engage in groups in the community, coupled with the cognitive impairment that people are experiencing. The co-occurrent nature of these mental health problems in the satellite club population also highlights the importance of the clubs in screening for and monitoring of mental health problems in addition to the dementia/cognitive impairment. It is this ongoing support, monitoring, prevention and intervention with clients within the clubs, that make them integral to the mental and physical well-being of clients compared to community groups that do not offer the same degree of monitoring and intervention.

The percentage of attendees living alone in the community was 58.9, which highlights their vulnerability to risk due to their cognitive problems and to other mental health problems (NICE, 2006). A third of clients were described as being socially isolated in their files, in line with the department of health (2005) guidelines, which stipulate that due to the increased social isolation older adults are likely to experience, each client should be able to choose from and participate in a diverse range of stimulating one to one and/or group activities in day care or community settings. As the satellite clubs provide this to clients, if they were to be cared for elsewhere in the community it is unlikely that they would receive this degree of social participation or varied activities.

The degree of input clients are receiving from mental health professionals suggests that these clients have complex needs that require additional intervention. The satellite club adheres to the department of health stipulation that mental health services for

older people (DOH, 2005) should offer a needs based and flexible service that changes in line with people's unique needs. They should be comprehensive, multidisciplinary, accessible, responsive, individualised, accountable and systematic (DoH, 2005). These are guidelines currently being adhered to by Satellite clubs.

The results also highlight that clients attending the satellite clubs not only have a complex range of mental health needs, but a range of physical health problems too. The most common physical health problem noted was blood pressure problems. Attendance at satellite club allows monitoring of client's well-being and allows professionals running the clubs to refer onto medical services or to access the GP when necessary. Obviously, this is important when considering risk factors for cardiovascular and cerebrovascular diseases, for example, stroke (NICE, 2006; NSF, 2006).

Factors affecting the engagement of clients were assessed and included sensory impairment, falls and self-neglect. These are all impairments that can have a significant impact on how a person would interact in the community, or the support they may need to aid interaction within the satellite club service.

Younger people with dementia are also catered for within the Satellite clubs. The department of health (DOH, 2005) stipulate that day care should be offered to this population, to ensure the different needs of younger sufferers are catered for. The satellite clubs currently provide a unique and specialist service to these younger people with dementia and their families.

Future research that would enrich the data collected from the audit could incorporate the views of service users and their carers on the provision provided from the Satellite clubs (Department of Health, 2005, Welsh Assembly Government, 2003). Qualitative information regarding what people personally gain from attendance, and what their needs are could help inform and develop satellite club service delivery.

Additionally an audit of what the Satellite clubs offer to clients, would allow conclusions and inferences to be drawn from the data to see if the satellite clubs are currently meeting client's needs.

The data indicates a high degree of complexity in the needs and presentations of the clients attending satellite club, and suggestions that satellite club attendee's needs could be better met outside of secondary mental health care downplays the level of skill and expertise in satellite club staff. An extension of the work provided from this audit could be to present it to the members working within the Satellite clubs, in order to increase the value they place on their input and skills working within the clubs.

Critical review

As all the data collected was from the MDT notes, it is possible that some of the accuracy of the information gleaned is compromised by the quality of information recorded in the notes. Additionally some of the data relies explicitly on the subjective opinion of the staff, for example, for the specific question regarding 'engagement skills' this relied solely on the person filling out the form.

To conclude, results reveal that satellite club attendees have complex needs and experience a combination of serious mental health problems (e.g. Alzheimer's disease) combined with chronic medical health

conditions (e.g. cardiac problems). They also experience a low level of social support in the community. Most of them are living alone and are coping with a number of debilitating conditions that inhibit their ability to successfully engage with wider community, outside mental health services. These include disabilities such as deafness, language problems, poor mobility, poor vision, and falls amongst others. It is difficult to see current community facilities meeting and sustaining these individuals in the community; consequently, it is concluded that satellite club is an effective approach to meeting the needs of this clientele on the community as part of a multi disciplinary service for older people.

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Evaluating the effectiveness of training using operationalised scoring criteria for the Mini Mental State Examination

Susanna Moss & Helen Barker

This paper reports the findings of a piece of small-scale research undertaken by the first author during her older adult trainee placement in 2006. The research emerged following discussions between the team regarding the marked fluctuations observed within client's MMSE scores, largely hypothesised to be dependent upon differences in staff administration and scoring style.

The MMSE is a widely used cognitive screening tool. It is suggested that the lack of standardised training in utilising the MMSE has contributed to the development of idiosyncratic scoring and administration, thereby threatening the reliability of MMSE scores. The current research aimed to establish whether variance in scoring criteria exists within the current service area (Old Age Psychiatry), and whether any variance may be reduced through training in locally defined operationalised scoring criteria. Participants were asked to score a video-taped actor completing the MMSE before training and after training. Thirteen participants attended one of four training sessions. Results illustrated variance in scores before training and a significant reduction in variance following training. Post-training participants were noted to score the MMSE more conservatively. The results of this investigation concur with findings of previous published studies, and suggest that if the MMSE is still in use within services, training using operationalised scoring criteria should be provided locally if MMSE scoring is to be consistent.*

THE Mini Mental State Examination (MMSE) (Folstein et al., 1975) is a widely used 30-item cognitive screening test designed to detect cognitive impairment. Items assess orientation to time and place, attention, language, constructional ability and memory. Each item has an individual score, and the 'total' score may range from zero to 30.

The National Institute of Clinical Excellence (NICE, 2009) suggests that clinicians use the MMSE to inform clinical decisions regarding initiation and discontinuation of acetylcholinesterase inhibitors. Amended NICE guidance (2009) suggests that acetylcholinesterase inhibitors are prescribed for patients' for whom MMSE scores fall between 20 and 10 points. As such significant clinical implications for service users rest upon the outcomes of MMSE scores, it would seem reasonable to expect that scoring of MMSEs between professionals are reliable. There is,

however, some research evidence to suggest that differences in scoring criteria employed in clinical practice may compromise the reliability of MMSE scores.

Research has predominantly focused on the reliability and validity of the psychometric properties (Molloy et al., 1991), however, a few studies have examined the use of the MMSE in clinical practice, with somewhat alarming findings. Davey and Jamieson (2004) for example, reported a lack of awareness of standardised scoring criteria among professionals using the MMSE in their clinical practice. This postal survey identified that only 10 per cent of 234 individuals were aware of the standardised scoring criteria. Bowie et al. (1999) further suggest that scoring may not be consistent between professionals. Their study reported that 40 colleagues who 'scored' the same responses to a MMSE, obtained scores ranging from 14 to 27.

* Since this research was undertaken the ACE-R (Mioshi et al., 2006) is now the cognitive screening test of choice within our service.

The clinical implications of such diversity in scoring are serious, not only with respect to the use of the measure in accurately identifying individuals' suitability for acetylcholinesterase inhibitors, but also in identifying those individuals with early indications of cognitive decline and the accurate monitoring of progression.

Folstein et al. (1998) reflected upon the use of the measure within clinical populations, and the variations of the MMSE that have developed. In particular they mention the common practice of multiple professionals administering and scoring MMSE's for the same client. Gifford and Cummings (1999) suggest that in such situations where multiple professionals are involved in MMSEs for one client, that if inter-rater agreement is poor, then differences in test scores may reflect differences in reliability, rather than differences in the client's cognitive functioning or mental health.

The aforementioned ignorance of scoring criteria reported by Davey and Jamieson (2004) suggests a possible lack of training in scoring the MMSE, something that Folstein et al. (1998) have acknowledged. Gifford and Cummings (1999) suggest that such a dearth of training may lead to professionals developing their own scoring criteria, and thus affect the reliability of the measure.

Objectives

The aim of the study was to firstly establish if the problems identified with individual differences in scoring style of the MMSE were occurring within the local service and secondly to explore if such differences could be minimised through the production of locally developed operationalised scoring definitions delivered through a short training session.

Two hypotheses were proposed; firstly that, pre-training, the clinicians would be using different scoring criteria and variance would be seen in their scores and secondly that post-training there would be significantly less variance between the clinicians' scores.

Methodology

Design

A one-group pre-intervention, post-intervention design was used. This design enabled the researchers to establish a baseline measure of scoring variances, followed by an 'intervention' and a return to the 'scoring' condition, in order to establish any difference between the scoring variances pre- and post-training. The intervention referred to is the teaching of operationalised MMSE scoring criteria.

Participants

Clinicians were volunteers recruited from the local mental health hospital and the corresponding Community Mental Health Teams. Of the 13 staff who participated in the training session, all were qualified nurses. Two were community psychiatric nurses, whilst the remaining 11 worked either in an inpatient mental health ward, a dementia assessment unit, or a day hospital. Of those working in the inpatient units, three were ward managers. All participants had prior experience of administering the MMSE.

Tools

(i) Operationalised scoring criteria

Operational scoring criteria were agreed upon locally prior to the research being conducted. Scoring criteria were debated and agreed by a panel comprising of a consultant psychiatrist, clinical psychologist, nurse manager, memory clinic lead nurse, community psychiatric nurse and trainee clinical psychologist. The agreed criteria were incorporated into a document and used as a format for the training session. Each participant was given the document at the beginning of the training and participants were able to refer to the document in the post-training condition.

(ii) Scoring sheets

The MMSE scoring sheet used by Trust staff when scoring a MMSE was used to score the 'actor'. Two scoring sheets of differing

colour were provided, stapled together. No participant identifiers were contained on the scoring sheet.

(iii) Information sheet

A sheet containing additional information was also provided for participants. This contained information that was not available to the participants, but essential for accurate scoring. The information sheet contained details of the date, time and place that the assessment was undertaken, the sentence written and the intersecting pentagons copied by the client.

(iv) Training scenario

A video cassette, camcorder and television were used. The assessment of the client was played through the camcorder to a television. The cassette featured a MMSE being carried out by the researcher on an 'actor' posing as a 'client'. The answers provided by the 'client' were typical of an individual referred for cognitive assessment. The 'client' provided responses that often provoke 'correctness' dilemmas (e.g. where the client asks for a prompt for what number they were up to during serial sevens). Several of the answers were based on the discussion that took place, between the different professions, when agreeing the scoring criteria. The video cassette was viewed prior to the onset of the training by an individual with experience of cognitive assessment, to assess face validity. It was deemed to be both believable and suitable.

The operationalised scoring criteria were used as part of the training session. Scoring dilemmas associated with each item were discussed, and the agreed scoring criteria explained.

Procedure

Trust Research and Development approval was sought and received. The Local Research Ethics Committee confirmed that they did not feel the research required submission to their panel for ethical approval.

(i) Training sessions

Training sessions were arranged four weeks in advance and held at the local hospital providing accessibility for community and inpatient staff. Sessions were timed between shift handovers in order to maximise opportunities for staff to attend. The sessions were open to staff from all disciplines and were targeted at those who use the MMSE. Four training sessions were conducted.

(ii) Outline of the session and instructions

Training sessions were conducted by a trainee clinical psychologist with previous experience of work within a memory team. Each session followed the same format, beginning with an outline of the purpose of the research. Whilst explaining the background to the research, particular mention was made of the evidence for inconsistencies in scoring, within the literature and within the researchers' own clinical experience. The purpose of this was to put the training into context and to encourage participants to share their scoring dilemmas.

For the initial presentation of the video, participants were asked to 'score' the actor completing the MMSE, as they would do in their normal clinical practice, for example, if participants only used 'serial sevens', they were asked to ignore the 'world backwards' question. As the sessions were intended to be informal, participants were encouraged to ask questions before watching the video, and during the training. Attention was drawn to the information sheet, and participants were reminded that it contained information necessary for scoring. Participants were asked not to confer with their colleagues regarding their scoring, and not to alter any of their scores once the training had begun.

(iii) Informed consent

Written consent to participate was not obtained prior to training. Participants were informed that for the purpose of the research it would be helpful if the scored sheets were collected at the end of the session, but that this was not compulsory.

Consent was, therefore, communicated if participants left their scored sheets. This enabled professionals who did not want to participate in the research to receive the training.

(iv) Scoring the client – Pre-training session

The researcher played the videotape, checking on times one and two, that the volume level was adequate for all participants. There was no set time within which individuals had to complete their scoring. Training did not begin until all scoring was complete.

(v) Training

Following the video, participants were asked which of the client’s responses had caused them the most dilemmas. This was noted down by the researcher and particular attention was paid to such areas during the training. The guidelines for scoring the MMSE were distributed and each item was discussed in the context of potential score-dilemma responses. The examples used by the author were different to the responses of the client in the video, to ensure that the research was not confounded. There was no time limit to the training. Following the training, participants were provided with an opportunity to raise any further queries they had regarding the scoring criteria.

(vi) Scoring the client – Post-training session

The researcher played the same video. There was no set time within which individuals had to complete their scoring. As with the initial presentation, the researcher requested that participants did not discuss their scores with their colleagues.

(vii) Further questions

Following the second viewing of the video, there was an opportunity for further questions.

Results

Analysis of data

Data was analysed using both descriptive statistics and Wilcoxon’s Matched-Pairs Signed-Ranks Test, as the data obtained did not approximate to a normal distribution. This distribution-free test is a popular non-parametric analogue of the *t*-test for related samples.

As shown in Table 1, post-training, the variance in the MMSE scores obtained by different professionals decreased significantly. Analysis of the difference between the deviations from the mean between pre-and post-training scores, using Wilcoxon’s Matched-Pairs Signed Ranks Test, revealed a highly significant reduction in variance post-training ($t(13)=7.5, p<0.005$).

Comparison of raw MMSE scores pre-and post-training, again using Wilcoxon’s Matched-Pairs Signed Ranks Test, revealed that training had lead to more conservative scoring of the MMSE ($t(13)=0, p<0.005$).

Discussion

Support for Hypothesis One was obtained in that the scores obtained pre-training ranged from 19 to 24. This suggested that staff had developed individual differences in scoring, which contributed to a reduction in the inter-rater reliability of MMSE scores. However, on a more positive note, the range of scores obtained within this study, was not of the magnitude (14–27) of some reported within the literature (e.g. Bowie et al., 1998).

Table 1: Minimum, maximum, mean, variance and range of MMSE scores obtained pre- and post-training in the use of operationalised scoring criteria.

N=13	Minimum Score	Maximum Score	Mean Score	Variance	Range
Pre-training	19	24	21.15	2.64	5
Post-training	18	19	18.3	0.23	1

Support was obtained for the second hypothesis, that training would reduce the variance obtained between different professionals scoring the MMSE. Post-training the range of scores obtained was consistent (18–19).

Of note, post-training, scorers had become more conservative, the actor, on average being awarded three points fewer. In terms of clinical practice, more conservative scoring of the MMSE will lead to more timely and prolonged access to dementia medication if NICE guidance is strictly adhered to regarding the prescription and discontinuation of acetylcholinesterase inhibitors.

This research demonstrated that a short training session dramatically improved the inter-rater reliability of the MMSE. The implication of this finding is that for a small time investment, service quality in terms of the detection and monitoring of dementia progression can be improved and that patients will be afforded more timely access to acetylcholinesterase inhibitors (if appropriate) as a result of increased conservatism in MMSE scoring.

The study could be criticised for not following up whether use of the operationalised scoring criteria was maintained in

the long-term. This problem of maintenance could be addressed through the amalgamation of the operational scoring instructions into the routinely used MMSE scoring papers.

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An evaluation of a psychiatric and medical shared care service model offered at a general hospital site

Amanda Rooke & Sarah Morgan

This article aims to describe an evaluation of a 'shared care' service model combining psychiatric and medical care to older adult inpatients residing at a general hospital medical ward. The first ward of its kind in the UK, it was set up in April 2008 with the aim of providing good quality care for older adults experiencing a combination of mental and physical health problems. The project evaluated the utility of the care model using group comparison of shared care and non-shared care inpatient case notes on a number of variables including the location the patient was discharged to, number of days spent as an inpatient at hospital, and number of transfers to alternative wards in hospital.

Results revealed that more 'shared care' patients were discharged home as opposed to care homes, they also spent significantly less time in hospital and experienced less transfers to other wards whilst residing in hospital.

CURRENT demographic change within the UK indicates that the population of older adults over 65 years of age is fast increasing compared to other age groups (World Health Organisation, 2002). There are currently 9.7 million people aged over 65 years living in the UK, with a projected increase to 12.5 million by 2020 (Government Actuary Department 2005). In Wales there is a higher concentration of older adults than elsewhere in the UK: 17.6 per cent of the population are aged 65 or over and this is projected to increase to 24.7 per cent by 2029 (Welsh Health Survey 2003–2004). Older adults currently occupy two-thirds of NHS beds and 60 per cent of older people admitted to general hospital will have or will go on to develop a mental health problem (Department of Health, 2001). In light of such a high percentage, there is a need for all practitioners to develop some knowledge and expertise in recognising, preventing and addressing mental health needs in older people. *Everybody's business* (CSIP, 2005) states that mental health care should be integrated into the everyday workings of the hospital, addressing all aspects of the patient's emotional, psychiatric, physical, social, spiri-

tual and cultural well-being. Services, therefore, need to be able to provide physical and mental health care in tandem to manage the needs that this group of patients presents. Thereby, also allowing medical and psychiatric clinicians to disseminate and share their knowledge and skills with each other to the benefit of the patients. Effective interventions that address both the medical and psychological concerns may result in better management of the patient's overall health resulting in shorter hospital stays, as well as reducing morbidity and decreasing the utilisation and dependence on other services such as long-term health and social care placements. Comprehensive assessment of the range and complexity of older people's needs and prompt provision of care has the potential to improve their ability to function independently, decrease the need for premature admission to a residential care setting (NSF, 2006), or transfer to other wards for further assessment of their needs, for example, move from medical ward to psychiatric ward once medical issue has been managed.

Following a bed usage survey in Lincolnshire the NAO (2007) revealed that patients with dementia were found most

often on acute wards and most no longer needed to be there. Delayed discharge is a particularly acute problem for hospitals and has massive financial implications and costs to the individual and their families who are living with a high degree of uncertainty at a time of heightened vulnerability. Furthermore the NAO found that hospital old age psychiatric liaison teams were not always available and varied widely in their approach and resources. They also found that dementia diagnoses may not always be made in hospital, as health care staff fear it could be a barrier to discharging the patient to suitable rehabilitation or intermediate care.

The recent emphasis in service development is to provide care within the patient's own home and to minimise hospital stay, (NSF OP, 2006). It is necessary to provide integrated, efficient, seamless care within the hospital setting in order to facilitate discharge, and return home or to the community with the most appropriate care. One study in the US evaluated the effect of psychiatric liaison in the care of people who had experienced hip fractures. Results indicated a reduction of two days in length of hospital stay with psychiatric liaison (Strain, Lyons, Hammer et al., 1991). With these developments in view, the shared care model was established on a general medical ward through the co-operation of the medical and psychiatric directorates.

The ward in question consisted of 25 beds which admitted older adults for a number of medical reasons including fall, chest infection, UTI, CVA. Twelve of these beds were then converted into 'shared care beds' and the beds were then staffed by one RMN per shift combined with the already established general nursing time as well as input from the medical consultant and their team and a consultant psychiatrist.

This project explores the hypothesis that combined physical and psychiatric care on an inpatient ward, may, amongst other factors lead to patients with combined physical and mental health care needs being hospitalised for a shorter duration and

discharged home with appropriate care as opposed to long-term placement.

Objectives

The general hospital in question was the first in the UK to implement a pilot shared care service for older adults on a general medical ward. As this was a move into uncharted territory, the need to evaluate the service was paramount. A six-month project was commissioned which evaluated the impact of the shared care model on the variables described above as well as reporting the impact on the patients and carers themselves and on staff. Due to constraints of space, only the group notes comparison will be reported in this paper.

In summary the evaluation entailed: A case note comparison between two groups: Group 1, shared care patients, and Group 2, a control group of non-shared care ward (medical ward) patients referred for mental health assessment prior to the shared care model being implemented.

The project evaluated, whether combined medical and psychiatric care in the ward, in the form of shared care impacted on variables including location patient discharged to, number of transfers to other wards whilst in hospital, and total length of stay in hospital.

Methodology

Design

The case notes of the two groups were compared using a form designed to tap into the variables identified above. The form was designed following discussion and consultation with the lead clinical nurse manager of the ward, consultant psychiatrist, and clinical psychologist. The data collected allowed the production of descriptive statistics and one *t*-test statistical comparison.

Participants

Inclusion Criteria: All participants were originally admitted to hospital for a medical problem, but also had a psychiatric diagnosis or required psychiatric service input.

Group 1: The Shared Care Group:

In total 38 patients were referred to the shared care ward during the first three months, and were subject to the evaluation.

The shared care sample included 14 males and 24 females, and had differing diagnoses (see Results section), mean age: 84 years.

Group 2: The Non-Shared Care Control Group:

The notes available for evaluation included 16 patients who had resided on a medical ward and had been referred for psychiatric assessment – post-implementation of shared care would have meant that these individuals would have been transferred to the shared care ward. Unfortunately, data was only available on 16 patients in this group. The Group 2 sample equated to eight males and eight females of differing diagnoses, mean age 82 years.

Figures 1 and 2 below demonstrated that the groups were relatively well matched on possible confounding variables including psychiatric diagnosis, despite the differences in group size.

Procedure

Data was collected from case notes of shared and non-shared care patients using the agreed form. Approval was sought and granted from the trust and local ethics committee who explained that as the project was an evaluation of a service in place, there was no necessity in participating in the full ethical review panel.

Results

A total number of 38 case notes from shared care were compared with 16 case notes from the comparison group on a number of variables.

Group 1 patients (N=38) subject to shared care, and Group 2 patients (N=16) were patients admitted to a general medical ward (also experiencing combined medical and psychiatric issues).

Uptake of the shared care service had been good with 38 cases being accepted in the first three months. This led to a disparity between the two samples as data was only available on 16 non-shared care patients. It was preferred to evaluate all of the shared care patients within the three-month period to fully encapsulate the issues involved.

Figure 1 illustrates the range of presenting psychiatric problems among those who stayed or were residing on shared care compared with the control group.

The chart displays the high incidence of dementia and delirium in both groups and the figure suggests face validity in terms of the equivalence of the groups on this variable.

Reason for admission

Figure 2 illustrates the initial medical reason for admission to general hospital. This is an important factor in rehabilitation, as physical health will inevitably impact on mental state and recovery.

The category ‘generally unwell’ referred to a deterioration in health, whereby a relative/carer had expressed concern for example, if their relative hadn’t eaten for some days, appeared lethargic, and was not ‘themselves’. The category of ‘pain’ refers to any complaint of pain, for example, a common complaint was abdominal pain, which was getting progressively worse.

Admission/Discharge Location

Figure 3 illustrates where patients were admitted to hospital from.

Figure 4 illustrates where patients were discharged to following their stay in hospital.

The charts show that the majority of inpatients were admitted from home. Only 12.5 per cent (two out of 16 patients) from the comparison group returned home compared to 40.5 per cent (13 out of 32 patients) shared care patients.

Duration of stay on ward

Figure 5 compares the length of time patients were on the shared care/comparison ward.

Figure 1: Psychiatric diagnoses.

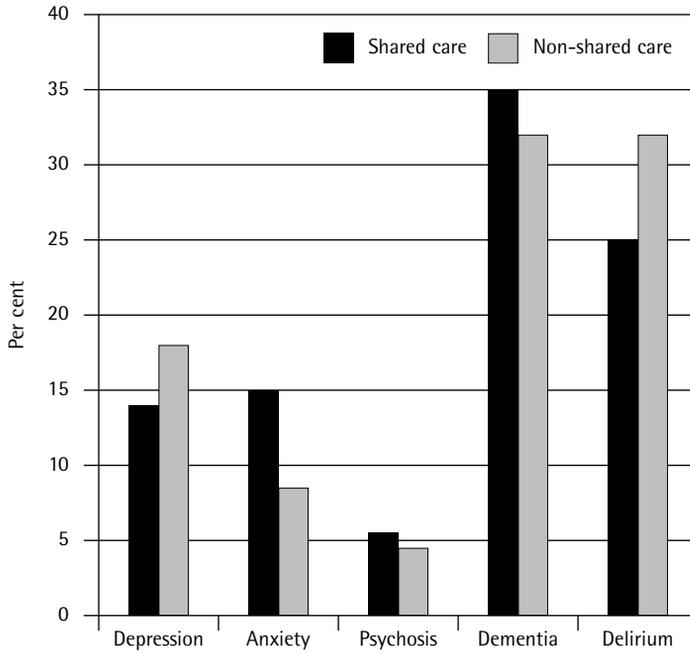


Figure 2: Reason for admission.

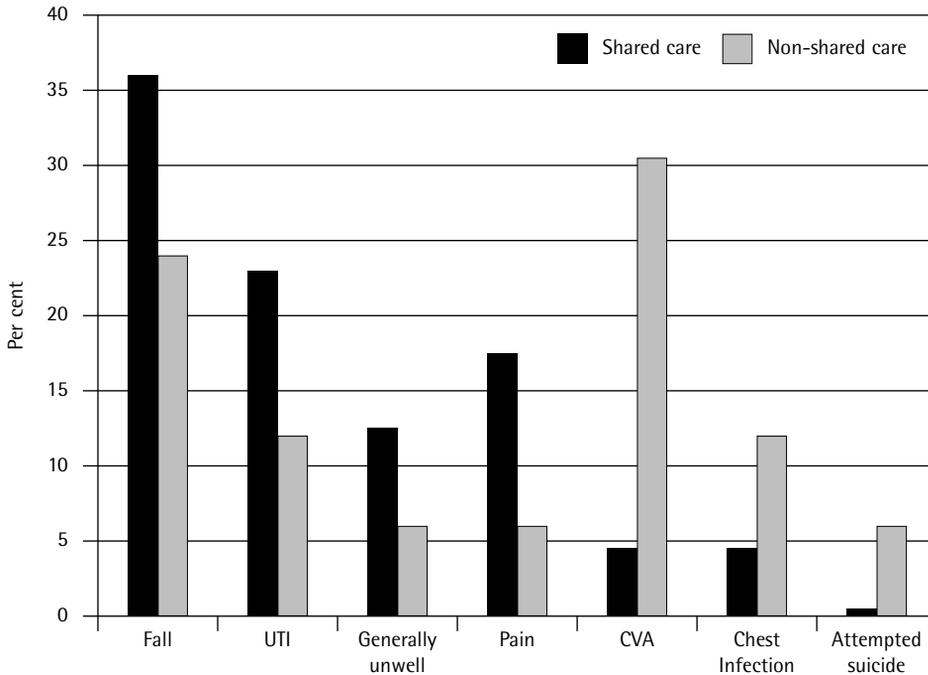


Figure 3: Location admitted from.

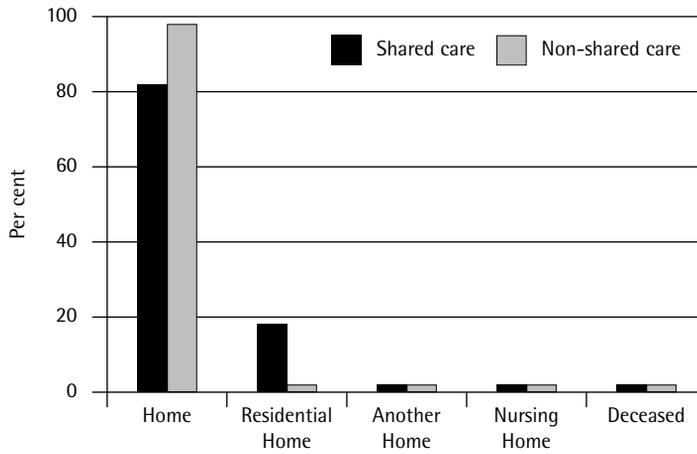


Figure 4: Location discharged to.

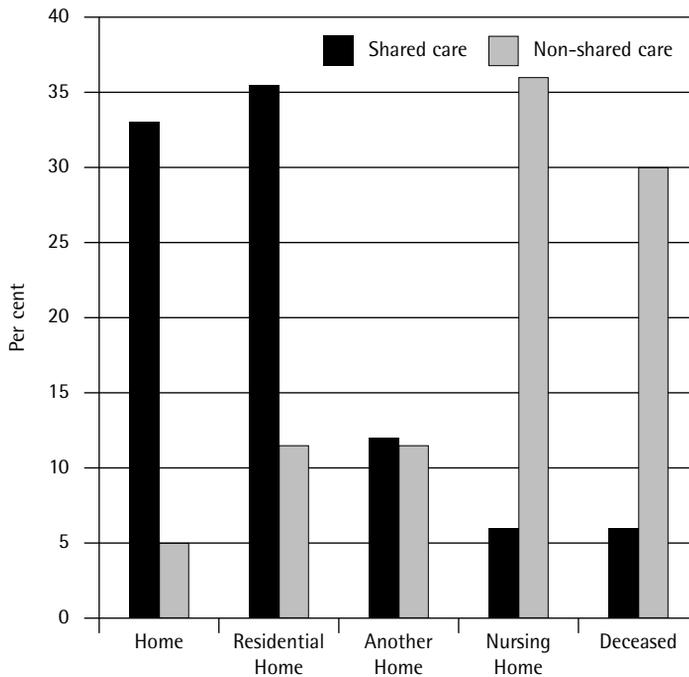
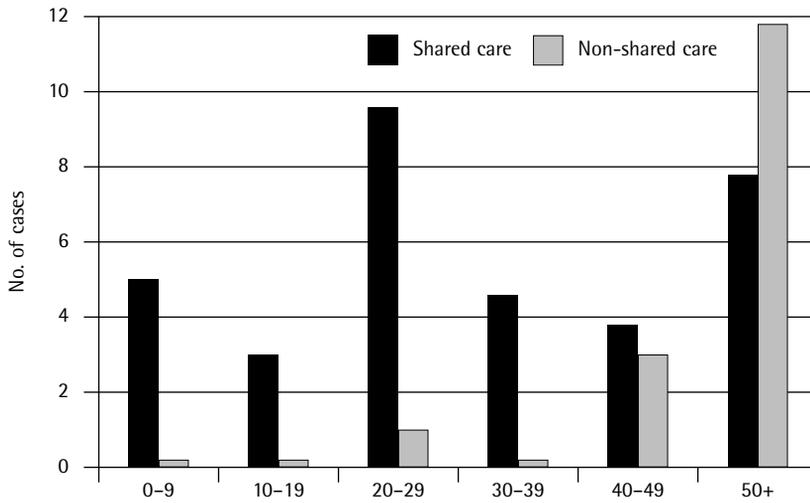


Figure 5: Duration of stay on ward.



The figure illustrates that five shared care cases resided in hospital from 0 to 10 days, and 10-20 days in three cases. Whereas the lowest stay under the previous model was 20–30 days in one case, with the majority of non-shared care patients (12 cases) hospitalised for 50+ days.

An independent *t*-test was carried out on the data $t(47)=3.99; p=.014$. The results indicated that there was a statistically significant difference between the two groups at a 0.01 level of significance. The mean length of hospital stay for shared care was 36 days ($M=36.36, SD=24.65$) compared with a mean average of 73 days ($M=73.38, SD=37.88$) for the comparison group. Therefore, the model appeared cost effective in terms of minimising length of stay in hospital.

Number of patient ward moves prior and post-ward admission

The evaluation also compared the number of ward moves prior and post admission to the shared care/comparison medical ward (not including CDU). Please refer to Table 1.

Discussion

The service evaluation was conducted to examine the impact of a shared psychiatric and medical care model implemented as a pilot scheme on a general hospital site. The main objective was to compare data collected from patient notes who had been in receipt of shared care ($N=38$) with data obtained from those who hadn't ($N=16$). The relevant factors, included length of hospital stay; number of ward moves, location the patient was discharged to and admitted from.

Summary of results

Group equivalence-reasons for admission and psychiatric diagnoses

Despite the disparity in group numbers, the two groups were seen to be equivalent on most variables apart from the fact that within the non-shared care group, there was a greater proportion who had been admitted following CVA (Figure 2). The data showed that dementia and delirium was common in

Table 1.

	Number of Moves	0 Number (%)	1 Number (%)	2 Number (%)	3 Number (%)
Shared care cases (N=38)	Pre-shared care ward	3 (7.9)	28 (73.7)	4 (10.5)	3 (7.9)
	Post-shared care ward	32 (84.2)	4 (10.5)	2 (5.3)	0 (0)
Non-shared care cases (N=16)	Pre-medical ward	5 (31.3)	7 (43.8)	4 (25)	0 (0)
	Post-medical ward	6 (37.5)	4 (25)	3 (18.8)	3 (18.8)

both groups followed by depression, anxiety and psychosis respectively. Most patients in the shared care group had been admitted due to a fall, this was also common in the non-shared care group, although the most common reason for admission in that group was CVA, this fact obviously would have an impact on the results and must be borne in mind whilst interpreting the other data.

Location patients admitted from and discharged to

Most patients in both groups had been admitted from home and some patients in the non-shared care group had been admitted from a residential care home. The results revealed that 40.5 per cent of shared care patients who were admitted from home returned home, compared to only 12.5 per cent in the comparison group. This appeared to be a particularly positive finding and conformed to the principles recommended in the NSFOP Wales (2006).

Duration of hospital stay

The results also showed that patients admitted to shared care had a statistically significant shorter ward stay than those in the comparison group. There was an average of 37 days difference in duration of ward stay between the two groups ($t(47)=3.99$; $p=.014$).

There could be a number of different reasons why the length of ward stay was longer with the comparison group. Shared care could have led to a quicker engagement with social services to facilitate placement and home care packages, because of the knowledge the psychiatric staff in terms of services available in the locality. The mental health input could have led to a better understanding of the patient's mental health needs, thereby alleviating staff anxiety about discharging someone with mental health problems into the community and this may have contributed to quicker discharge. Also previous delays in hospital might have been because the medical/physical health side were waiting for psychiatric assessment prior to discharge. We must also bear in mind the higher rate of admission due to CVA in the non-shared care group; consequently, this group of patients may have spent longer in hospital due to the nature of their disabilities and medical condition in comparison to the shared care group who had only two patients having experienced CVA.

Number of transfers to other wards

The results also revealed that those in shared care moved less to different wards than those in the comparison group. This is positive for the older adult as it is well known that patient mortality is higher after a significant

move. Furthermore, only seven out of 38 patients were discharged to another ward after shared care, the main reason for transfer to another ward was that either their physical health condition worsened or their mental health condition was unstable and they required placement on the mental health ward.

Summary and recommendations

Despite the study drawbacks, the evaluation yielded some tentative positive results for the shared care pilot, results which can be evaluated further with the continued establishment of the model, preferably utilising a matched groups design. There may also be some utility in comparing the groups with another patient group subject to traditional psychiatric liaison. Indeed, the study has shown some utility in considering alternative models of care to best address the needs of this complex and vulnerable patient group. There is also a need, however, to qualitatively evaluate the care packages of the individuals concerned, as it is likely that additional multi-disciplinary input is likely to enhance the service model. Clinical psychology and occupational therapy time may help to address some of the issues outstanding for this patient group.

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Development of stroke services in Wales

Julie Wilcox

STROKE is one of the leading causes of morbidity in the UK. Eleven-thousand people in Wales have a stroke each year and 25 per cent of them are under the age of 65. As well as physical and speech problems following stroke, most will have some degree of cognitive impairment. One-in-three will have significant intellectual impairments, 30 per cent suffer from depression, and a significant minority experience personality change and behavioural problems.

The Royal College of Physicians National Clinical Guidelines for Stroke (2008) and the National Stroke Strategy for England have recognised the importance of effective multi-disciplinary teams that include clinical psychology in the care of stroke survivors.

The situation in Wales has been highlighted by several policy documents over the last few years. The National Service Framework for Older People in Wales (2006) stated that integrated stroke care pathways be developed and implemented to support the prevention of stroke and the effective treatment, care and rehabilitation of those who have suffered a stroke. The 2006 Royal College of Physicians (RCP) national Sentinel Audit, published in May 2007, stated that stroke services in Wales require urgent attention and concluded that rates of mortality and morbidity from stroke in Wales are unnecessarily high. The audit contained recommendations for improving stroke services in Wales, with the highest priority being given to the development of specialist stroke units and services in the community.

This prompted the Welsh Assembly Government to act to improve the situation. In August 2007 the Welsh Assembly Government issued Welsh Health Circular WHC (2007) 058 entitled *Implementation of National Standards for Stroke Services in Wales*. This outlined the need for formal partnership to inform and support action at national,

regional and local level in implementing NSF stroke standards. As a result the Wales Centre for Health (WCfH), National Public Health Service for Wales (NPHS) and the National Leadership and Innovations Agency for Healthcare (NLIAH) established a formal partnership to work on action in relation to the improvement of stroke services in Wales. A further Welsh Health Circular (2007) 082 entitled *Improving Stroke Services: A Programme of Work*, set out a formal programme of work to improve services for those at risk of, or who have had a stroke.

The objectives of this newly-formed Stroke Service Improvement Programme (SSIP) were to:

1. Develop a specification for a comprehensive stroke care pathway.
2. Identify indicators and outcomes to measure progress.
3. Carry out a gap analysis.
4. Develop a service improvement collaborative involving a range of professionals from across Wales.
5. Develop an action plan.
6. Provide a workforce development tool.
7. Develop and implement a symptom awareness campaign.

The Welsh Stroke Alliance was formed to act as a Clinical Reference Group to advise the SSIP. It is a voluntary alliance of stroke professionals and includes a service user and the voluntary sector. The main aim of the group is to provide a mechanism for the project teams to obtain rapid feedback on clinical issues. The WSA consists of four subgroups: Acute/TIA services; Rehabilitation services; Education and Training; and Community services. The first three sub groups are up and running, the community group has yet to be established. There is clinical psychology representation on the main WSA group and on both the Education & Training and Rehabilitation subgroups (a psychologist chairs the latter).

The Education and Training group have established an accredited multi-disciplinary two-day 'Understanding Stroke' module in Wales. This is supported by Agored Cymru. The module includes sessions on the 'Impact of Stroke on Cognition' and 'Emotional Impact of Stroke' plus 'Introduction to Goal Planning'. The group is now focussing on the introduction of the use of a stroke competency workbook into stroke services across health and social care.

The rehabilitation sub-group was established in June 2008 to evaluate rehabilitation stroke services throughout Wales; identify gaps in service provision and devise an action plan to improve these services through a multi-professional reference group.

The first task of the group was to revise the Profession Specific Audit tools as Wales had been targeted as a pilot site by the RCP for the forthcoming audit at the end of 2008. The group revised existing tools and included items specific to Wales. At the time there was no Profession Specific Audit Tool for podiatry and clinical psychology so both professions worked on developing a tool. The clinical psychology audit tool was successfully completed and included, the podiatry tool is still undergoing ratification. There has also been some interest in developing a social services audit tool and this will be pursued. The revisions were completed by the end of July 2008 and were included in the RCP Sentinel Audit in October 2008. An organisational audit was also revised and the Welsh version now includes social services, podiatry and clinical psychology provision.

The focus of the group then turned to developing multi-disciplinary stroke rehabilitation standards. This has been closely linked with the work begun by NLIAH and

the All Wales Stroke Service Improvement Collaborative (AWSSIC) in developing rehabilitation care bundles and intelligent targets. The rehabilitation group has been consulted on the development of these targets and the viability of collecting the outcome data. Several rehabilitation units have been highlighted as pilot sites for this process and the rehabilitation sub-group will facilitate units in carrying this work forward and implementing the database.

As a result of the development in stroke care over the last few years in Wales the number of clinical psychology posts have increased. There are now three full-time psychology posts dedicated to stroke care in Wales. These posts are located in each of the three local health boards in south-east Wales. There is continued understanding and pressure that this remains inequitable throughout Wales and is an insufficient resource. Mobile or early supported discharge teams rarely have any access to psychology. The development of the NICE Stroke Standards and NICE Rehabilitation Guidelines will demonstrate continued need within this area as will the next RCP audit.

The political focus remains on stroke at present though financial constraints are evident. Nevertheless there is a degree of optimism within Stroke services that the situation is improving.

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How do we work effectively with Welsh-speaking older adults?

Becci Dow

GREAT BRITAIN is an increasingly multi-lingual nation which adds a further layer of complexity to the clinical psychologist seeking to communicate meaningfully and effectively. The large Welsh/English bilingual population offers a unique opportunity to explore culture, language and communication for both Welsh- and English-speaking practitioners, providing insights into working with difference and diversity that are transferable across situations and settings.

Attending to the needs of Welsh-speaking clients is an increasingly pertinent topic for clinicians in Wales (WAG, 2008–2009). This mirrors a general impetus to promote and value the Welsh language, driven by shifts in cultural and political power; linked to an increased knowledge of language demographics (Jones, 2003) and the collection of statistics (Census, 2001) as well as legislation placing a statutory responsibility on social care organisations to provide care through the medium of Welsh (Welsh Language Act, 1993, WAG www.wales.gov.uk). There is also emerging comment and small scale research indicating the beneficial outcomes of attending to Welsh language issues in health care (Madoc-Jones & Dubberley, 2005; Misell, 2000, www.llais.org.uk) as well as burgeoning research in issues of race and culture in health (see Patel et al., 2000). However, whilst there is a varied and complex body of literature pertaining to language and psychotherapy, bilingualism and neuropsychology and to more generic power and diversity themes, for clinical psychologists, there remains a dearth of specific Welsh language research. How to proceed effectively in a clinical setting, therefore, continues to present a challenge.

In this article I will attempt to provide an overview of the context for older adult Welsh speakers; review the history and cultural context of the Welsh language and draw on this when considering clinical practice.

Welsh language

Welsh is an ancient language based on Celtic tradition rather than Latin, it has links with Breton and Cornish and is entirely separate and bears little commonality with English. The written form exists from the 6th Century and the current literary standard is still based on the translation of the bible in 1588. There are 29 letters in alphabet (**a b c ch d dd e f ff g ng h i j l ll m n o p ph r rh s t th u w y**) and initial consonants mutated under certain conditions. There are male and female verbs, formal and informal forms and variations between the spoken and written elements of the language. In addition there is variation in accent, word and usage across Wales with the most noticeable difference between the North Wales and South Wales dialect, for example, bachgen, crwt, hogan – all words for boy.

Knowledge of Welsh across the region is highly variable and the pattern of Welsh language acquisition is complex and changeable. Table 1 is a partial reproduction of the data available from the 2001 Census.

These results demonstrate the variability of language skill across Wales, with over 60 per cent of the population of Gwynedd in North Wales rating themselves as able to speak, read and write in Welsh, compared with only 7.18 per cent in Newport in South East Wales. The proportion of older adults (>65-years-old) speaking Welsh in Wales is calculated to be between 18 to 21 per cent, with a higher proportion in the over-75

Table 1: Knowledge of Welsh (percentage – all people over 3).

Area	Population	% of the population that speaks, reads and writes Welsh	% of the population that has no knowledge of Welsh
Anglesey	64,679	50.51	29.60
Gwynedd	112,800	60.63	23.89
Ceredigion	72,884	44.11	38.76
Pembrokeshire	110,182	16.35	70.65
Swansea	216,226	9.36	77.53
Neath Port Talbot	130,305	12.83	71.18
Newport	131,820	7.18	86.63
Cardiff	294,208	8.75	83.69

From Census 2001: Report on the Welsh Language.

group. The fluency rates in older adults has been shown to be in decline across Census records (between 1991 to 2001, Jones, 2003) with reasons including migration patterns from rural to urban areas, inward migration of English speakers to rural areas as well as increased English language media and decline in Chapel activities (Bwrdd yr iaith.org.uk). Prior to this a significant drop in Welsh speakers since the 1911 Census was observed and felt to be associated with the political and economic issues of the era. The First and Second World Wars were shown to have an enormous impact on the Welsh language and culture, both by the high mortality rates of Welsh speaking soldiers and by the introduction of English language based newspapers and radio bulletins around this time. The decline in the language then contributed to the creation of Plaid Cymru, the political party for Wales, which sought independence and power for the language. The creation of 'Cymdeithas yr Iaith' a Welsh language society then saw hundreds of individuals during the 1960s, 1970s and 1980s engaging in pro-language acts to generate greater power and awareness of the language – many of which were judged against the law and the individuals involved were charged and jailed for their actions (see Davies, 1993)

History and culture

The language and its use is directly related to the history of Wales and the complex relationship that exists with England and Great Britain. The Acts of Union in 1536 and 1543 ultimately eliminated Wales's independent legal and administrative systems and led to the population becoming subjects to the English Crown – an act seen as an attempt to destroy the language. Davies (1998) suggests that psychologically this ruling led to the domination of Wales, similar to that observed during Colonial rule and she details the methods by which such domination was maintained in Wales. Education is described as a means of encouraging conformity as it used the English language to maintain progress and promoted the 'myth' of Welsh language as a barrier to progress. Rulings in the 18th century enforced English as the formal language of religion, implying Welsh to be invalid for worship and further reducing the use in formal settings. As a devolved nation there is now an enthusiastic drive to build on the gains of Welsh immersion education, Welsh medium schools and legislation is being sought to establish equal status for the Welsh Language, but a legacy exists and is perpetuated regarding the 'oppressive ideologies', the stereotypes and beliefs associated with the Welsh people and language. (Madoc-Jones, 2004).

Older adults, language and health care

For older adults the attitude towards language, their use of it domestically, socially and professionally has changed dramatically over the past 100 years. Unfortunately, despite the increased attention for the language and recognition that large proportions of the population speak, read and write in Welsh, no formal statistics are currently available on referrals into the health service. Health Boards in Wales are now duty bound to employ a Welsh language co-ordinator to generate changes and professionals groups are seeking the data (e.g. DCP Wales). In Wales, Welsh speakers also speak English and as such may not 'seem' different. Llais, the Welsh language awareness support structure is placing its emphasis on raising language awareness – thus encouraging services to recognise language difference and offer appropriate services. Madoc-Jones (2004) emphasises the absence of Welsh language awareness amongst health care policy in mental health and yet Wales' new older persons commissioner, Ruth Marks has made initial steps to emphasise the need for consideration of amongst this population, with the Strategy for Older People in Wales 2008–2013) stating explicitly 'In both the engagement of and service provision for older people it is essential that their Welsh language needs are addressed' (paragraph 2.13, p.20).

Clinical Psychology Services for Welsh-speaking older adults

Language in the context of older adult clinical psychology has multiple layers of relevance, incorporating the verbal traditions of assessment and the talking therapies, the need for literacy skills for many standardised questionnaires and tests as well as the neuropsychological perspective and the salience of language and its decline in organic impairment. This article offers an overview of some elements to consider.

Referral

There are multiple issues associated with identifying psychological needs and gaining

access to appropriate psychological services for older adults (see Knight, 2004; Woods, 2006, Sutton & Gaskell, 2009). In addition there are issues of attending to race and culture in the health service generally that may result in Welsh speaking older adults having particular difficulty making their needs known (Gibson, Lokare & Tress, 2000; Madoc-Jones, 2004). Davies (1998) states that Welsh speakers are underrepresented in psychological health services and that few providers of therapy are able to offer a service through the medium of Welsh. That health care settings are traditionally English speaking may impede a decision to seek help. That written information and letters are usually provided in English may be influential and certainly offering a language choice at assessment is as yet not standard practice across all health care settings. It is likely that there are multiple influences prior to referral that may affect access to specific services.

Assessment

There are currently limited numbers of Welsh language assessment tools (see www.Llais.org.uk for current list). As for all translations, standardisation requirements are stringent and in certain cases Welsh represents an additional challenge. Firstly, written Welsh is a formal, rigorously correct and traditional style of language that does not parallel the spoken form. Secondly, Welsh is a phonetic language that can be read as written, thus assessments with any element of complex language do not generate the same impact and finally there are many confident Welsh speakers who do not approach writing and reading Welsh with the same level of competence. There is an increasing awareness of the need to adopt the 'tafodiaith' of the Welsh language, literally translated as tongue language as this is most likely to reflect the words and meanings used day to day.

For older adults, as with all clients, the context and history of their difficulties is critical to generating a thorough assessment

prior to psychotherapy or psychological intervention (see Laidlaw et al., 2003; Knight, 2004). Whilst there are elements of personal history that will always require exploration, specific events in Wales that are pertinent to the language may need to be recognised by the practitioner in order that their significance can be explored. Examples such as the coal tip disaster at Aberfan in 1963 have generated a national meaning within Wales (see Couto, 1989, and Williams & Murray-Parkes, 1975) and are independent of the language. However the 'Welsh not' period, where Welsh language was banned from school at the beginning of the 20th century as well as the work of the Cymdeithas yr Iaith are all events generating consequences, emotion and meaning for Welsh speakers (see Davies, 1998; Madoc-Jones, 2004).

The need to explore the specific elements of language, that is the idioms, metaphors and expressions, is also universally acknowledged as good practice within talking therapies. Direct translation fails to convey meaning – 'mewn da'r bara, mas da'r buns' or in with the bread and out with the buns offers no indication that this is the Welsh equivalent of 'one sandwich short of a picnic.' Failure to attend to the native language meanings may compromise a thorough assessment and may inadvertently maintain elements of distress and discord (Madoc-Jones, 2004). If an individual holds beliefs and thoughts in Welsh, they will not be accessed easily by therapies conducted through the medium of English. Assessment in post-traumatic stress, for example, requires precise recall of experience and as such requires explicit encouragement to work and recall in the language of the experience. Individualised stories, internal representations and memories may all be mediated by language issues (Altarriba, 2001)

Neuropsychology

There are multiple issues associated with neuropsychological assessment and cross-

cultural issues (see Patel, 2000), which are pertinent to Welsh speakers. As mentioned previously there are very few translated assessments and very limited normative data. There is no published research to date on language changes amongst Welsh speakers with deteriorating organic impairment and no work on any changes one might expect in the English language skills of Welsh speakers. How to proceed with bilingual, fluent English speakers and whether there is any need to adapt the neuropsychological measures remains a complex issue. In a clinical setting, it may be that completing standardised versions in English first and exploring variations in Welsh to report qualitative difference may be the most pragmatic step at this stage.

A more in depth review of neuropsychological issues is available on request

Formulation

By definition a formulation needs to describe and understand the nature of an individual's specific difficulties in order that a clinician may proceed effectively. Johnstone and Dallos's (2006) cross-perspective review of formulation shows that regardless of theoretical stance, a person's context and background is critical to developing an effective and accurate understanding of an individual and from certain perspectives (systemic, social constructionist) the context is the understanding. Knight's contextual, cohort-based, maturity, specific challenge model (CMSC, Knight, 2004) explicitly invites the professional to consider context when working with older adults. He states:

'The specially created social contexts in which many older adults live invite us to understand older adults in a specific context and to consider the context as a source of their problems and as a target to change to benefit older clients' (pp.23–24).

In terms of the Welsh language what is required, therefore, is awareness and recognition of its value and relevance, and preparedness on behalf of the clinician to

explore its role in an individual's presentation and context. This also pertains to contexts of communication difficulty and awareness of Welsh language needs in care settings, with carers and families (Irvine et al 2006).

Therapy

As stated previously there are few providers of therapy who work through the medium of Welsh (Davies, 1998; Lloyd, 2001) and many indications that individuals value this type of intervention in their native language (Misell 2000; Madoc-Jones & Dubberley 2005). There is recognition that the overwhelming majority of the world's population is multilingual and studies elsewhere reveal elements of difference in the way individuals may work therapeutically within two or more languages. Altarriba (2001) uses cognitive models of language representation to suggest that meanings are related across languages and there may be certain emotion words associated with a dominant language but other words linked to a second language. De Zulueta (1990) suggests few therapists acknowledge the implications of linguistic difference and emphasises the need to be mindful of issues of tradition, identity and autonomy expressed through language choice. Madoc-Jones (2004) suggests a sense of 'self' may be lost when Welsh speakers are asked to interact through the English language. It is to be noted that where there are inter-generational differences in language, as is often the case in older adult Welsh language individuals, adopting the dominant language may be disempowering.

Where there is a match of language in therapy there is an opportunity to study the words, idioms and expressions of a language to gain insight. Where there is no match, there is a need to firstly identify and share language difference and then explore, either through discussion, translation or where necessary with interpreters. The use of interpreters in therapy is undergoing greater scrutiny where the myriad of languages presenting clinically are not

possible to be matched with a native speaking therapist (D'Ardenne et al., 2007) however, the use of interpreters for Welsh speakers remains rare.

Information and written text

Unfortunately, the availability of Welsh language information for older people remains the exception to the rule. Guidelines are emerging, together with dictionaries of Welsh words that may be helpful clinically (Prys & Lloyd Davies, 2005). In terms of the in-session paperwork that may be used, self-help guides and records of behaviour, any Welsh versions currently appear to be those generated individually by specific practitioners working creatively to meet client needs. Recognition of the verbal tradition of Welsh may mean adapting English forms for use with Welsh examples of thoughts, feelings attitudes or may mean explicit discussion about how reporting would work most effectively with that client. Providing this information through the medium of Welsh for clients, carers and family may improve understanding as well as demonstrating an awareness of needs (Madoc-Jones, 2004).

Evaluation

Completing evaluative questionnaires through the medium of English may yield equivalent outcome data for Welsh speakers, but this has not been established formally. Welsh language versions of certain measures have been developed and further standardisation is required. Researchers are being encouraged by the Welsh language research unit, Llais to consider their recruitment and methodologies in order that systematic biases are not introduced. Guidelines are available via their website (www.Llais.org.uk)

Conclusions and reflections

Understanding and meeting the needs of Welsh-speaking older adults in Clinical Psychology Services requires an increased knowledge and awareness of the nature and history of the language; its impact and role in

personal psychology and identity as well as the differences bilingual speakers present cognitively. Welsh-speaking clinical psychologists are a scarce resource and yet working through the medium of Welsh may contribute to improved experiences and outcomes for clients. To this end greater consideration may be required amongst training providers and recruiters. For those working across languages, pragmatic steps may be required to firstly identify and then explore the language issues; appreciate the various levels of relevance that language issues hold and make adaptations to practice where necessary. Welsh speaking practitioners may also need to explore their interactions, the use of translation and the limitations of current neuropsychological data.

Personal reflection about the Welsh language is likely to be the most informative initial stance. Have you thought about it, if not, why not? If you don't see many Welsh speakers, why might that be? And what would you do if you did? As with all other elements of cultural reflection and working with diversity; the practitioner holds the responsibility to explore difference and with it come risks, challenges, costs and benefits (Patel et al., 2000)

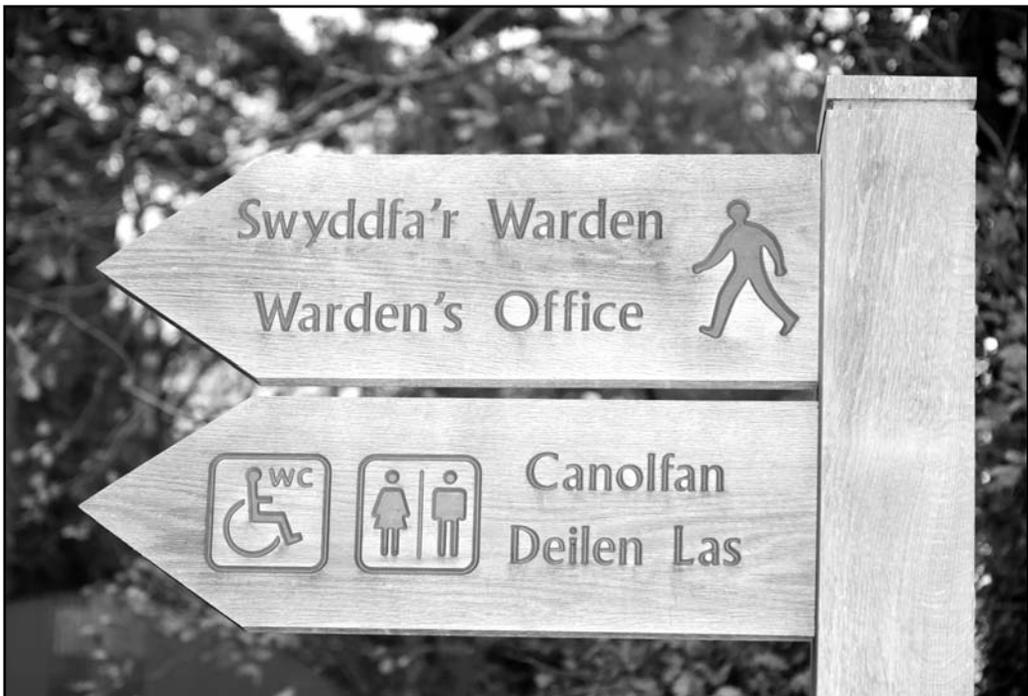
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'Where are all the older people?' They're not here either. Referral rates of over- and under-65s in Dumfries & Galloway

Anna Robson & John Higgon

Here we report an audit of the number of older adult and working-age adult referrals to the Dumfries & Galloway Psychological Services and Research department (hereafter referred to as 'Psychological Services') over a 15-month period. Although older adults comprised 25.3 per cent of the local population we found that they accounted for just 8.9 per cent of referrals to Psychological Services. Working-age adults were between three and four times more likely to be referred to Psychological Services than older-age adults. This finding lends further support to the hypothesis that ageist practices result in under-referral of older adults relative to working age adults.

The finding of relative under-referral in Glasgow, the Scottish Borders and Dumfries & Galloway, together with the lack of any contrary findings, suggests the likely existence of a trend throughout Scotland toward under-referral of older adults to psychological therapies.

THIS ARTICLE was prompted by the findings of Broomfield and Birch (2009) and Harte (2004), both of whom found evidence of a relative under-referral of older adults, compared to working-age adults, to psychological therapy services in their respective areas of Scotland. Broomfield and Birch (2009) reported a referral audit of older people into primary care mental health teams in NHS Greater Glasgow. They found that although older adults comprised 16 per cent of the Greater Glasgow population, they accounted for just 3.21 per cent of referrals to primary care mental health teams. Harte (2004) conducted a similar piece of audit in the Scottish Borders, which is a rural area of Scotland, and found that although older adults made up 18.9 per cent of the local population they only account for 9.7 per cent of referrals to clinical psychology. Both authors suggested that ageist assumptions on the part of referrers might account to some extent for the under-referral of older adults.

UK population estimates suggest that 9.8 million (16 per cent) of the total UK population (61 million) are 65 years old and

above and that by 2031 over 65s (OAs) will account for 23 per cent of the national population (Dunnell, 2008). In Dumfries & Galloway, a rural area in the south-west of Scotland, the population of older adults is already estimated to constitute 25.3 per cent of the region's total population of 148,000 (General Register Office for Scotland, 2008). This equates to a figure of approximately 37,000 OAs in the Dumfries & Galloway region.

Studies of prevalence of depression in the OA population suggest that approximately one-in-eight older adults might suffer from this condition. Beekman et al. (1999), in a review of prevalence studies in community-dwelling older adults, suggested a prevalence rate of 13.5 per cent. Blazer (2003), in a review of late-life depression, suggests a prevalence rate of between eight per cent and 16 per cent. Anxiety disorders may be more prevalent than mood disorders in the OA population (Brenes et al., 2008) and there is evidence that co-morbidity rates for the two conditions are greater in the OA population than in the working age population (Katona et al., 1997).

Psychotherapy has been shown to be beneficial in the treatment of mental health problems in the OA population (for a brief review, see Laidlaw et al., 2003). In spite of that psychotherapy is infrequently prescribed to older adults. Alvidrez et al (2002) found only 27 per cent of primary care workers in the US said they would refer a depressed older adult for psychotherapy. Similarly, Callahan et al. (1996) and Rothera et al. (2002) found that general practitioners (GPs) prefer to prescribe anti-depressants to depressed older adults than to refer them for psychotherapy, despite the evidence that a combination of medication and psychotherapy yields the best outcome (Thompson et al., 2001).

GPs play an essential role in the recognition and referral of mental health problems, particularly since 40 per cent of older adults attending GP surgeries suffer mental health problems (Philips & Appleby, 2005). However, recognising mental health problems in older adults can be difficult (IAPT, 2009). Physical symptoms tend to dominate and depression often occurs without sadness (Gallo & Rabins, 1999) making it difficult to distinguish between physical and mental illness.

Even when mental health problems are identified, diagnosis does not necessarily result in a referral for psychological therapy. GPs often don't refer because they don't know what psychotherapy is available and how effective it can be; they view depression as an inevitable part of ageing and thus less deserving of treatment; or they assume that older adults are not interested in psychotherapy because of the stigma they associate with mental illness (Laidlaw et al., 2003). However, cognitive behavioural therapy, interpersonal and problem-solving therapies have all been found to be effective in the treatment of older adults with depression (Klausner et al., 1999). Furthermore, older adults may have a preference for psychotherapeutic approaches rather than psychotropic medication. Callahan et al. (1996) found 13 per cent of older adults

refused anti-depressants whereas only five per cent refused a mental health referral. Whilst older adults are often reluctant to add anti-depressants to the list of medications they are already taking, there is evidence that they tend to have more positive attitudes towards psychotherapy than younger adults (Rokke & Scogin, 1995).

Despite literature reporting the prevalence of depression and anxiety in older adults, the effectiveness of psychotherapy in treatment of these conditions, and the preference of older adults for psychotherapy rather than or in addition to medication, referral rates of older adults to psychological services tend to be low when compared to the working-age population. This caused Broomfield and Birch (2009) to ask the question 'Where are all the older people?' The aim of the present study was to establish whether the pattern of relative under-referral described by Broomfield and Birch in their urban context, and by Harte in her rural context, would be found in our own area.

Methods

Data on the total number of referrals made to the Psychological Services in Dumfries & Galloway NHS within a 15-month period, between 1 April 2008 and 30 June 2009, were collected. The percentages of the working-age population referred to the Psychological Therapies service and the older adult population referred to the service were then calculated and compared using a retrospective survey design. The figures were further examined by speciality.

Finally, the staffing ratios in the Older Adult and Adult Mental Health Psychology Services were compared.

Results

5014 adults were referred to Psychological Services, Dumfries & Galloway, NHS between 1 April 2008 and 30 June 2009. Of these 5014 referrals, 446 were older adults (accounting for 8.9 per cent of all over-16 referrals) and 4568 were of working-age (accounting for 91.1 per cent of all over-16 referrals).

We made the assumption, for the purposes of the audit, that each referral was of a unique individual, whereas in fact some individuals may have been re-referred during the time period of the audit. We then calculated the proportions of the OA and working-age populations that had been referred to Psychological Services. We found that 1.5 per cent of the local older adult population, and 5.25 per cent of the working age population, had been referred to Psychological Services during this time period. Thus, the probability of a working-age adult being referred to Psychological Services was three-and-a-half times greater than the probability of an older adult being referred.

Pearson's chi-square showed a significant association between age group membership and the likelihood of a person being referred to psychology ($\chi^2(1)=748.280$, $p<.001$).

Specialities

Some specialities do not employ an upper age limit in their referral criteria. These are self-help, stroke, neuropsychology, learning disabilities, health and forensic. The Older Adults service sees people of the age of 65 and above. The rehabilitation and general medicine service is intended for people of working age. The adult mental health service sees clients up to the age of 64 and, as can be seen from Table 1, occasionally continues to provide a service to adults of 65 years and above, generally in cases where the client has a prior record of attendance. The eating disorders service employs an age cut-off of 64 years.

The Self-Help service, which accounts for the greatest proportion of older adult referrals (26.2 per cent), does not employ an upper age limit in its referral criteria. The service consists of a very brief intervention delivered by self-help workers under the

Table 1: Referrals of working age and older age adults to Psychological Services in Dumfries & Galloway NHS 2008/2009.

Speciality	65 years and over (N and %)	Under 65 years (N and %)	Total Referrals	% of referrals over 65 years
Self-Help	117 (26.2%)	1742 (38.1%)	1859	6.29
Stroke	59 (13.2%)	25 (0.5%)	84	70.2
Older Adults	103 (23%)	0 (0%)	103	100
Neuropsychology	28 (6.3%)	75 (1.6%)	103	27.2
Rehab	1 (0.2%)	61 (1.3%)	62	1.6
Adult Mental Health	15 (3.4%)	1167 (25.5%)	1182	1.3
Learning Disabilities	5 (1.1%)	128 (2.8%)	133	3.8
General Medicine	5 (1.1%)	77 (1.7%)	82	4.5
Health	26 (5.8%)	84 (1.8%)	110	23.6
Eating Disorders	0 (0%)	6 (0.1%)	6	0
Forensic	0 (0%)	12 (0.3%)	12	0
Not classified	87 (19.5%)	1191 (26.1%)	1278	6.8
Total Referrals	446 (100%)	4568 (100%)	5014	8.9

supervision of a CBT therapist. It is designed primarily for individuals with mild-to-moderate mental health problems.

An association between age and referral rate can be seen in particular specialities: stroke; older adults; neuropsychology and health, where the percentage of older adult referrals is higher. The Older Adults service is made up exclusively of referrals of those 65-years-old and over and, after self-help, is the speciality to which the majority of older adult referrals are made (23 per cent). Stroke services have the second highest rate of older adult referrals (70.2 per cent). Although stroke can occur in working-age adults it is a predominately late-life condition. Neuropsychology and Health services also receive a high proportion of older adult referrals, 27.2 per cent and 23.6 per cent respectively, presumably because cognitive abilities and physical health are both known to decline with age.

There are a high proportion of referrals where speciality is unknown. From the referral summary database it was not always clear what specialty they had been referred to and due to the large numbers involved it was not possible to search client records to collect this information.

Staffing ratios

The Older Adult psychology service in NHS Dumfries & Galloway comprises 2.5 w.t.e clinical psychologists.

The Adult Mental Health service consists of 12.15 w.t.e clinicians: 2.3 w.t.e. CBT therapists; 2.4 w.t.e. counsellors; and 7.45 w.t.e. clinical psychologists.

When taken in relation to the local population, the Older Adult psychology service has 1 w.t.e. per 12,000 local older adults compared to 1 w.t.e. per 7242 local working-age adults in Adult Mental Health psychology services. Thus, for every clinician per head of population in older adult services there are 1.7 clinicians per head of population for adult services. However, collectively across Scotland, for every clinician per head of the population in older

adult services there are 3.7 clinicians per head of population for adult services (ISD, 2008).

We note that particular specialities such as stroke psychology tend to attract a relatively high proportion of over 65s referrals owing to the nature of the speciality. We did not include the Stroke Psychology service, the Neuropsychology service or the Health Psychology service in our staffing figures because none of these services operates age-based limits on referral criteria.

Discussion

This audit of adult referrals to Psychological Services in Dumfries & Galloway suggests that the referral rate of working-age adults is three-and-a-half times greater than the referral rate of older age adults. This pattern is consistent with the findings of the previous audit by Broomfield and Birch (2009), namely, that older age adults in Glasgow were less likely than working age adults to be referred to primary care mental health teams. It is also broadly consistent with Harte's findings relating to the situation in the Scottish Borders (Harte, 2004).

Staffing ratios for the speciality lag behind those for working-age adults, but compare relatively favourably to many other areas in Scotland.

There are two methodological shortcomings to the audit. First, we excluded from the staffing ratio analysis those posts that were attached to services which did not operate a 64/65-year referral cut-off. These services generally tended to see relatively large numbers of older adults. For example, 70 per cent of referrals to the stroke psychologist were of people over the age of 65.

Second, we assumed that each referral was of a unique individual. However, it may have been the case that some individuals were referred more than once during the period of the audit. In order to answer that question, we would have needed to review case notes, which was considered unfeasible. There is no reason to suppose that referral rates of older adults should have

been markedly different from those of working-age adults, however.

Discussing the impact of late life mood disorders, Reynolds and Charney (2002) observe that:

'treatment works, but mood disorders in old age remain a big public health issue. Disability, decline, diminished quality of life, demands on care givers (persist) ... partnerships among researchers, clinicians, governmental agencies, third payers, patients and family members will be essential to further progress in the next 10 years.'

As the older adult population grows and, perhaps, becomes more vocal, services will come under increasing pressure to meet the increased need for psychological therapies within tight financial constraints. One solution might involve the gradual re-deployment of resources currently allocated to working-age adults, in line with the shifting demographics. Another approach might involve re-configuring services, perhaps along non-age-related lines. For example, services of the future might be designed around complexity and co-morbidity rather than the patient's date of birth. Finally, it seems that referrers still require assistance in identifying mental health problems in the OA population, and perhaps in overcoming ageist attitudes. We noted earlier that, in

25 years time, it is estimated that 23 per cent of the population will be over the age of 65. The vision for the future has to be that services for older adults will recognise and respond appropriately not only to dementia but also to general mental health needs. In line with this, we hope that referral audits of the future, unlike Broomfield and Birch (2009), Harte (2004) and our own study, will no longer be reporting the same old story.

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Pre-retirement occupation and current self-assessed health and life satisfaction

Michael J. Lewis, Anthony C. Edwards & Hayley M. Singlehurst

The aim of this study was to investigate the relationships between aspects of pre-retirement occupation, current self-related health (SRH) and life satisfaction, in a sample of retired men and women. The results revealed positive and significant correlations between scores on a life satisfaction measure and SRH, retirement stress, and retirement adjustment (all $p < .001$). A path analysis indicated aspects of previous employment that may predict an adverse influence on current satisfaction, for example, the stress of managing subordinates. We believe that many of the adverse effects of pre-retirement occupation can be helped or avoided through appropriate interventions, including retirement preparation and training.

Keywords: Retirement, elderly, life satisfaction, health, occupation.

A NUMBER of studies have been carried out at The University of Northampton (TUON) on factors that may contribute to optimal ageing. One of these had the primary aim of investigating leisure pursuits of 230 older adults aged 60 to 85, but some subsidiary statistical analyses were carried out later on the biographical data. An unexpected finding was that the current self-rated health of retirees was significantly and positively correlated with seniority of pre-retirement occupation, as categorised using the UK Standard Occupational Classification 2000 (ONS, 2008) (Lewis, Knight & Ball, 2010). For example, the health rating for professional and managerial categories was significantly higher than for sales or customer service occupations.

A further study was initiated using 133 retired men and women aged 60 to 93 years, and a similar correlation was obtained. For example, retired senior managers rated their health higher than did those who had worked either in sales, customer services, or trades jobs (Lewis, Edwards & Burton, 2009). Additionally, self-rated health was found to be significantly and positively related to scores on a measure of life satisfaction. In order to investigate just what factors could be involved in the relationship between health

and pre-retirement occupation, a new study was carried out (Lewis, Edwards & Singlehurst, under review). Some of the findings from this are included in the present article.

A search of the relevant literature has not revealed the same links between health or life satisfaction and earlier occupation, as were indicated in the TUON studies, but some reports involving a range of cultures have touched on related aspects. For example, in a US survey Heidbreder (1972) found that adjustment to retirement was highest with those who were better educated and had good or excellent health. However, O'Brien (1981) surveyed Australian retirees and failed to find any direct association between skill utilisation in pre-retirement occupation and current life satisfaction. In another US study, Herzog, House and Morgan (1991) showed that the levels of both physical and psychological well-being of participants aged 55-plus were influenced by whether or not their work reflected their personal preferences, rather than occupational status (e.g. professional, clerical, sales, blue-collar). Jonsson (1993) carried out a literature review on retirement from an occupational perspective, and noted that factors such as economics and health have a strong correlation with retirement satisfaction.

A Chinese study carried out by Li, Yu, Li and Wang (1999) surveyed men and women (mean age 67 years) retired from different occupational groups (professionals, senior administrators, junior administrators, and 'workers'), to investigate how life satisfaction might be influenced by aspects such as physical and mental health, social function and living standards. They found that psychological health was ranked first in importance by members of all four job categories, and that physical health was ranked second by the professionals but living standards was thus ranked by the other three categories. Ranked third in importance for the professional category was living standards, for junior administrators and 'workers' it was physical health related issues, and for senior administrators it was what was translated as 'treatment of the individual after retirement'. Although unfamiliar terminology and probable cultural differences make comparisons between these and the TUON findings difficult, it does appear that the retirees from the professional level occupations were the most satisfied with their physical health, and in this regard the two studies do concur.

More recently, Westerlund et al. (2009) surveyed employees from a French gas company, and found that perceived health problems reduced on retirement from jobs with a poor work environment, but that this was not the case for those of high occupational grades coupled with low demands and high work satisfaction. It is of interest that the health benefits, when they did occur, were maintained for up to 10 years after retirement.

Thus the findings from the literature survey were mainly peripheral or indirectly relevant to those found in the TUON studies. They inter alia suggest that, as might be expected, individuals with a good education, good health and adequate finances are better able to experience retirement satisfaction. One could speculate that these people would be in senior occupational positions, but this is only made more explicit with

regard to physical health in the Li et al. (1999) study.

Because of this dearth of supporting evidence for the relationship between pre-retirement occupation and current self-rated health and life satisfaction, as found in the earlier TUON studies, we designed a new survey to probe aspects associated with the job such as stress, responsibilities and decision freedom, to try and identify variables that might be responsible for these links. If explanations can be found for adverse influences on life satisfaction in retirement, opportunities for possible intervention and remedial strategies could emerge. Our study was thus mainly exploratory, but in general we hypothesised that there would be significant and positive links between aspects of pre-retirement occupation and current self-rated health and life satisfaction.

Method

Participants

The participant sample comprised 121 individuals with a mean age of 75.8 years (range=60–98), of whom 73 (60.8 per cent) were women and 47 (39.2 per cent) men, with one not stated. They were all retired from full-time work, and lived independently in the community within the county of Northamptonshire, but were recruited from several locations within a radius of about 30 miles.

Participants were asked to state their pre-retirement occupations, as these were needed for the hypotheses testing, but they also provided an indication of the socio-economic of the sample. We categorised the jobs according to the UK Index as: 14 (12.2 per cent) manager or senior official; 17 (14.8 per cent) professional; 18 (15.7 per cent) associate professional or technical; 32 (27.8 per cent) administrative or secretarial, and with 25 (21.8 per cent) comprising a combination of trades, service, sales, and operative. A further nine (7.8 per cent) were women who just stated 'homemaker', and six were not recorded. The sample was thus somewhat biased in favour of the higher status

occupations. The mean years retired from full-time work was 15.26 (SD=7.23, range=0–32).

Materials

We created a self-report questionnaire that mostly required forced choice responses, the items being grouped in several discrete sections. In a preface, we stated that any question that proved difficult or unacceptable could be omitted. No names were required, and no attempts were made to identify the participants, but we did request basic biographical details such as sex, age and marital status. The following questions were then asked:

1. Optimal ageing. We chose as an indicator of life satisfaction the CAS-14 scale that assesses a combination of Control, Autonomy and Self-reliance, and which was our modification of the original CASP-19 of Hyde et al. (2003), as used by the UK Department for Work and Pensions. The CASP-19 had an additional five questions that assessed Pleasure, but we found that this had poor discriminating ability for our purposes. The alpha estimate for the CAS-14 was a satisfactory 0.83, with individual item-total correlations ranging from 0.12 to 0.65. There are 14 questions, each with four response options: often, sometimes, not often, never. Some questions are reversed to limit response bias. Example questions are: 'I feel that what happens to me is out of my control', and 'I choose to do things that I have never done before'. The maximum possible score is 56, and the minimum 14.

2. Self-rated health. We employed a simple unitary scale for SRH comprising the question 'On a scale of 1 to 10, how would you assess your average health?' The scale was anchored at 1 (poor) and 10 (excellent). We also used the short scale of Bath (2003) to assess health change, using the question: 'Compared with five years ago, do you think you are (either) 'more healthy', 'about as healthy', 'less healthy', 'much less healthy'.

3. Pre-retirement occupation. We asked for the main job before retirement, but also included the main headings from the UK Classification Index for the participant to check the one most appropriate. To assess 'job stress', we asked if whether the ideal level of seniority had been reached, how satisfying the job was, the degree of mental and physical stress, the freedom to take decisions, and the stress of managing subordinates. To assess 'retirement stress', we included questions on which of these aspects of pre-retirement living were missed: social, income, mental and physical activity, and making a meaningful contribution in life. Finally, five questions assessed 'retirement adjustment', asking how the participant now felt he or she was achieving each of the following: social activities, income, mental activity, physical activity, and making a meaningful contribution in life. For each of these short scales, five-point Likert response options were provided.

We left a blank space toward the end for participants to add whatever additional qualitative comments they wished to make.

Procedure

Following ethical approval by the School of Health Ethics Committee, TUON, we distributed questionnaires to volunteers at community gatherings where meetings were already being held, and through personal contacts. Those who were willing could also take additional copies for their friends and family. We specified that participants should be aged 60 or above, be retired from full-time work, and be living in the community. In all cases the completed forms were returned to the lead researcher by means of stamped envelopes supplied, and this had the advantage of preserving anonymity. A total of 161 questionnaires were distributed, and 121 useable ones were returned, which represents an acceptable 74.5 per cent response rate. An earlier version of the questionnaire was piloted by four volunteers of the appropriate age group, and all completed the responses in about 10 minutes.

The quantitative responses were coded, entered into a database, and subjected to appropriate statistical analysis with the aid of the computer program Statistical Package for the Social Sciences. The pre-retirement occupations were coded according to the UK Standard Occupational Classification list, by consensus of two of the researchers, because some interpretation was needed to match the descriptions given by participants. If responses to a maximum of two questions of the CAS-14 scale, or only one question of other scales, were omitted, we computed the subscale totals from the mean of the completed items. If more than the permitted number of questions was omitted, we excluded the complete subscale from our statistical analyses. In the case of the women who had only recorded their job as homemaker, all the subsequent questions relating to job satisfaction were excluded as we made the assumption that homemaking is not an occupation from which women suddenly retire. Qualitative comments were noted for possible help with explaining subsequent statistical analyses, but very few were included by participants.

Results

1. Reliability of measures used

The reliability of the CAS-14 scale had been confirmed on previous usage, but we had combined various individual questions to form other sub-scales. These were: 'job stress', assessing the level of stress the person

experienced when in full-time employment (six questions); 'retirement stress', to assess the losses experienced immediately on retirement (four questions); 'retirement adjustment', to assess whether or not the participant had now adjusted or compensated for the losses experienced on retirement (five questions). Table 1 shows the reliability statistics of the three new scales.

Nunnally (1978) suggested that an alpha of 0.7 or above for a full scale, and 0.2 or greater for individual items, indicated an adequate scale reliability. The combination of items that made up the job stress scale was clearly unreliable and could not, therefore, be used in total for subsequent computations. Instead, we conducted analyses on the individual questions when exploring this variable. The retirement stress and retirement adjustment subscales were both deemed to have satisfactory reliabilities and were used as is.

2. Descriptive statistics

Summary statistics for the scales, and individual variables relating to job stress, are shown in Table 2. The skewness and kurtosis estimates were satisfactory for all measures except for the individual questions 'reached ideal job level' and 'job satisfaction', which were both over the limit of 2.58 recommended by Clark-Carter (1997); thus parametric computations could not be used for hypothesis testing involving these variables. We deemed all the other measures to comply with the requirements of parametricity.

Table 1: Chronbach alpha reliabilities for job stress, retirement stress, and retirement adjustment subscales.

Measure	Full scale alpha	Individual alphas	<i>N</i>
Job stress	0.268	0.001–0.356	92
Retirement stress	0.712	0.417–0.645	107
Retirement adjustment	0.698	0.310–0.586	118

Table 2: Summary statistics for quantitative measures used.

Measure	M	SD	Range	Kurtosis	Skewness	N
Age	75.77	7.07	60-98	.30	.22	121
S. R. Health	7.58	1.60	2-10	1.29	-.90	117
Health compare	2.65	0.72	1-4	.02	-.34	120
CAS-14	43.27	6.06	29-53	-.48	-.35	119
Retirement stress	5.39	3.60	5-20	.90	-1.05	107
Retirement adjustment	17.48	3.45	8-24	-.11	-.29	118
Reached ideal level	3.76	0.66	2-5	3.39*	-2.18	102
Job satisfaction	4.18	1.04	1-5	2.64*	-1.66	103
Mental stress	2.79	1.11	1-5	-.77	.18	103
Physical stress	3.78	1.29	1-5	-1.12	-.57	103
Decision freedom	3.51	1.33	1-5	-.68	-.67	103
Subordinate stress	3.87	1.23	1-5	-1.05	-.60	103

*Outside acceptable limits

3. Hypothesis testing

Before proceeding with the main computations, we checked for sex-based differences in scores on the main variables. Only one was found: males reported greater stress in managing subordinates than did women (males mean=3.54, females=4.13, $t(100)=-2.44$, $p=.016$. Note: for all statistics reported in this paper, probability values are two-tailed). Thus the combined scores from all participants could be used for hypothesis testing, with the exception of subordinate stress.

3.1 Main relationships involving Life Satisfaction

Zero order correlations (Pearson) for the main subscales are given in Table 3.

Positive and significant inter-correlations were found between the life satisfaction measure (CAS-14), self-rated health, retirement stress, and retirement adjustment. The effect sizes of these can be classed as close to or exceeding ‘large’ according to the criteria suggested by Cohen (1988) (0.1=small; 0.3=medium; 0.5=large). The significance of relationship between health and retirement stress ($p=.012$) would reduce to borderline if corrected for multiple analyses. No significant relationships between job category and either health or life satisfaction were obtained, contrary to previous findings.

Table 3: Pearson correlations between CAS-14, self-rated health, job stress, retirement stress, and retirement adjustment measures (with 2-tail probabilities).

Measure	S. R. Health	Job	Retirement stress	Retirement adjustment
CAS-14	.564 (.000)	.057 (.545)	.444 (.000)	.606 (.000)
S. R. Health		-.083 (.382)	.247 (.012)	.389 (.000)
Job category			.025 (.797)	.156 (.097)
Retirement stress				.253 (.009)

3.2 Relationships involving job category

An aim of this study was to assess the extent to which degree of stress experienced varied over the different job categories, but this could not be done using the combined scores of the six pertinent questions because they did not form a reliable scale. We thus computed Pearson's correlations using the individual questions, with the exceptions of 'ideal level' and 'job satisfaction' where Spearman's rho was used because of the non-parametric score distributions for these variables. Additionally, separate estimates were carried out for men and women on the 'subordinate stress' question, due to the sex-based differences on this variable. Table 4 shows the outcomes.

After correcting for multiples, the main significant findings indicated that the more senior the job category, the greater the mental stress but also the greater the freedom to take decisions. Additionally, job satisfaction was related to the freedom to take decisions, compared with having a job

where duties were defined. For women, the stress of managing subordinates was related more to high seniority jobs than to low ones; the trend is similar for men but the significance level falls outside the level usually adopted in the social sciences after correction for multiples. For men only, the stress of managing subordinates was inversely correlated with decision freedom, suggesting that managerial decision options may be constrained by company policy, and that this can lead to frustration.

3.3 Path analysis

We wished to obtain a clearer picture of the main links between the co-variables and the criterion of current life satisfaction, with the specific aim of identifying the predictive and mediatory roles that some variables might play. To this end we conducted a path analysis on the job and health-related variables, using a step-wise multiple regression analyses with the CAS-14 scores as the initial criterion. Each predictor from the previous

Table 4: Correlations (Spearman for 'ideal level' and 'job satisfaction'; Pearson for all others) between measures for job category, ideal level, job satisfaction, mental stress, physical stress, decision freedom, and subordinate stress (separate computations for men and women), showing significance levels at two-tailed probabilities.

Measure		Ideal level	Job satisfaction	Mental stress	Physical stress	Decision freedom	Sub men	Sub women
Job category	<i>r</i> Sig	-.129 .198	-.188 .057	.258 .009	-.950 .342	-.417 .000	.359 .013	.344 .009
Ideal level	<i>r</i> Sig		.208 .035	.009 .927	.157 .116	.212 .032	-.107 .474	-.021 .877
Job satisfaction	<i>r</i> Sig			.132 .182	-.100 .317	.286 .003	-.003 .985	-.114 .401
Mental stress	<i>r</i> Sig				.197 .046	.029 .768	.313 .032	.213 .115
Physical stress	<i>r</i> Sig					-.110 .270	-.063 .672	.232 .085
Decision freedom	<i>r</i> Sig						-.398 .006	-.182 .179

analyses then serves as the criterion for the next stage of regression with the variables not yet utilised. The path coefficients represent standardised partial regressions with the remaining variables (β weights), and the process continues until no further significant results are obtained. The outcome of this exercise is shown in Figure 1.

The first iteration resulted in a three-factor model, with retirement adjustment, self-rated health, and retirement stress each predicting the criterion of life satisfaction (CAS-14). With the second iteration, using retirement adjustment as the criterion, the resulting two-factor model showed that both health change and ideal job level were the predictors. With SRH as the criterion, health change was the single predictor. In the case of retirement stress being substituted as the criterion, the sole predictor was subordinate stress. A third iteration with this latter variable as the criterion, yielded a three-factor model with job category, mental stress, and decision stress all being predictors of subordinate stress. There were no further significant outcomes for any of the variables.

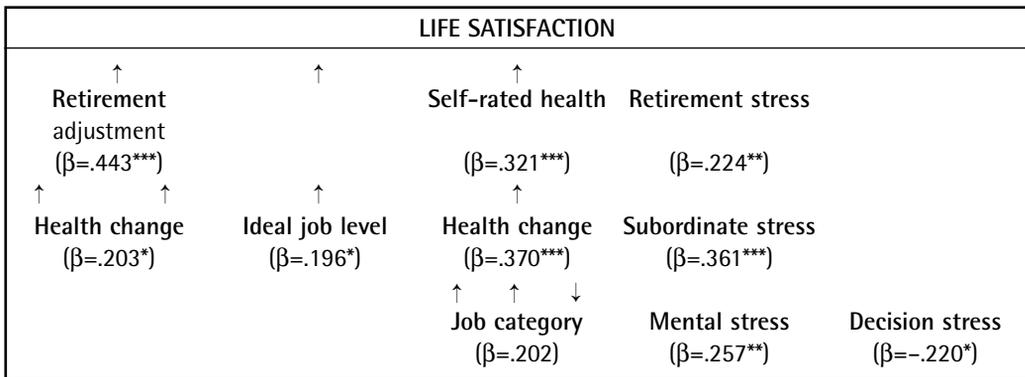
With the path analysis procedure, variables that do not directly predict another variable can nevertheless be shown to play a mediatory role. For example, the model suggested that self-rated health can mediate between observed health change and current life satisfaction. Likewise, the stress of managing subordinates may mediate between the stress of retirement and other aspects of the job such as job category, mental stress and the stress of making decisions.

Discussion

The aim of this study was to explore possible links between aspects of pre-retirement occupation and the current self-rated health and life satisfaction of retirees. Although we did not confirm a direct relationship between seniority of occupation and either health or life satisfaction, we did find a positive and significant correlation between the latter two variables and both the recollected negative impact (stress) of retirement at the time, and current adjustment to life in retirement. With regard to retirement stress *per se*,

Figure 1: Path diagram illustrating the interrelationships between the criterion of Life Satisfaction and variables associated with self-rated health and pre-retirement occupation.

Note: Beta values from multi-regression analysis indicate strength of relationships.



* $p<.05$ ** $p<.01$ *** $p<.001$

the path analysis indicated that this can be predicted by the stress of managing subordinates and, in turn, subordinate stress can be predicted by mental stress associated with the job, the stress of making decisions, and seniority of job category. This analysis also suggested that retirement adjustment is predicted jointly by health change and having reached one's ideal job level. Another interpretation of path analysis is to suggest that some variables might play an intermediate or mediatory role, linking elements further back in the chain with the criterion. Individual correlations concerning pre-retirement occupation also revealed relationships between reaching one's perceived ideal job level, job satisfaction, and the freedom to take decisions.

Although our present findings concerning life satisfaction or self-rated health, and seniority of pre-retirement employment, did not yield the same trend found previously (Lowis et al., 2009, 2010), the correlations we obtained between specific aspects of the job, health and current life satisfaction are of particular interest in that they could be used to suggest interventions to enhance optimal ageing. Previous reports have endorsed the importance of aspects such as good health, education and economics on retirement satisfaction (Heidbreder, 1972; Jonsson, 1993), and the Chinese study of Li et al. (1999) specifically highlighted what they called psychological health. Equally relevant is the finding of Herzog et al. (1991) that both physical and psychological well-being are influenced by achieving personal preference in one's employment rather than occupational status *per se*, although Westerlund et al. (2009) showed that health improvement on retirement only occurred with those employed in a poor work environment.

Our own results confirmed that self-rated health does have an impact on retirement satisfaction. We also found that the stresses associated with the previous employment, and their impact on the adjustment to a life that should be free of such pressures, linger

on and can adversely influence the attainment of optimal ageing for retirees. The 121 participants who took part in the survey had been retired for an average of 15 years (range=0–32). We found no positive correlation between retirement duration and scores on the life satisfaction measure; rather there was a general trend for these scores to reduce with age and this could have masked any upward trend linked to the release from full-time employment. The elements that comprised the retirement stress subscale required participants to assess (retrospectively) how much they missed each of the following when they retired: social, income, activity, and making a meaningful contribution to life. As seen from the path analysis, scores on this subscale were predicted by aspects of the job including seniority of job category, and various aspects of stress associated with management. The retirement adjustment subscale asked similar questions about how these aspects were currently being resolved. The predictors were achievement of ideal job level, implying a position where both the stresses and challenges were under control, and the degree of health change over the previous five years.

If these results reflect a true situation, it is unfortunate that the retirement that follows many years of hard work is adversely affected by job pressures during the latter stages of employment, many of which could possibly be reduced or avoided through appropriate intervention. Responsible and caring employers have an obligation with their older staff to discuss ways of phasing in retirement over several years, and to reduce stress factors where possible by replacing some of the arduous managerial tasks with planning, mentoring, advisory or training roles. Not only could this allow promotional opportunities for those lower down the hierarchy, and for the retiree-elect to help train and groom subordinates for the more senior positions, but it may help the older individual to arrive at the retirement day without the debilitating burden of stress and tension that is likely to mar retirement for many years to come.

Some aspects of retirement training need to be covered several years before retirement, for example financial planning and decisions concerning accommodation, as these are best accomplished whilst the person is earning a full-time salary. A training programme offered in the final year needs to achieve a balance between practical and psychological topics if it is to avoid 'retirement shock' (Atchley, 1989). For example, a programme of six sessions, devised and facilitated by Lewis and Picton (1996), covered: myths and stereotypes of old age, benefits and advantages of retirement, the work role and phases of retirement, health, finances, accommodation, family and friends, legal issues, leisure and interests, gains and losses, successful agers, and religion and reminiscence. After each topic, delegates were asked to make specific notes about their personal needs and concerns, which were then formulated into a personal and dynamic action plan.

As is the case with quantitative studies in general, reliant as they are on statistical computations based on mean scores, the present research was not able to explore individual differences among the participants. Thus any interventions based on the reported data might not be appropriate for all people. Also, the participants were drawn from within an area of only about a 30-mile radius of one town in one part of the UK, and thus generalisation to wider populations needs to be made with caution. Finally, although efforts were made to ensure the reliability of all assessment scales used, their validities were often judged on face value alone, and this includes the scores on some single questions.

With these reservations in mind, we believe that our research has added to the understanding of factors that can impact on life satisfaction in retirement and, in particular, on how the stresses of work during the last few years of full-time employment can have far reaching and adverse influences on post-retirement adjustment. Most, if not all of the potential problems should respond to appropriate interventions, especially in timely retirement preparation training programmes.

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Inappropriate sexual behaviour observed within an older adult service: The use of the St Andrew's Sexual Behaviour Assessment (SASBA) in formulation, intervention and outcome

Inga Stewart, Caroline Knight, Nick Alderman & Laura Hayward

Inappropriate sexual behaviour (ISB) within older adult populations is arguably overlooked within the literature in comparison to other challenging behaviour such as aggression, yet the impact on service users and staff is equally disruptive and demanding. Additionally, there can be stigma attached to ISB. Inconsistencies in terminology and lack of measurement tools for ISB limit the degree to which such behaviour can be identified, reported and managed and as a result prevalence rates vary considerably.

The St Andrew's Sexual Behaviour Assessment (SASBA: Knight et al., 2008), based on the Overt Aggression Scale – Modified for Neurorehabilitation (OAS-MNR: Alderman et al., 1997), was conceived to increase knowledge and understanding about ISB, provide clinical information to inform treatment, and make available a means of enabling appropriate, open discussion about the subject. The scale allows continuous observations of four categories of ISB, each with four levels of severity, which were developed with reference to relevant literature.

Information captured using the SASBA has been demonstrated to meaningfully contribute to a formulation about ISB, which can underpin the design of an appropriate intervention, and to measure outcome. Field data using SASBA has led to further insight about the nature of ISB within older adult populations. Clinical uses of the scale are outlined and the associated benefits and limitations are discussed.

Keywords: *Inappropriate sexual behaviour; measure, older people.*

Challenging behaviour within older adult populations

THE IDENTIFICATION and management of challenging behaviour is essential to protect clinical staff and fellow service users, and to deliver appropriate timely interventions for those in inpatient settings (Braun & Kunik, 2004; Department of Health, 1999; NHS Security Management Service, 2005). The impact of challenging behaviour in healthcare settings cannot be underestimated, with wide ranging consequences for staff including physical (medical treatment), psychological (fear; resentment; emotional exhaustion) and trained

professionals considering alternative careers (Bonner & McLaughlin, 2007; Evens, Tomic & Brouwers, 2001; McKenna et al., 2003). Available research suggests that inappropriate sexual behaviour (ISB) is uniquely disruptive and challenging for clinicians as it requires them to acknowledge their own personal and cultural views, is associated with a high degree of burnout and has been reported to impact adversely on rehabilitation, and yet there is often insufficient training (Anderson Light & Holroyd, 2006; Bezeau, Begod & Mateer, 2004; Guay, 2008; Harris & Wier, 1998; Hughes & Hebb, 2005). Sexuality is evidently part of human nature

throughout the lifespan, and being considered 'elderly' does not equate with sexlessness; yet additional complexities are reported to exist with regards to ISB exhibited by older adults related to stigma attached to older age and sexuality, as well as what should be considered 'appropriate' (Alagiakrishnan et al., 2005; Harris & Wier, 1998; Higgins, Baker & Begley, 2004; Johnson, Knight & Alderman, 2006; Mayers & McBride, 1998; Zilbergeld, 2004). The factors that underpin and/or mediate challenging behaviours within older adult populations remain unclear, though may include pre-morbid personality factors, psychosis, mania, neurodegenerative illness and communication difficulties, as well as the effects of medication and the environment, including interaction with carers (Alagiakrishnan et al., 2005; Higgins et al., 2004; Pulsford & Duxbury, 2006).

Defining inappropriate sexual behaviour (ISB)

Some studies encompass ISB in definitions of aggression and violence in older people (Brodaty & Low, 2003; McKenna et al., 2003; Morgan et al., 2005). Other researchers argue that ISB should be studied independently as a factor in its own right due to inconsistent definitions, poor conceptualisations and a general paucity of research (Johnson et al., 2006; Knight et al., 2008; Matsuoka et al., 2003). In contrast to service user ISB, aggression is considered to have a more substantial evidence-base (Bezeau et al., 2004; Johnson et al., 2006; Nagaratnam & Gayagay, 2002). It is widely argued that the range and inherent subjectivity of the terms employed provide an unstable foundation for the identification and assessment of ISB (for a comprehensive review see Johnson et al., 2006; Knight et al., 2008). Despite its relative scarcity in the literature, an array of terms are evident, such as 'sexual behaviour', 'sexual advances' (Souder & O'Sullivan, 2003), 'sexual behaviour that annoys other people' (Matsuoka et al., 2003), 'hypersexuality', 'propositioning' (Nagarat-

nam & Gayagay, 2002), 'sexually intrusive behaviour' and 'inappropriate commentary' (Bezeau et al., 2004). For the purposes of this paper, the evidence-based and 'necessary conceptual framework' (Knight et al., 2008, p.131) from which more accurate identification, assessment and management of ISB could occur will be taken from Johnson and colleagues: Inappropriate Sexual Behaviour is defined as 'a verbal or physical act of an explicit, or perceived, sexual nature, which is unacceptable within the social context in which it is carried out' (Johnson et al., 2006, p.688).

Prevalence of ISB within older adult populations

Aggressive behaviour is reported to be the most common reason for referral of older people from care homes to psychiatric services and for institutionalisation (Hope & Patel, 1992; IPA, 2003; Taylor, Duqueno & Novaco, 2004). However, estimates of the prevalence of aggression among older people vary considerably due to the lack of standardised definitions of aggressive behaviour employed across studies. Research in various older adult populations suggests that symptoms are evident in up to 90 per cent of the clinical population (Boller et al., 2002; Bowie et al., 2001; Cohen-Mansfield, 2001; Guay, 2008; Hope & Patel, 1992; Kolanowski & Garr, 1999; Leger et al., 2002; Ryden, 1988; Scott et al., 2002; Stewart, Knight & Johnson, 2008; Stewart & Knight, in press). In contrast, prevalence rates associated with ISB exhibited by older adults are significantly more modest. In their sample, Alagiakrishnan et al. (2005) found 1.8 per cent of cognitively impaired older adults had engaged in ISB. Similarly, Devanand et al. (1992) discovered 2.9 per cent of outpatients with Alzheimer's disease to display 'sexual disinhibition'. Other studies suggest it is more prevalent. For example, Tsai, Hwang, Yang, Liu and Lirng (1999) reported between 2.9 per cent and 15 per cent of inpatients with dementia to exhibit ISB and Black, Muralee and Tampi (2005) reported

rates between seven per cent and 25 per cent. Other findings have suggested a seven per cent prevalence rate (Burns, Jacoby & Raymond, 1990). Lack of standardised assessment tools (Johnson et al., 2006) and within-service user variability (Cohen-Mansfield, 1999) are likely to account for variability in prevalence estimates. ISB is also likely to be underreported (Knight et al., 2008). Inaccurate data collection has implications for increased understanding and the management of challenging behaviours, resource allocation and staff training (Pulford & Duxbury, 2006; Souder & O'Sullivan, 2003). Furthermore, inconsistent definitions of ISB mean comparison across studies, specialities and time becomes problematic (Johnson et al., 2006).

As with aggression, it has been suggested that ISB is a predictive factor for institutionalisation (O'Donnell et al., 1992). Although prevalence rates remain unclear, what is apparent is the need for specialist services for older people who exhibit challenging behaviour such as ISB and for the resources necessary to sustain these services to be considered. Further, accurate measurement of these behaviours remains essential in order to identify behaviours that require intervention, guide formulation and ultimately measure outcome.

Specialist Services in St Andrew's – Townsend

St Andrew's Healthcare – Townsend, part of St Andrew's Healthcare, Northampton, has come to specialise in meeting the needs of people primarily over the age of 55 who present with challenging mental health problems that require safe accommodation and care. Referrals are made nationally to the charity because of high levels of risky and challenging behaviour which have not been easily met by local NHS provision. Specialist services include provision of 115 beds for those with early-onset, acquired, static or progressive neurological conditions such as dementia or Huntington's disease, forensic services for older men and for older women,

and services for those requiring higher levels of physical or palliative care. Service users have extremely complex needs due to a mixture of psychiatric, cognitive and physical problems. Many present with challenging behaviour including aggression and ISB. St Andrew's Healthcare – Townsend works to reduce risk and maximise and maintain the function and quality of life of service users whilst ensuring the best possible support for a service user's autonomy and dignity. This is undertaken within a person centred framework (Brooker, 2007) where knowing the individual and seeing their life history is important and central to meeting their needs.

Measuring ISB: The St Andrew's Sexual Behaviour Assessment (SASBA)

The St Andrew's Sexual Behaviour Assessment (SASBA: Knight et al., 2008), based on the Overt Aggression Scale – Modified for Neurorehabilitation (OAS-MNR: Alderman et al., 1997), was devised to increase knowledge and understanding about ISB, provide clinical information to inform treatment, and make available a standardised means of enabling appropriate, open discussion about the subject. Conceived within an operant conditioning framework, the SASBA seeks to explore and monitor the relationship ISB has with the environment. This scale allows continuous observations of four categories of ISB, each with four levels of severity, which were developed with reference to relevant literature (Johnson et al., 2006). It also offers assessment of the setting events to ISB, including any contributing environmental factors and the direct antecedents, as well as the interventions used by staff. Further, interventions are considered in relation to degree of intrusiveness in order to promote best practice. The SASBA has been demonstrated to have strong construct and content validity, and good inter-rater and test-retest reliability. Both the OAS-MNR and SASBA are routinely employed within St Andrew's Healthcare – Townsend with all service users. All staff within the service are trained to use both tools.

This paper reports on a clinical audit of the ISB observed within an older adult service as captured by the SASBA over a three-month period, and explores its use in formulation, intervention planning and measuring outcome. The data are also discussed within the context of the wider challenging behaviour exhibited by the population, including overt aggression.

Method

Observational data concerning all ISB observed across all the wards within St Andrew’s Healthcare – Townsend during a three-month period were recorded using the SASBA. For each behaviour data were recorded concerning the setting event (contributing factors and the direct antecedent), the type of ISB, including Verbal Comments (VC), Non-Contact behaviours (NC), Exposure (E) and Touching Others (TO), the severity of the ISB and the intervention used by staff to manage it.

A total of 97 inpatients were audited, comprising 76 males and 21 females. Mean age was 68 years (range 25 to 87).

Results

Frequency, classification and severity of ISB

Over the three-month period SASBA data showed that 32 per cent of service users engaged in 225 episodes of ISB. A breakdown by type and severity of ISB is shown in Table 1 and Figure 1. The most frequent type of ISB

recorded were ‘Verbal Comments’, followed by ‘Non Contact’ ISB and ‘Touching Others’, whereas ‘Exposure’ was recorded the least.

Summary statistics regarding severity of ISB are also presented in Table 1. Ratings from each category were weighted using criteria by Knight et al. (2008). Using this, ISB is ranked in terms of severity across and within the categories (with a total possible severity score of 16). Whilst being recorded as the most frequent behaviour, the verbal comments category was also the least severe, followed by non contact behaviour. Exposure and touching others, which were reported less often, were rated overall as being significantly more severe.

Antecedents to ISB

The antecedents observed by staff are presented in Table 2. Two sets of antecedents are recorded using the SASBA. Firstly, three ‘contributing factors’ include: structured activity, noisy environment and epileptic fit within the last 24 hours. Secondly, 15 setting events that are observed to directly precede ISB were recorded.

With regard to possible setting events, the majority of ISB occurred outside the context of formal sessions (71 per cent). A noisy environment did not appear to have an association with ISB and was only associated with four per cent of all ISB recorded. No epileptic activity was recorded prior to an incident of ISB.

Table 1: Frequency and weighted severity of observed ISB by type.

	Frequency	%	Mean weighted severity	SD
Verbal Comments	99	44.0	1.60	0.968
Non Contact	49	21.8	2.49	1.043
Exposure	33	14.7	4.79	2.977
Touching Others	44	19.6	6.18	4.266
Total	225	100	3.16	2.961

Figure 1: Frequency and weighted severity of observed ISB by type.

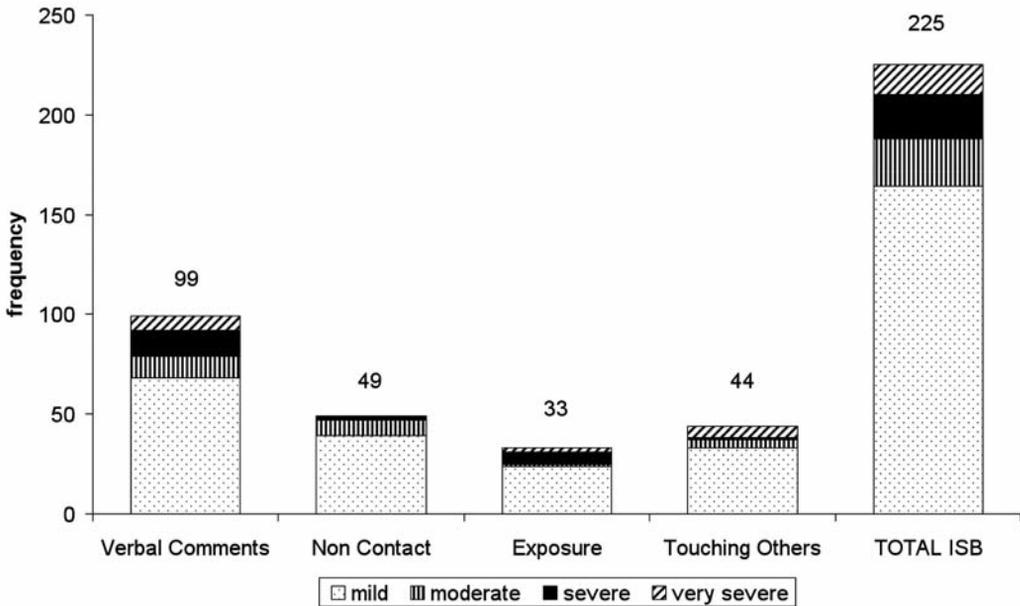


Table 2: Antecedents to observed ISB.

	Frequency	%
<i>Contributing factors</i>		
Structured activity	66	29.3
Noisy environment	9	4.0
Epileptic fit in last 24 hours	0	0
<i>Observed directly before aggression</i>		
No obvious antecedent	130	57.8
Other verbal interaction	46	20.4
Direct verbal prompt to comply with instruction	10	4.4
Physical guidance/facilitation	8	3.6
Given verbal/visual feedback	8	3.6
Other	7	3.1
Agitated or distressed	6	2.7
Purposeful behaviour is downplayed	6	2.7
Given verbal guidance/advice	3	1.3
Response to other service user entering personal space	1	0.4

Of the 15 categories of antecedent, only 10 were recorded (Table 2). Two antecedents were associated with 78 per cent of all ISB. Over half of the ISB exhibited over the three-month period had no obvious observable antecedent. For the remaining incidents of ISB, the most frequent antecedents related to verbal interactions with staff, including general verbal interaction and direct verbal prompts to comply with an instruction.

Interventions used in the management of ISB

The type and frequency of intervention used by staff are summarised in Table 3. Six of the 14 intervention categories were recorded. With regard to management, two categories accounted for 85 per cent of the interventions used by staff during this three-month period. The most frequent interventions used were talking to the service user, including prompts and ‘downplaying’ or ignoring the ISB (TOOTS: ‘time-out-on-the-spot’). These interventions are in line with teaching all staff receive on the RAID® course (Davies, 2007)

and complement principles of person centred care (Brooker, 2007).

Eleven of the intervention types specified on the SASBA can be ranked in order of degree of intrusiveness. Using the hierarchy of intrusiveness of intervention created by Alderman et al. (1997) – where 1 indicates the least intrusive and 11 indicates the most intrusive - the most frequent intervention of talking to the service user ranks as 3 and downplaying the behaviour ranks as 1. None of the remaining 10 intervention categories exceeded 15 per cent of the recordings, and there was no use of isolation or PRN medication to manage the ISB.

Time of day ISB observed

Recordings of ISB were made by staff 24-hours a day during the three-month period. A breakdown of the time of day the ISB incidents were observed is shown in Table 4. Data indicated that the majority of ISB was recorded during the afternoon and morning; ISB was least likely to be observed throughout the night.

Table 3: Interventions to observed ISB.

	Frequency	%
Talking to service user	102	45.3
USB ignored/played down (TOOTS)	89	39.6
Closer observation	19	8.4
Holding service user	9	4.0
Physical distraction (leading service user away)	4	1.8
Other	2	0.9

Table 4: Time of day ISB observed.

	Frequency	%
Morning (06.01 – 12.00)	89	39.6
Afternoon (12.01 – 18.00)	105	46.7
Evening (18.01 – 11.00)	30	13.3
Overnight (11.01 – 06.00)	1	0.4

Discussion

ISB observed within St Andrew's Healthcare – Townsend as captured by the SASBA was audited over a three-month period. The SASBA provided data to objectively demonstrate the frequency of ISB, as well as facilitated an analysis of the type and severity of ISB incidents. Further, the SASBA allowed exploration of precipitating factors and responses from staff in order to investigate the relationship ISB had with the environment and promote best practice. Results presented in this paper comprise a brief summary of some of these principal findings.

The current audit: The use of the SASBA in formulation, intervention and outcome

A total of 255 episodes of ISB captured by the SASBA were evident, with all four categories of ISB recorded. 'Verbal Comments' were most frequent (just under half of the incidents recorded), but rated by staff as the least severe type of ISB. Conversely, exposure occurred infrequently (around a sixth) but along with touching others (making up a fifth), receive the highest severity ratings.

Recorded incidents of ISB typically occurred during the daytime, specifically the afternoon. ISB was most frequent when service users were not engaged in formal sessions and consequently when expectations were likely to be lower. Over half were noted to occur in the absence of an overt antecedent. These data suggest that ISB did not generally have an escape/avoidance function, whereby a service user may engage in ISB in order to evade an activity. Instead, ISB may provide a means by which some service users initiated contact and attention, potentially serving a psychological need for intimacy that has been sexualised (Higgins et al., 2004). ISB may also serve a stimulatory function (Knight et al., 2008). For the remaining incidents, most related to verbal interactions with staff (just under a third), also supporting a hypothesis that some ISB may result from a need to communicate a need or desire (Higgins et al., 2004) or from a misinterpretation of the actions of another

(Mayers, 2000). Conversely, it also could suggest ISB may serve a social distance reduction function, whereby a service user may engage in ISB in order to *avoid* an interaction.

Following the majority of the incidents, staff responded by talking to the service user (just under half), suggesting that the function(s) of ISB may subsequently be enhanced and reinforced by attention from staff (Knight et al., 2008) and is consistent with the conclusions made above in relation to the typical absence of an antecedent. This highlights a need for staff to review and discuss specifically what form an intervention of talking to a service user might take. Talking to the service user might encompass a range of reactions, including reprimand or redirection/distraction, and staff need to ensure that their response is formulation led, planned and consistently implemented. Conversely, a large proportion of the remaining incidents were managed by withdrawing attention from the ISB whilst providing positive reinforcement for appropriate behaviours. Here intermittent reinforcement of the behaviour is circumvented, whilst the needs of the person can still be attended to in a person-centred way. Both these two interventions can be interpreted as 'less intrusive' when ranked alongside the available alternatives (Alderman et al., 1997).

While considered at group level, variability in type and severity of behaviour as well as precipitating factors and staff interventions naturally result in varied formulations. Despite this, population trends and patterns do emerge which can be particularly helpful for considering service delivery. The SASBA, therefore, lends itself to single cases in order to gain maximum advantage in formulation (for example see Alderman, 2008). The SASBA is intended to provide a means of *monitoring* ISB, irrespective of intent (Knight et al., 2008). As such, person-specific evidence-based functional analysis and formulation can develop from subsequent clinical debate on an individual basis. Where ISB is less characteristic, continued

monitoring can alert staff when the frequency or severity escalates to a level where action is required. The stage is then already set for testing emerging hypotheses and measuring efficacy of interventions. The SASBA, therefore, assists in: the identification of challenging behaviours that require intervention; formulation on a single-case basis regarding the function of such behaviours; intervention design; service planning and outcome measurement on both a single case and group level.

Challenging behaviour: ISB and aggression

Within the same three-month period, a total of 4361 incidents of aggression were recorded on the OAS-MNR (Stewart & Knight, in press): most occurred when service users were not engaged in formal sessions (around two thirds). A greater range of antecedents were associated with aggression than ISB (15 vs.10), and a wider array of interventions were deployed to manage the former (12 vs.6), although the 'intrusiveness' of these interventions remained low.

Consideration of SASBA data alone suggests that ISB may be frequently expected within older adult services. However, when the proportion of ISB was compared to all challenging behaviour (ISB: SASBA plus aggression: OAS-MNR) ISB accounted for only five per cent of the behaviour recorded across the service. Interestingly, when compared to the earlier, although smaller, sample of a similar population investigated by Knight and colleagues, the proportion of challenging behaviour attributable to ISB for the current audit is smaller (Knight et al., 2008: $N=22$; ISB=13 per cent of challenging behaviour). However, this difference may in part be a reflection of the more homogeneous sample generated from investigating one ward against a whole service. In addition, the distribution of ISB across service users may skew frequency rates due to within-individual variability if a small number of service users are found to account for a large proportion of the data (Cohen-Mansfield, 1999).

Prevalence of ISB compared to other studies

A notable finding was that aggression was characteristic of most service users, whilst ISB was not. OAS-MNR recordings were made for 70 per cent of service users (Stewart & Knight, in press); in contrast, SASBA data was collected for only 32 per cent of service users. As discussed earlier, comparison between prevalence studies are complicated by the heterogeneity of population samples, inconsistency of definitions and lack of standardised measures of ISB (Johnson et al., 2006; Knight et al., 2008). Further, it is possible that different measures of ISB have differing levels of tolerance in terms of what is and what is not considered to be 'appropriate'. Potentially, the SASBA might have a higher level of behaviours embedded in the categories that would otherwise be deemed 'normal' but are regarded to be 'inappropriate' because of the environmental context. Nonetheless, the prevalence rate for ISB found in the current study would be considered considerably higher than those presented in the literature of under three per cent (Alagiakrishnan et al., 2005; Devanand et al., 1992) and even those comparatively more generous rates of up to 25 per cent (Black et al., 2005; Burns et al., 1990; Tsai et al., 1999). Certainly, the specific population being measured needs to be considered when comparing prevalence rates, with these cited studies included both institutional and community settings. Even so, non-institutionalised settings do not preclude the occurrence of ISB, for example Alagiakrishnan et al. (2005) found over half of their 'sexually inappropriate' population to be living and managed within the community. Further, the population within the current audit is widely heterogeneous, including a mix of males and females of a broad age range, and including those with and without cognitive impairment, mental health problems or forensic presentations. Nevertheless, application of the SASBA tool in capturing greater incidents of ISB cannot be overlooked, and the authors would argue that this audit has achieved a more accurate

and objective analysis of ISB through the utilisation of the SASBA.

These findings support the assertion in the literature that ISB is prevalent in older adult populations. Although, for those who do exhibit challenging behaviour aggression typically remains more frequent. They also illustrate the importance of employing a standardised definition and measure of ISB such as that achieved by the SASBA. This is especially relevant for specialist challenging behaviour services, where a better knowledge of ISB may be even more necessary than in more traditional older adult settings.

Conclusion

This clinical audit supports the growing research-base suggesting that despite its relative scarcity in the literature when compared to investigations of aggression, ISB within older adult populations is prevalent. This was discussed within the context of the wider challenging behaviour exhibited by the population. The SASBA permitted a more accurate and objective analysis of ISB in comparison to anecdotal accounts or case notes, both of which rely on retrospective memory, and permitted a broader functional analysis of behaviour than direct observation and recording of single incidents would allow. In addition to type and severity, the scale identified environmental factors such as observed antecedents and interventions that are considered to have a relationship with ISB and yet had generally been neglected in previous attempts to capture it (Johnson et al., 2006). Further, by promoting consistency of what comprises ISB, the SASBA provided a universal language for clinicians working with older adult populations on the assessment, treatment and management of ISB.

By objectively determining the relationship that behaviours have with environmental factors and social responses, information captured on the SASBA has been demonstrated to meaningfully contribute to formulation about ISB, the

design of appropriate interventions and to measure outcome (Alderman, 2008; Knight et al., 2008). Along with the history and other assessments pertaining to the individual service user, the SASBA aids clinical discussion, allowing for an understanding of the function of the behaviour and for frequency and severity to be monitored over time. However, the SASBA does have limitations when considering formulation on a group basis due to the variability in the type and severity of ISB exhibited both between and within service users as well as variability in precipitating factors and staff interventions. Nevertheless, as a continuous monitoring tool on a group basis, the SASBA uncovers population trends and patterns that increase knowledge and understanding about ISB, as well as informs wider service delivery. This enables on going analysis of incidents, allowing staff to gain an understanding of how to reduce or manage ISB in the long-term. Further, the SASBA opens general discussion pertaining to sexuality and older age in general and subsequently encourages staff to recognise what is 'normal' and consequently not ISB.

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Cognitive tests to predict referral for a driving assessment in people with dementia

Nadina B. Lincoln, Walter P. Bouman & Kathryrn A. Radford

Objective: Previous work by Lincoln and colleagues (2006) led to the development of a cognitive test battery for predicting safety to drive in people with dementia. The aim of the current study was to check the accuracy of this battery in an independent cohort of patients with dementia.

Methods: 65 participants (age range 59 to 88, mean=75.2, SD=6.8) with dementia who were still driving were recruited. They were assessed on cognitive tests including measures of concentration, executive function, visuospatial perception, verbal recognition memory, and speed of information processing. Patients were then assessed on the Nottingham Neurological Driving Assessment by an Approved Driving Instructor who was blind to the cognitive test results.

Results: 13 participants were unsafe and 52 safe to drive. Using a cut-off of >0 to indicate safety to drive, the original predictive equations correctly classified 49 (75.3 per cent) of the 65 participants.

Conclusions: A lower proportion of participants were found to be unsafe on the road than in previous studies. Despite this, the previously identified equation predicted safety to drive in most patients. We suggest that the cognitive test battery might be used in routine clinical practice for identifying those patients with dementia who would benefit from an on-road assessment.

IN THE UK when people are diagnosed with dementia, they are legally required to inform the Driver and Vehicle Licensing Agency (DVLA). According to DVLA Guidelines (DVLA, 2008), 'Those who have poor short-term memory, disorientation, lack of insight and judgement are almost certainly not fit to drive'. Although people suffering from dementia may be allowed to continue driving, they must have annual reviews of their license and are asked to update the DVLA if their condition deteriorates. Psychiatrists give the DVLA information on the cognitive abilities of people with dementia who wish to continue driving in order for the DVLA to make the decision. However, there is a lack of consistency in the methods used to advise the DVLA (Donnelly & Karlinsky, 1990; BPS, 2001). Breen et al. (2007) also reported that some psychiatrists believed that the forms used by the DVLA to request information about patients wishing to resume driving were unsatisfactory. There is a call for standardised tests that clinicians can use to advise on safety to drive and the need for an on-road assessment

Research into cognitive tests predictive of driving ability in people with dementia has indicated several possible predictors (Molnar et al., 2006). Lincoln et al. (2006) reported a test battery comprising: the Stroke Drivers Screening Assessment (SDSA); Mini-Mental State Examination (MMSE); Behavioural Assessment of the Dysexecutive Syndrome (BADSD) Key Search and Rule Shift; Visual Object and Space Perception Battery (VOSP) Incomplete Letters; Salford Objective Recognition Test (SORT) Immediate and Delayed Recall; Adult Memory and Information Processing Battery (AMIPB) Information Processing A and B; and the Stroop Colour Word Test. This correctly classified 92 per cent of drivers with dementia. The aim of the current research was to validate the predictive method by checking its accuracy in an independent sample of drivers with dementia.

Methods

Ethical approval was granted by Trent Multi-Centre Research Ethics committee. Partici-

pants with dementia who were driving were recruited through clinical teams. Participants were included if they consented to take part, had dementia, had no other medical condition that would preclude them from driving, lived within 100 miles radius of Nottingham, had driven in the last five years, had a current driving licence and had not taken part in the previous study (Lincoln et al., 2006).

Sixty-five participants completed both cognitive tests and the road test. They were aged 59 to 88 ($mean=75.18$, $SD=6.79$) years and 49 (75 per cent) were men. There were 34 (52.3 per cent) with Alzheimer's disease, 14 (21.5 per cent) with vascular dementia, two (3.1 per cent) with Lewy body dementia, one (1.5 per cent) with Fronto-temporal dementia, one (1.5 per cent) with mild cognitive impairment and four (6.2 per cent) with mixed type dementias. In nine patients the type of dementia was not available. Participants had been driving for between 19 and 73 years ($mean=52.54$, $SD=9.98$).

Cognitive assessments were conducted by a research psychologist in patients' homes. The assessments included:

- Mini Mental State Examination (MMSE: Folstein et al., 2000): total score.
- Stroke Drivers Screening Assessment (SDSA: Nouri & Lincoln, 1994) Dot Cancellation shortened version (12 lines were used instead of 24 and the time limit was set as 10 minutes instead of 15) time and errors; Square Matrices Directions; and Road Sign Recognition.
- Salford Objective Recognition Test (SORT: Burgess et al., 1996) immediate and delayed recognition of words.
- Stroop Colour Word Test (Victoria version: Strauss, Sherman & Spreen, 2006) as a measure of executive function. The score was colour-words time – non-colour words time.
- Visual Object and Space Perception Battery (VOSP: Warrington & James, 1991) number correct on Incomplete Letters, as a measure of visuospatial perception.
- Behavioural Assessment of the Dysexecutive Syndrome (BADS: Wilson et al., 1996) Key Search and Rule Shift raw scores to measure executive function. Profile scores were used in the analysis.
- Adult Memory and Information Processing Battery (AMIPB: Coughlan & Hollows, 1985) Information Processing A subtest Adjusted score, to assess speed of information processing.

In the previous study (Lincoln et al., 2006), all 24 lines of the SDSA Dot Cancellation were administered, with a time limit of 15 minutes. To shorten the test battery, only the first 12 lines of Dot Cancellation were used and prorated to the full test to allow the data to be entered into the previous equation. Additionally, to shorten the battery, two of the assessments from the original equation (Lincoln et al., 2006) were removed: SDSA Square Matrices Compass and AMIPB B. These scores were prorated from the Square Matrices Directions and AMIPB A respectively.

The Nottingham Neurological Driving Assessment (NNDA: Radford, 2001) was conducted by a single Approved Driving Instructor (ADI), experienced in assessing people with dementia, who remained blind to the cognitive test results. Drivers were able to drive either their own car, or the driving instructor's dual-controlled car, depending on their choice. At the end of the drive, the ADI gave an overall rating of 'definitely unsafe', 'probably unsafe', 'probably safe' or 'definitely safe' to drive.

Results

The results of the cognitive tests are shown in Table 1.

The predicted safety to drive based on previous research (Lincoln et al., 2006) was calculated using the following formulae:

$$\begin{aligned} \text{Unsafe} = & (\text{Dot cancellation time} * 0.0332) \\ & + (\text{Dot cancellation errors} * 0.817) - (\text{Square} \\ & \text{Matrices Directions} * 0.437) + (\text{Square} \\ & \text{Matrices Directions} * 0.6396 * 0.247) + (\text{Road} \\ & \text{Sign Recognition} * 0.00238) + (\text{MMSE} \\ & * 4.272) + (\text{BADS Rule shift profile score} \end{aligned}$$

Table 1: Characteristics of patient sample (N=65).

Mean	SD	Range	
SDSA			
Dot Cancellation (12 lines)			
Time	593	192	160-600
Errors	17.4	17.8	0-98
False Positives	4.2	25.2	0-202
Square Matrices Directions	11.3	8.9	0-32
Road Sign Recognition	4.1	2.9	0-12
MMSE	23.0	4.0	11-30
Stroop Time 2 - Time 1	35.6	58.9	-74-254
BADS Rule Shift	2.58	1.19	0-4
BADS Key Search	2.25	1.47	0-4
VOSP Incomplete Letters	17.6	3.6	0-20
SORT Words immediate	9	2.8	2-12
SORT Words delayed	7.8	2.9	0-12
AMIPB Information Processing A adjusted score	33.6	20.8	0-94

SDSA: Stroke Drivers Screening Assessment; MMSE: Mini Mental State Examination; BADS: Behavioural Assessment of the Dysexecutive Syndrome; VOSP: Visual Object and Space Perception Battery; SORT: Salford Objective Recognition Test; AMIPB: Adult Memory and Information Processing Battery.

*1.412) - (BADS Key Search Profile score *4.82) + (VOSP Incomplete letters total score *6.906) + (SORT Words Immediate *1.244) - (SORT Words Delayed *3.058) + (Information Processing A adjusted score *0.0525) + (Information Processing A adjusted score *0.7989 *0.627) + (Stroop *0.265) - 135.994.

Safe=(Dot cancellation time *0.0269) + (Dot cancellation errors* 0.788) - (Square Matrices Directions *0.494) + (Square Matrices Directions *0.6396 *0.239) + (Road Sign Recognition *1.12) + (MMSE *5.165) + (BADS Rule shift profile score *0.448) - (BADS Key Search Profile score *3.775) + (VOSP Incomplete letters total score *6.593) + (SORT Words Immediate *2.488) - (SORT Words Delayed *4.556) - (Information Processing A adjusted score *0.194) + (Information Processing A adjusted score *0.7989 *0.744) + (Stroop *0.260) - 141.674.

Two patients had missing data on the Stroop because of colour blindness. Their scores were prorated as 19, the median Stroop for drivers with dementia in the Lincoln et al. (2006) study. The discrepancy between safe and unsafe was calculated. Those who scored more than 0 were predicted to be safe, and those scoring 0 or less unsafe. Forty-six patients were predicted to be safe to drive and 19 unsafe.

On the road, 28 participants were 'definitely safe', 24 'probably safe', one 'probably unsafe' and 12 'definitely unsafe'. The predicted safety to drive was compared with performance on the road. Results are shown in Table 2.

Using these criteria, 49 (75.4.3 per cent) participants were correctly classified. The sensitivity for detecting safe drivers was 78.8 per cent, and specificity 61.5 per cent (Positive predictive value 89.1 per cent, negative

Table 2: Comparison of on-road performance with predicted performance from cognitive tests, based on equations from Lincoln et al. (2006).

		Fail (<0)	Pass (>0)
Road assessment	Pass	5	41
	Fail	8	11

Sensitivity for safety to drive=78.8%; Specificity for safety to drive=61.5%; Accuracy=75.4%; Positive predictive value=89.1%; Negative predictive value=42.1%.

predictive value 42.1 per cent). Eight out of 13 (61.5 per cent) of the unsafe drivers were predicted to be unsafe and would have been recommended for an on-road driving assessment.

As previous research had suggested changing the cut-off can improve predictive accuracy, a ROC curve was plotted. This indicated the optimum cut-off was 0.224, so those scoring more than 0.224 would be predicted to pass and those 0.224 or less to fail. Using this cut-off gave an accuracy of 76.9 per cent (sensitivity 78.8 per cent, specificity 69.2 per cent) and only four participants were incorrectly identified as safe to drive when they were actually unsafe.

Discussion

Validation of the predictive equation developed by Lincoln et al. (2006) on an independent sample correctly classified 75.4 per cent of participants with dementia as safe or unsafe to drive. However, 15 were incorrectly classified. Eleven people were predicted to be unsafe to drive but were found to be safe on the road. Seven of these people were rated as ‘probably safe’ on the road, rather than ‘definitely safe’ suggesting they were borderline in driving ability. Five participants were predicted to be safe to drive, but were unsafe when tested on the road. These participants highlighted that clinical information needs to be taken into account when considering safety to drive, though this may not necessarily account for their incorrect classification. One person was rated as being ‘probably unsafe’ as opposed to ‘definitely unsafe’ to drive, and was the only person in

the study to be given this classification. Perhaps this individual was borderline and may have performed similarly in daily driving to those rated as ‘probably safe’. The second participant had only been driving for 19 years and may have less developed driving skills. The third incorrectly classified participant was definitely unsafe, but the ADI commented that he might be more competent in an automatic car, which notably, is what he drove for several months a year whilst living in Hungary. One participant was depressed and was taking anti-depressant medication and hypnotics, both of which have been suggested to hinder driving (Verster et al., 2006). Finally one participant drove very slowly which caused frustration to other drivers. The ADI commented that this patient might be able to benefit from lessons and had the potential to be a safe driver, even though judged at the time to be unsafe. In clinical practice such qualitative information could be taken into account.

In clinical terms it is a bigger problem if an unsafe driver is allowed to continue driving than if a safe driver is required to complete an on-road assessment. In most cases drivers with dementia are not formally assessed on the road, but decisions about retaining or withdrawing their licences are made on the basis of clinical information. Thus, an over-cautious predictive battery must be preferable to one that misses unsafe drivers. Furthermore, the fact that seven out of 11 of those incorrectly classified as unsafe were probably safe, not definitely safe, when tested on the road suggests that they would have benefitted from a driving assessment.

It is unlikely that a cognitive test will ever be completely accurate but the aim was to develop a measure which could be used to advise patients and to identify those in need of an on-road assessment. For many patients driving assessment centres are a long way from where they live, and expensive and intimidating to attend. Therefore, it is important to send people for an on-road assessment when they really need it.

A limitation of the research is that we do not know how many patients refused to consider taking part and therefore how representative our sample was of all drivers with dementia. These driving assessments were conducted blind to cognitive tests and clinical information for the purpose of the research. However, in clinical practice, this information would be incorporated in the driving assessment process. We incorrectly classified five people who were predicted to be safe to drive but were actually unsafe when tested on the road. These people highlight the additional need for clinical involvement in the decision-making process, in terms of considering medication, previous driving experience, and current driving habits.

A core aim of this research was to address previous observations of a failure to identify cut-offs for cognitive tests to identify safe versus unsafe drivers (British Psychological Society, 2001; Ott et al., 2008). The current data support the validity of the predictive assessment developed by Lincoln et al. (2006). We argue that this justifies the test battery being incorporated in routine clinical practice. The tests are intended to identify safe drivers, who can then be allowed to continue driving. The cognitive tests do not have sufficient accuracy to be used to withdraw a driving licence, but they may be helpful in making decisions about who to refer for on-road assessment and to give advice to patients about their likely

driving abilities in order to help them to decide whether they wish to undergo the formal on-road assessment. Patients diagnosed with dementia could complete the cognitive test battery at a time when their licence is due to be renewed. Those who score more than 0 may be permitted to continue driving, with the usual review schedule applying (DVLA, 2008), whilst those scoring less than 0 on the cognitive assessments should be referred for an on-road assessment at their local Regional Mobility Centre.

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Guidelines for writing reflective articles

THERE HAS BEEN an increase in the numbers of reflective articles submitted to the *PSIGE Newsletter* for consideration of publication. The quality of submissions varies and it seems timely to clarify what would be expected of this genre of paper in order for it to be accepted for publication in the Newsletter.

1. Identify a current issue and how this may be of relevance to the readers.

For example, 'there is a move toward services becoming 'ageless' which has implications for clinical psychologists specialising in working with older people.'

2. Discuss the historical and legislative factors that contextualise the issue

For example, 'there is a poor history of specialist services being provided for older people despite the development of initiatives such as the *National Framework for Older People*. Ironically, the move to combining working age and older adult services comes at a time when issues specific to older people are in the forefront (e.g. National Dementia Strategy, etc.).'

3. Explain what aspect of this issue you will be discussing

For example, 'I am concerned that the training and experience base currently held by new therapists (e.g. IAPT workers or trainees who have not had specialist Older Adult placements) may not equip them to deal with issues brought by older generations.'

4. Explain your interest in this area

For example, 'I am a clinical psychology trainee with experience in my training and in assistant posts in working age services. I am currently on my Older Adult place-

ment, being one of only four in my cohort lucky enough to get a specialist placement. My experience suggests that working-age services are not currently equipped to deal with the complexity of needs presented by older people.'

5. Discuss, with reference to your own experience, what issues have arisen for you and how you feel they may generalise/be of interest to others

For example, 'In my first experience of therapy with an older person, I found he referred a lot to the losses in his life. I was surprised at my response – I had always assumed that loss was a normal part of growing older, and had not considered that the impact would be so intense in someone in their 70s. Luckily, my supervisor was experienced in this area, and we explored my surprise in the context of my client's experience of the world – a world that makes assumptions about the 'normality' of loss of friends, family, independence and of functioning.'

6. Discuss the implications of your experience for your client, your own learning, or for your service, i.e. how does your reflection add to what we already know? How can we use it?

For example, 'We agreed in supervision that my comments could be usefully fed back to managers in the older person's directorate as a way of illustrating the case for specialist therapy services. I was able to use my experience to inform my casework by asking my client about how he thought others viewed his losses. He believed he was not listened to, that others did not appreciate the losses he had experienced. Sharing this feeling with family members who were close to him was the basis of therapeutic change in our time together.'

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Notes



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The Society's free Research Digest service features cutting-edge research reports, links to the latest journal special issues, and to the best psychology-related newspaper and magazine articles available on the web. You can subscribe to the fortnightly e-mail, or visit the blog.

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Notes for Contributors

The *PSIGE Newsletter* welcomes the following submissions for publication: articles, research updates, Letters to the Editor, book reviews. These can be on any aspect of psychological theory or practice with older people.

Articles

Articles form the bulk of contents submitted to the *Newsletter*. As the *Newsletter* aims to cover a broad, cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication. These can cover empirical investigations, pilot studies, descriptions of service developments, audits and evaluations. Articles should be submitted three months before publication (i.e. October for the January issue, January for the April issue, April for the July issue, and July for the October issue).

Articles of any length up to a maximum of 3000 words will be considered. Experimental reports should follow convention in terms of subheadings and sections: Abstract, Introduction, Method, Results, Discussion, References.

References should follow conventional format as in journals such as *Psychological Review*:

- (1) Book reference:
Mischel, W. (1986). *Introduction to personality*. New York: CBS.
- (2) Journal article:
Martin, A. & Fedio, P. (1983). Word production and comprehension in Alzheimer's disease: The breakdown of semantic knowledge. *Brain and Language*, 19, 124–141.
- (3) Paper in a book:
Garrett, M. (1980). Levels of processing in sentence production In B. Butterworth (Ed.), *Language Production (Volume 1) Speech and Talk*. London: Academic Press.

Research Updates

The *Newsletter* is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, e.g. ideas for discussion or early stage results, which are not ready for formal publication. Try to keep these submissions below 500 words.

Letters to the Editor

The Editor welcomes correspondence which combines brevity with rational argument. Letters may be edited if more than 250 words in length.

Book reviews

Submissions up to 250 words reviewing a text of relevance and interest to the PSIGE membership will be considered. These submissions must include full details of the book (including publisher).

The Editorial Board reserves the right to make minor changes to any submissions. Where major editing is necessary, the authors will be informed.

Images

The *Newsletter* is published in black-and-white. It is not advisable to send complicated, colour diagrams. If you are unsure, try printing the image or photograph out on a mono laser printer to check for clarity.

Please send original image files (.tif, .jpg, .eps or the like), not simply a Word document with the pictures imported into it, as these do not print properly.

Submission Procedure

All submissions must be written in language that is inherently respectful to older people and consistent with the British Psychological Society's guidelines.

All contributions must be word processed. Formatting should be consistent with the British Psychological Society's guidelines.

Please submit articles as a Word file via e-mail to the Editor.

When submitting articles please send the following information:

- Full name;
- Affiliation (title, place of work);
- Contact details (should you be willing to be contacted by the membership);
- Acknowledgements (as appropriate).

Finally, all reports of research should indicate whether or not Ethics Committee approval was awarded, and by which Ethics Committee, or whether the work was carried out as an audit/service evaluation project.

All contributions should be sent to: Louisa.Shirley@ntw.nhs.uk

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