Ψ PSIGE Newsletter

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The Scottish Branch

Psychologists' Special Interest Group
Working With Older People

PSIGE

Psychologists' Special Interest Group 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 Guest Editors

Liz Baikie & Pauline Thomson

WELCOME TO THE Scottish edition of the newsletter. The past few years have been an exciting and challenging time for psychologists in Scotland. In 2000 the Scottish Parliament passed The Adults with Incapacity Act (2000) Scotland, which has major implications for how we contribute to the definition and assessment of capacity. We have organised seminars and conferences to discuss such issues, particularly innovative ways of assessing capacity. Scottish psychologists have also been involved in discussions with colleagues from other parts of the UK where similar legislation is being developed. Aspects of this Act are discussed in Arlene Astell's paper as well as issues relating to assessing capacity to give consent.

PSIGE members Susan Olley and Cerys MacGillivray organised a successful conference in November on 'Sharing the Diagnosis'. Speakers included Alan Jacques (formerly Consultant Psychiatrist, Royal Edinburgh Hospital; Mental Welfare Commissioner Scotland; and Convenor of Alzheimer's Scotland – Action on Dementia), and others more familiar to you, Arlene Astell, Hilary Husband, Caroline Williams, Dot Weeks and Esme Moniz-Cook. Some have kindly provided an article for this newsletter or will contribute at a later date.

The two clinical psychology training courses in Scotland at Glasgow and Edinburgh Universities have recently increased their intakes of trainees significantly. In Edinburgh this is partly due to the establishment of a new flexible training scheme, outlined later by Ken Laidlaw, which runs in parallel with the existing three-year course. This has necessitated a review of how best to meet increased supervision needs within a limited workforce. Ken and Clara O'Shea discuss in another paper their pioneering work developing an e-learning package as part of the teaching on the older adult block in Edinburgh which is likely to have implications for how we teach trainees in the future.

Although trainees in Glasgow are not required to undertake a piece of small-scale research with older adults, as is the case in Edinburgh, they are encouraged to carry out their thesis with this population. Close links developed with researchers in the areas of neuropsychology, clinical health and sleep provide opportunities for this. In this edition we are pleased to present a number of projects carried out by trainees on placement in Edinburgh and the Scottish Borders.

And finally…the front cover. We agonised over this with suggestions of photographs of the PSIGE members, castles, lochs, mountains, highland cows and men in kilts (quickly rejected for being boring or sexist). Then we decided on a highland cow in a kilt outside a castle by a loch with a mountain in the background but nobody knew how to gain informed consent from the cow. (How did Beamer, Bermant & Clegg, 1969, get those ewes to consent to wearing coats and Halloween face masks?) Thankfully, we were rescued by Valerie Russell, Liz's secretary, who put her degree in graphic design to good use by designing and producing our cover. The butterfly she has superimposed on the Scottish Saltire is the Scotch Argus. It is native throughout Europe but most prevalent on high-ground in Scotland from late July to September. It has prominent red brick bands and is soft brown in body colour, with fawn shaded areas.

We hope you find the Scottish edition of the newsletter interesting. We leave you with Valerie's personal thoughts on the butterfly.

When I see a butterfly, I think of my thoughts and emotions.
They are very fragile and often rather flighty!
Our thoughts and feelings can be both bold as well as gentle, whilst attractive and often short lived.
From a little flicker and a small glimmer, our moments and thoughts, throughout us will flutter.

Liz Baikie & Pauline Thomson, *Guest Editors.*

EDITOR'S NOTE

A very big thanks to Scottish PSIGE for producing such a magnificent edition. You've done us proud. Special thanks go to all authors and Pauline, Liz and the very talented Valerie.

Scottish PSIGE quite rightly wanted to make this an exclusive issue. Therefore, apologies to anyone expecting to see their article in this edition. A very big, cringey apology from Sinclair to Victoria Carek for omitting her article by mistake from the April edition. It will be in the next one for sure!!!

Consent for research and treatment

Arlene J. Astell
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Abstract

The informed consent process is intimately related to autonomy and the capacity to make decisions. This relationship between consent and capacity has legal, ethical and practice considerations, which are briefly reviewed in this paper. Specifically the legal requirements for assessing capacity to give consent, situations in which consent should be sought and approaches to assessing capacity to consent are reviewed. In addition, actions to be taken with regard to people who are judged incapable of giving consent are considered, in particular proxy decision-making and advance discussion of wishes. Recommendations for good practice in the consent process are also briefly examined. Whenever possible evidence relating to older adults is considered, however this review highlights the need for more research in this area.

Legal requirements to assess capacity to consent

A number of recent legislative developments have implications for informed consent procedures. The Adults with Incapacity (Scotland) Act 2000 (AWI (S) Act), the Draft Mental Incapacity Bill in the rest of the UK, as well as EU clinical directive 2001/20/EC of the European Parliament all highlight the need to protect people when making decisions that involve potential risk and those who are unable to make informed decisions for themselves.

In Scotland the AWI (S) Act 2000 was passed to bring a more flexible and integrated approach to the management of the affairs of people deemed incapable of making informed decisions for themselves. The Act relates to those over 16 years of age and identifies medical treatment and participation in research as areas where capacity to give consent may come into question. In the Act capacity is judged with regard to context-specific decisions and requires that capacity be assessed only in relation to the decision at hand. Generalisation from capacity in one situation to capacity in another is prohibited as is stereotyping from a particular diagnosis, such as dementia or brain injury. In the Act incapacity is defined as incapable of 'acting; or making decisions; or communicating decisions; or understanding decisions; or retaining the memory of decisions.' (Part 1, Section 1 (6). AWI (S) Act 2000). Thus interventions under the Act require that an assessment of capacity be made in relation to a given decision, for instance consent to medical treatment or to participate in research.

Consent situations

Consent is always required for participation in research. In regard to medical treatment there are a wide range of decisions requiring consent including assessment, diagnosis and hospital admission as well as direct interventions as indicated in the good practice guidelines published by the Department of Health (November, 2001). In respect of referrals it is reasonable to assume that 'most adult clients attend an initial consultation voluntarily…and that the client has been well informed of the nature of the referral' (Willner, 2003, p25). However, Willner (2003) argued that the same assumptions cannot be made when referrals are initiated by another professional rather than by the client. In a survey of referrers of clients with a learning disability, he found that 14 per cent of referrals had not been discussed with the client, 29 per cent had not been discussed with the main caregiver and that in 21 per cent of referrals the referrer assumed that the client consented as 'the client did not refuse' (Willner, 2003). Additionally, in 65 per cent of referrals there was no record of the consent procedure in the case notes, 29 per cent of referrers assumed that the client knew that they could refuse to accept the referral and 25 per cent assumed that the client understood their right to refuse (Willner, 2003).

Understanding the reason for a referral and the possible outcomes of the referral are particularly pertinent for older adults referred for a neuropsychological assessment. The decision to refer should be discussed with the client by the referrer. However, the purpose should also be discussed prior to the assessment, particularly when the investigation is of cognitive changes that may relate to a dementia process. Abramovitch, Finstad and Silberfeld (1993) interviewed 17 elderly patients referred for neuropsychological investigation and found a wide range of understanding and capacity to give consent for the assessment. However, there has been little other research into patients' understanding of the purpose and potential implications of neuropsychological assessment or of the consent processes involved.

When people present for assessment it is usually with the aim of receiving an explanation for the changes they have experienced or others have noticed in them. The client should be encouraged to make a decision about whether they would like to be given a diagnosis, if they would like someone with them and if so who.

However, there is disagreement about the sharing of diagnoses, especially if these are perceived to be negative (Mosconi, Meyerowitz, Liberati & Liberati, 1991; Pinner & Bouman, 2002). In a study of dementia diagnoses approximately 50 per cent of clinicians revealed that they do not disclose the diagnosis to their patients and the majority of family carers would prefer a dementia diagnosis not to be disclosed to the patient (Pinner & Bouman, 2002). However, the majority of these caregivers and clinicians reported that if they themselves were the patient, they would like to know the diagnosis (Pinner & Bouman, 2002). Unsurprisingly, most elderly people said that they would like to know the outcome of assessments with between 88 per cent (Ajaj, Singh & Abdulla, 2001) and 96 per cent (Meredith *et al.*, 1996) saying they would wish to know if the diagnosis was cancer and 86 per cent if it were Alzheimer's disease (Pinner & Bouman, 2002).

The benefits of having a diagnosis are graphically illustrated in the following quotation:

'At the age of 61, when I was first diagnosed with Alzheimer's, I was very happy…I was happy because I now had a reason for my forgetfulness and an explanation for the changes in my normal pattern of behaviour…I still consider myself fortunate. I believe my early diagnosis led me to accept the disease more easily. We can make important decisions about my future treatment. My wishes can be discussed in a rational way.' (Alderton, 2000, p.1)

Even though involving people in decisions about their healthcare and future treatment, including hospitalisation, has positive effects on health outcomes (Edwards, Elwyn & Gwyn, 1999) many older people are not given this opportunity. In a study of older people with dementia, Mukherjee and Shah (2001) found that 'a large number of psychiatric patients are informally admitted [to hospital] despite lacking the capacity to consent to the admission because they do not dissent.' (Mukherjee & Shah, 2001, p.335). In their study of consecutive acute inpatient admissions to a geriatric psychiatry unit over a six-month period, they found that 48 per cent of those admitted lacked the capacity to consent. This mainly resulted from patients having a dementia, increased severity of cognitive impairment and reduced insight into their situation (Mukherjee & Shah, 2001).

Assessment of capacity

In Scotland the AWI (S) Act explicitly requires assessment of the capacity to make decisions, the ability to communicate decisions, comprehension of information and memory processes. A survey of capacity assessment and knowledge among Scottish health and welfare professionals carried out in the six months prior to the AWI (S) Act coming into force revealed wide variation in practice, mainly along professional lines (Astell & Wilkinson, 2001). Typically clinical psychologists favoured selective use of neuropsychological tests and batteries whereas medics favoured the Mini Mental State Examination (MMSE; Folstein, Folstein & McHugh, 1975) and clinical judgement (Astell & Wilkinson, 2001).

Commenting on the AWI (S) Act, the Scottish branch of the British Psychological Society Division of Clinical Psychology (BPS DCP; Scotland), in its response to the Draft Mental Incapacity Bill consultation process in the rest of the UK, noted that the 'most significant issue is how capacity is being assessed' (Point 4). The report highlighted a great deal of inconsistency across Scotland in implementation and the fact that no single assessment package is either available or suitable (BPS DCP: Scotland, 2003). This reflected concerns raised in the AWI (S) Act pre-implementation period when the specific need for more information on capacity assessment, a strong desire for formal training and for agreed guidelines on the assessment of capacity were all reported in the Scottish survey (Astell & Wilkinson, 2001).

The BPS DCP (Scotland) report suggested that decision-specific assessments or structured algorithms could be developed to address these issues. However, there are a number of formal measures of capacity or competency already available, including a number that were developed to assess capacity to give consent for medical procedures. These include cognitive tests such as the Cognitive Competency Test (Wang & Ennis, 1987), the Hopkins Competency Assessment test (Janofsky, McCarthy & Folstein, 1992) and the Competency Interview Schedule (Bean, Nishisato, Rector & Glancy, 1997); tests employing specially composed vignettes portraying consent to treatment decisions (e.g. Seckler, Meier, Mulvihill & Paris, 1991) and tests designed to be ecologically valid such as the Coin Test (Goodman & Zarit, 1995) and the Financial Capacity Instrument (Marson *et al.*, 2000). Very few respondents in the Scottish survey reported using formal capacity assessment measures such as the above (Astell & Wilkinson, 2001). However, the popularity of the MMSE (Folstein *et al.*, 1975) in capacity assessment accords with findings from other studies, and in spite of evidence that it is poor at distinguishing capable from incapable patients (Holzer, Gansler, Moczynski & Folstein, 1997; Rutman & Silberfeld, 1992).

In a post-AWI(S) Act study comparing neuropsychological assessment of capacity with assessment by a medical practitioner based on clinical interview and the MMSE, there was disagreement in 21 per cent of 33 cases of elderly patients assessed for capacity to consent to medical treatment (Whyte, Wilson, Hamilton, Primrose & Summers, 2003). In all but one of these the neuropsychological assessment indicated that the patients were incapable whereas the medical assessment suggested they were capable. In addition, the neuropsychological assessments, involving informal and formal questioning, typically took much longer (mean duration 82 minutes) than the medical assessments (mean duration 24 minutes; Whyte *et al.*, 2003).

Such lack of agreement on determinations of capacity to give consent has been consistently reported both within and between professions (Barton, Mallik, Orr & Janofsky, 1996; Marson, Kern, Annas & Glantz, 1994). In addition, comparison of formal assessment, in this case the MMSE and the Cognitive Competency Test (Wang & Ennis, 1987) with clinical judgements made by a competency panel, resulted in a higher number of judgements of capacity to make consent decisions (Rutman & Silberfeld, 1992) made by the panel, thus bringing the use of formal assessments into question.

Consent decisions for people judged incapable of consenting for themselves

Where a person is adjudged incapable of making decisions, alternate practices are used to seek consent for research and treatment decisions. In Scotland, any intervention under the AWI (S) Act 2000, must take account of the person's wishes, both past and present, plus the views of the nearest relative and or guardian. Interventions must represent the least restrictive option and can only be made if they will benefit the adult. The implications of using proxy decision-makers and the importance of advance discussion for participation in research and medical treatments of adults judged to be incapable are considered below.

Medical treatment

In Scotland, there is the provision for decisions by proxy in respect of medical treatment for incapable adults (Part 5, Section 50, AWI (S) Act 2000). The importance of knowing and taking account of the patient's previously expressed and current wishes was highlighted in the following vignette study of resuscitation decisions (Seckler *et al.*, 1991). In a direct comparison of the views of surrogates and physicians with actual decisions made by older adults on resuscitation in two scenarios - current health and progressive dementia – the majority of participants chose resuscitation in both scenarios (Seckler *et al.*, 1991). In addition, 90 per cent predicted that their physicians and 87 per cent their family would make same decision. However, the actual level of agreement was considerably lower, especially in the advanced dementia scenario. In addition only 16 per cent had any prior discussion of their wishes with family and even fewer, seven per cent, with their physician (Seckler *et al.*, 1991).

Encouraging both identification of a proxy or surrogate and advanced discussion of possible healthcare decisions is clearly important if the correct decisions are to be taken (Azoulay *et al.*, 2003). When previous and current wishes are not known, proxies must use other criteria to make their decisions. In a study of 46 substitute decision makers who had consented to a relative being tube fed, the majority reported that there had been no advance decision made (Mitchell & Lawson, 1999). In this study the majority of proxies felt that they understood the benefits (84 per cent) but less than half understood the risks (46 per cent) and more than a quarter (29 per cent) had not discussed the intervention with a doctor (Mitchell & Lawson, 1999). About half of the respondents were confident that the patient would want the intervention (56 per cent) and less than half said that they would choose the intervention for themselves (45 per cent). These findings reinforce the importance of advance discussion and the need for further research into the criteria proxies use to make treatment decisions.

Research

Research with participants who are unable to give informed consent creates a tension between protecting the individual and allowing research with the potential to bring future benefit (American Geriatrics Society Ethics Committee, 1998). Part 5, Section 51 of the AWI (S) 2000 permits research with those who are unable to consent only when the research could not be carried out with people who could consent and the person does not indicate unwillingness to participate. The purpose of the research must be to further knowledge and understanding of the person's illness and must have the potential to produce real benefits for the person or to benefit sufferers in the future. In this situation consent can be given by the person's guardian or welfare attorney or nearest relative.

This essentially corresponds to the principle of 'maximal potential risk' (Post, 2003) which proposes that research involving some potential risk to participants who cannot consent for themselves should be allowed up to an agreed level, restricting research at the point where the potential risks or actual harm and discomfort become unacceptable (Post, 2003). This issue has particular resonance for research into potential treatments for moderate to severe dementia requiring participants who are unable to give informed consent.

Whilst some have argued for proxy consent to be standard practice in research, including that with higher than usual risks to participants (Post, 2003), the role of proxy decision-makers has been described as a 'murky legal area' in a recent review of legislative and regulatory policy in the US (Kim, Appelbaum, Jeste & Olin; 2004). In the UK, the use of proxies to give consent for incapable people to participate in clinical trials has been challenged as 'ethically totally unsatisfactory' and failing to protect the interests of vulnerable people by putting research first (Corrigan & Williams-Jones, 2003).

In part the controversy over participation in research by those unable to give their own consent arises from the lack of potential benefit to participants. Unlike medical treatment, the purpose of research is to further knowledge, not to benefit participants (Beck & Shue, 2003). Typically research has the potential to benefit people in the future as 'direct benefit…is almost always ephemeral or nonexistent, even when

the project involves the trial of a new therapy' (Schiffer & Radebaugh, 2003). In addition, the idea of stressing the potential benefits of participating in research may misjudge the motivation of participants and proxies. Potential participants and their families are often more altruistic than researchers think and are interested in helping those who may be affected in the future (Alzheimer's Society, November 2003). As such, it seems that more information on the potential future benefits of the research to society should be given during the informed consent process (Schiffer & Radebaugh, 2003).

Advance discussion and decisions

Reticence to initiate advance discussion has been linked to a fear of putting people off making an affirmative decision. However, research into organ donation decisions found that prior discussion increased the number of donations made by families (Siminoff, Gordon, Hewlett & Arnold, 2001). These findings led Siminoff *et al.* (2001) to recommend that education and information on factors to be considered when making decisions should be provided sufficiently in advance of the decision being made.

In the US, the Alzheimer's Association recommends that an initial dementia assessment should include 'discussion of advance health care directive status – expressed wishes and chosen surrogate'. Whilst not legally binding in the UK (BMA, 1995), advance statements provide the opportunity for people to express preferences in the event that they are judged incapable at some time in the future (British Geriatrics Society, 1997). Person-centred approaches can assist in the completion of advance directives regarding treatment (Fazel, Hope & Jacoby, 1999) and increase satisfaction with the decision-making process (Briggs, Kirchhoff, Hammes, Song & Colvin, 2004). In addition, congruence between patients and identified proxies can be greatly improved and conflict over decisions reduced through patient-centered advance planning (Briggs *et al.*, 2004).

Good practice in obtaining consent

Consent rates are affected by a number of factors. These include the method and timing of presenting the consent decisions, assessment of risks and benefits and the type of consent being sought (Cohen-Mansfield, 2003). In a recent review of best practice to improve patient understanding of informed consent, Dunn and Jeste (2001) found that many problems arise due to the poor materials used in the consent-seeking process. They argued for creative interventions to enhance the consent process, especially for individuals with psychiatric and cognitive impairments (Dunn & Jeste, 2001). For example, computerised presentation of the consent process was found to enhance the participation in consent decisions of older adults with psychosis (Dunn, Lindamer, Palmer, Schneiderman & Jeste, 2001).

Recent moves to make consent procedures more patient-centred (Bridson, Hammond, Leach & Chester, 2003) reflect the view that the informed consent process is a 'dialogue' (Guerrero & Heller, 2003) between clinician and patient or investigator and participant. As such, the onus is on clinicians and investigators to provide as much information, including potential risks, in as simple a language as the patient or research participant needs, to give as much time as needed and to avoid any kind of pressure or coercion (Edwards *et al.*, 1999). This is clearly illustrated in the following excerpt from the Code of Federal Regulations on Research Risk: 'Informed consent is a process, not just a form. Information must be presented to enable persons to voluntarily decide whether or not to [consent]. It is a fundamental mechanism to ensure respect for persons through provision of thoughtful consent for a voluntary act. The procedures used in obtaining informed consent should be designed to educate the subject population in terms that they can understand' (Code of Federal Regulations, Title 45, part 46 Protection of human subjects (2001)). Department of Health and Human Services, National Institutes of Health, Office for Protection from Research Risks.

Researchers and clinicians are often concerned that providing too much detail will put people off consenting to research or treatment. However, in a study of the risks and benefits of colonoscopy, Agre, Kurtz and Krauss (1994) found that anxiety did not increase as knowledge increased. Indeed, it has been found that providing as much information as the patient or participant requires both enhances understanding and reduces anxiety (Edwards *et al.*, 1999). Conversely, failure to fully disclose and ensure understanding of all potential risks can constitute medical negligence (Sutton, 2003).

Conclusion

Consent decisions arise in relation to research and across a range of assessment and treatment situations. Recent legislative changes with regard to capacity to make decisions and the protection of those deemed incapable, have highlighted the importance of the consent process as an integral part of treatment and research practice. Consent procedures can be improved by providing more information, giving people more time to ask questions and being guided by the principle 'do unto others as you would have them do unto you'.

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Pre-diagnostic counselling with people with memory problems: What can we learn from HIV/GUM services?

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South Downs Health NHS Trust.

Introduction

PRE-DIAGNOSTIC COUNSELLING has been established as standard practice in HIV/GUM (Genito-Urinary Medicine) services. In contrast, older people presenting to mental health services with memory problems may still be given very little information prior to their assessment about the reasons they are being tested, what is involved in the assessment or what the implications of having a diagnosis of dementia might be. This paper examines what can be learnt about good practice in pre-diagnostic counselling from the HIV/GUM services.

What is pre-diagnostic counselling?

Pre-diagnostic counselling can be defined as follows: *'Pre-diagnostic counselling refers to the processes prior to a diagnostic assessment, including the pre-test discussion, which seek to ensure that the client is fully informed of the purpose of the assessment, the procedures involved and the implications of the outcome, in order to obtain informed consent to carry out the assessment and also to obtain an understanding of the client's needs and preferences in terms of sharing information about the diagnosis and prognosis.'*

'Pre-test Discussion' refers to the structured discussion that takes place prior to the actual assessment and involves the process of obtaining informed consent. It is the preferred term used in HIV/GUM services because the discussion involved may not always qualify for the term 'counselling'.

What do they do in HIV/GUM services?

The following description of practices in a HIV/GUM service is based on the framework devised by Richard Williams (personal communication), a health adviser in sexually transmissible infection. He was involved in the development of policies for Brighton Health Care NHS Trust during 1998–2000 which were primarily aimed at people who presented to the service concerned that they may have been infected with HIV. Although HIV/GUM services have since evolved (e.g. an HIV screening test is now offered to everyone attending the GUM clinic with a range of problems), this earlier period of service delivery has more issues parallel to current diagnostic services in dementia care and so will be the main basis of comparison.

Ethics and HIV testing

For consent to HIV testing to be valid, both explicit and informed consent must be given via a structured pre-test discussion. This requirement is based on guidelines from the General Medical Council (GMC, 1995, 1998) e.g.: *'Each patient should be given the opportunity to consider the implications of submitting to an HIV test'* (GMC, 1995).

Who should do the pre-test discussion?

Conventionally, since the introduction of HIV testing, the pre-test discussion was carried out by specially trained health advisers. Following the advent of the antiretroviral drugs and the move to offering a screening test to everyone attending the GUM clinic, other trained professionals, usually physicians, do this – except in cases where significant risk of infection is suspected; in these circumstances the client is referred to a health adviser. There is a service standard of a maximum wait to appointment with a health adviser of 48 hours.

How should the pre-test discussion be done?

Guidelines suggest that the approach taken must be flexible and the content of the discussions reflect the varying needs of individual clients in different clinical settings (e.g. hospital inpatient and outpatient settings). Additionally, the client's level of literacy and comprehension needs to be taken into account.

What should the content of the pre-test discussion be?

In HIV/GUM services the content of the pre-test discussion is clearly defined and should include:

● A realistic assessment of the client's risk of infection. The member of staff (usually a doctor or health adviser) has a responsibility to discuss the outcome of this assessment with the client.

● Information about the relevance of the three month 'window period' *(i.e. after infection, the test result may not show up as positive for three months).*

● Efforts to ensure that the client has adequate support if the result is positive.

● An explanation of the meaning of confidentiality.

● Clarification of the clinical indications for the test.

● Efforts to ensure the client understands how the results may affect him or her, thus obtaining informed consent.

● Preliminary discussions on partner notification.

● Future strategies for prevention, if appropriate.

What happens after the pre-test discussion in HIV services?

After the pre-test discussion, the client may decline or consent to the HIV antibody testing. Whatever the outcome of the discussion, all clients must be offered written information about HIV infection and be given an appointment with a health adviser or doctor to discuss any outstanding issues. When the pre-test discussion policies were being developed in 1998–2000, the use of a written consent form was explored. Table 1 is an example of the type of form used.

What documentation is needed after the pre-test discussion?

Documentation for inpatients is very stringent, particularly if they are seriously ill/unconscious and unable to give informed consent. The rationale for the HIV testing must be clearly recorded in the person's notes by the responsible consultant with relevant supporting opinions from an HIV physician, health adviser or representatives from other professional organisations. For other clients, a record of the pre-test discussion is written in the notes and the person may be asked to sign in agreement.

How does everyone involved liaise?

The client, health adviser and relevant staff all agree on how and when the result will be provided. Although staff must adhere to this agreement, the client may decline or defer receipt of the result. The client's decision must be respected and documented.

Differences between HIV/GUM services and dementia services

Before seeing how practices in the HIV/GUM services could be applied to services for older people with a suspected dementia, it is important to note some of the differences between the two client groups.

Firstly, dementia is not one disorder; rather the term refers to a group of disorders e.g. Alzheimer's disease, Vascular Dementia, Dementia with Lewy Bodies, Parkinson-related Dementia, etc. Secondly, there is no definitive test for dementia (yet); the assessment procedure involves identifying if there are signif-

Table 1: Client Consent Form for an HIV Test.

Client Consent Form
I confirm that the following have been discussed with me:
● The meaning of the three month 'window period'.
● The difference between HIV and AIDS.
● The advantages and disadvantages to me, my family and partner (s) of having the HIV antibody test.
● Coping strategies – should the results be positive.
● The clinical indications for the HIV antibody test.
● The importance of partner notification should the test be positive.
● The meaning of confidentiality in the context of my treatment and care.
● Information about prevention and transmission.

Signed: ....

Table 2: Doctor or Health Adviser Documentation.

Doctor or Health Adviser
I confirm that the pre-HIV test discussion that has taken place is in my judgement relevant to the needs and understanding of the client or the parent (s) or guardian (s) of the client, and is in accordance with the Trusts' Health Care HIV testing policy.

Signed: ....

icant cognitive problems and then trying to exclude all other possible causes. The diagnosis in the initial stages is rarely clear-cut and there may be quite a protracted period when the person is monitored to see if their difficulties progress before even a 'probable' diagnosis is made; a definitive diagnosis of Alzheimer's disease can really only be made at post-mortem. Thirdly, although there are some anti-dementia medications available, the prognosis for dementia is probably much worse than in HIV, where antiretroviral drug treatments have proved much more effective. Fourthly, in dementia, unlike HIV, there is no risk of infection, so early identification does not have the same value in terms of preventing the spread of the disease. However, it could be argued that failure to diagnosis dementia early enough may result in an increase in other risks, e.g. hazards related to continuing driving or the risk of possible harm to others if the person is disinhibited, aggressive or a potential fire hazard. In addition, some important preventative work can be carried out if an early diagnosis is made such as reducing the stress of the client and their families. Fifthly, people attending outpatient clinics for STI (sexually transmissible infection) and offered HIV testing as part of sexual health screening are less likely to have symptoms (of HIV disease) than people who are presenting for a dementia screening – who are probably already experiencing memory difficulties; this means that the pre-test discussion may need to be adapted to the particular cognitive difficulties of the client before these have been properly assessed.

It is interesting to consider what difference a blood test or another simple diagnostic test for dementia might make to how dementia services are organised. Cayton (1995) of the Alzheimer's Society commented that late diagnosis has been a comfortable option as the clinician has not had to face up to the difficulty of telling the person and their families the terrible knowledge of their inevitable decline. He speculates that a simple diagnostic procedure early in the disease would undoubtedly increase demands on health and social care but would allow support to be mobilised early and empower people with a dementia to take control of their remaining time. If such a test were to be developed, it may be possible to offer one to everyone at their over-75 health check – in a similar way that screening for HIV is now offered to everyone attending GUM clinics.

Application to dementia assessment services

The potential application of the pre-diagnostic counselling framework used in the HIV/GUM service to dementia services will now be examined – allowing for some of the differences identified between dementia and HIV. Each of the above sections will be discussed in turn.

Ethics

Certainly, from an ethical point of view, people with memory difficulties that might herald the onset of a dementia are in a similar position to people who may be infected with HIV: they have the right to know their diagnosis and the implications such a diagnosis might have. However, they also have the right not to know. A recent review found that disclosure of a diagnosis of a dementia is both inconsistent and limited with the perspectives of people with a dementia being largely ignored (Bamford *et al.*, 2004). Similarly, Marzanski (2000) concluded from a questionnaire study with people who had received a diagnosis of dementia: *'The diagnosis of dementia should not be routinely disclosed, but just as in other disorders, health care professionals should seek to understand their patients' preferences and act according to their choice.'*

Who should do the pre-test discussion?

The health adviser and other GUM staff would normally be specially trained to do the pre-test discussion in HIV/GUM testing. As far as I am aware, the use of specialist workers for this purpose has not been attempted in dementia services. The complex nature of dementing disorders and the diagnostic procedures involved might make this more difficult. A recent survey of primary health care nurses showed that they had low levels of knowledge about the epidemiology and diagnosis of dementia and rated themselves as particularly low in confidence in identifying dementia (Byrans, 2003). This indicates that they would need considerable training to be able to carry out the pre-test discussion but, given the resources, there is no reason why this could not be attempted. Other options could include using specially trained workers from the Alzheimer's Society or Admiral Nurses.

Another factor which may influence who takes on the role of carrying out the pre-test discussion is the particular model of service delivery used. Dementia diagnostic services vary across the country, ranging from walk-in memory clinics to more routine mental health services organised around community mental health teams (CMHTs). In the latter, it is not uncommon for the assessment to be carried out in several stages as follows: an initial history taking and cognitive screening test by a CMHT worker (such as a community psychiatric nurse), a more detailed neuropsychological assessment, a blood test, possibly a CT scan and an assessment by a psychiatrist. In this service model, informed consent from the client should be sought from the initial point of contact with the service but, it is suggested that a more structured pre-test discussion needs to take place prior to the neuropsychological assessment or, if this is not indicated/available, before being assessed by the psychiatrist. At this point in the process, it is thought that the clinician carrying out the assessment (i.e. the psychologist or psychiatrist) is probably the most appropriate person to conduct the pre-test discussion. However,

a service model specialising in diagnosis (such as a memory clinic) may be better placed to use specialist workers to do the pre-test discussions.

How should the pre-test discussion be done?
Guidelines in HIV/GUM services highlight the importance of the clinical setting and the literacy and comprehension level of the client when doing the pre-test discussion. This clearly appears applicable to dementia services. The referral route to the service may also be important factor; people referring themselves for a memory check-up may have differing needs to people referred by their doctors or relatives, particularly in respect of informed consent. Cultural and language factors must also be taken into account and interpreters used where appropriate. Furthermore, the person's degree of cognitive impairment, especially if it affects communication skills, should shape how the information is given and how often. Difficulties in understanding issues related to informed consent may possibly be remedied by educational interventions such as those used with older people with a psychosis (Dunn, Lindamer, Palmer, Schneiderman & Jeste, 2001).

What should the content of the pre-test discussion be?
The content of the pre-test discussion in dementia services could be very similar to that used in HIV/GUM services with some additions and adaptations. It should involve an exploration of the client's understanding of what the assessment is about and what they hope to achieve from it. The fact that a possible diagnosis of a dementia may be one outcome needs to be made explicit and further information may need to be given about different forms of dementia. A clear description of what is involved in the assessment with reassurance that they can decline any of the tests if they wish is important. People need to be made aware that there is not one definitive test for dementia and so the outcome of the assessment may be inconclusive and repeat testing may be needed. The advantages of receiving a diagnosis of dementia (such as knowing what is wrong with them, accessing treatment options and support, qualifying for benefits, having time to put their affairs in order, etc.), as well as the disadvantages (such as stress, social stigma, driving restrictions and other legal and financial affairs), need to be discussed.

The client is told that the results of the tests are confidential (with the usual provisos) but that the results would routinely go to their family doctor and other health professionals who may be involved in their care. Hughes (2002) notes that the GMC guidance on confidentiality (GMC, 1995b) does not adequately address the reality of modern practice in dementia services and that it should be regarded as a token of trust rather than an overriding principle.

At the same time the clinician has to be sensitive to the preferences and coping capacity of the client; the client may not want or be able to take in too much

detail at this point and the pre-test discussion needs to be adapted to meet these needs. Useful checks such as 'Shall I continue?' or 'Do you want to hear more?' are considered good practice.

What happens after the pre-test discussion in dementia services?
As in HIV/GUM service, the clients with a suspected dementia can decide whether or not they wish to proceed with the assessment. If they do not wish to proceed, they could be told who to contact if they change their minds and given further information about how to access practical support. If the person's difficulties have reached a stage such that they need the support of a carer, this person can be offered a carer assessment and given additional support in their own right.

Previously, service providers in the HIV/GUM service experimented with the use of a consent form for people presenting specifically for an HIV test (see Table 1). Table 3 overleaf shows how this could be adapted for dementia services.

The content of a consent form, as in the content of the pre-test discussion, if used with people with a dementia, may need to be adapted to take into account the client's preferences about the assessment results and abilities to comprehend them. For example, if people just want to know if their memory problems are worse than other people of their age, they may not want to have a full account of the different forms of dementia at this point. Useful models relating to the experiences of people with a dementia can inform this process (see Keady & Nolan, 1995; Clare, 2002, 2003; Pratt & Wilkinson, 2001, 2003).

Experience in HIV/GUM services was that consent forms were not necessarily a guarantee of informed consent and that clinical practice needed to be adapted to meet individual preferences and needs.

What documentation is needed after the pre-test discussion?
The outcome of the pre-test discussion in dementia services should be recorded on file as in the HIV/GUM service. The section on the client's preferences should include some idea of what they want to be told (e.g. general results of the memory tests only or a possible diagnosis as well) and who else they want informed of the results. The person conducting the pre-test discussion should also keep a record of the client's preferences as to how and when they want to receive the results and who they want to be present. Any other areas of concern should also be recorded such as the ability of the person to cope with the emotional impact of a diagnosis of a dementia.

Table 4 is an example of a form that could be used to record the client's preferences. Further information could be added to the above documentation based on the clinician's observations during testing and any additional preferences of the client recorded.

Table 3: Client Consent Form in Dementia Assessment Services.

Client Consent Form
I confirm that the following have been discussed with me:
- The purpose of the assessment is to determine if I have significant memory problems and to determine if these are part of a progressive disorder such as those found in a dementia.
- A description of possible diagnosis including Alzheimer's disease, Vascular Dementia, Dementia with Lewy Bodies and Mild Cognitive Impairment.
- An outline of what the tests involve.
- The fact that the results of the tests may not be conclusive and/or I may need to repeat them in one year's time.
- The advantages and disadvantages to me and my family of completing the assessment and possibly receiving a diagnosis of dementia – including the implications these might have for driving and managing my own financial affairs.
- My preferences about receiving the diagnosis – even if the diagnosis is ambiguous.
- The meaning of confidentiality in the context of my treatment and care.
- Treatment options and help available to me should I have a possible diagnosis of dementia
- Coping strategies, should the results suggest a dementia.

Signed: ....

Table 4: Pre-Diagnostic Counselling Record Form.

Pre-Diagnostic Counselling Record Form

Information to Client (Tick client's preferences).
'Would you like to know how well you have done on the memory tests? And would you like to be told what your diagnosis might be, even if it is not certain?'
- ☐ **Client does not want to know the test results (e.g. description of cognitive profile) or the possible diagnosis.**
- ☐ **Client wants to know test results but not diagnosis.**
- ☐ **Client wants to know the test results and the possible diagnosis.**

Information to Others (Tick client's preferences).
Is there anyone else such as your husband/wife/partner that you would like to be told and/or to be with you when you are told your possible diagnosis?
- ☐ **Client wants spouse/partner to be informed of diagnosis.**

List all others that the client wants informed of diagnosis:
Is there anyone that you do not want to be told your possible diagnosis?
- ☐ **Client does not want spouse/partner to be informed of diagnosis.**

List all others that the client does not want informed of the diagnosis.

Other comments
Preferences for when and with whom they receive the results?
Any support required in order to cope with diagnosis?

How does everyone involved liaise?
In the assessment of dementia there may be several parts to the assessment and the results can either be given at each stage or at the end – depending to some extent on how the service is organised and the capacity of the person to consent to all the assessment procedures at the beginning. However it is carried out, it is important that the information from each part of the assessment is collated and the client's preferences about what, when and with whom they are told are accommodated, as far as possible.

Conclusions

Comparison with HIV/GUM services has been valuable in highlighting some key issues around informed consent for a diagnostic assessment in dementia services and in offering some useful guidelines for pre-diagnostic counselling. The main message is to take the time to explore what the individual's needs and preferences are and to adapt procedures accordingly. Clearly, the earlier in the disease process the person is seen the more able they are likely to be to participate in pre-diagnostic counselling and to benefit from early intervention Services for older people should, therefore, strive to be more proactive in identifying people in the early stages of a dementia so that they can have the opportunity to discuss their preferences, access treatment and support as soon as possible and have the chance to make advanced directives, before the dementia progresses too far.

Acknowledgements

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Inspiring the next generation: Using online supportive learning environments to train clinical psychologists to work with older people

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Introduction

TRADITIONALLY, WORKING AS a clinical psychologist with older people has been much less attractive as a career option for trainee clinical psychologists. Partly this is to do with an outmoded and stereotypical image of working with older people as being unlikely to produce meaningful and life enhancing change in this client group. Research on successful ageing (Baltes & Smith, 2002; Valliant, 2002) and recent policy initiatives by the WHO (2002) challenge the notion of older people as passive recipients of care lacking in personal agency and the ability to benefit from psychological interventions (Laidlaw *et al.*, 2003a). Partly in response to the frustration of the negative stereotype associated with the older adults specialism, the idea of promoting positive and dynamic images of working with older people became realised through the concept of online learning, offering as it does many opportunities to elaborate on and enhance learning opportunities. A dynamic, flexible and stimulating online teaching curriculum that contains many of PSIGE national guidelines and recommendations for course syllabus for clinical training (Clare & Oyebode, 2004) has been developed as part of our Doctoral training programme.

Online courses provide the potential to reach out beyond the immediate environs, allowing participation and contributions to teaching, training and skills enhancement from individuals not locally based. In the Edinburgh e-online course we are fortunate to have contributions from local, national and international contributors. Each topic contains a lecture (text and powerpoint presentation) that is accompanied with interactive educational enhancement activities such as case studies, audio-visual information, self-tests, internet activities, discussion forums, links to online journals and quick links to important policy documents. Each topic area has been produced with clinician tools such as treatment manuals, questionnaires and other relevant material such as patient education leaflets.

The project work formally commenced in January 2004, and is funded by a development grant received from NHS Education for Scotland (NES). Originally we had planned to adapt an existing online course developed in the US by Bob Knight at the Andrus Gerontology Center, University of Southern California. This course, entitled *GeroClass 522: Counselling Older Adults,* is a very comprehensive psycho-gerontological-based psychotherapy course that has much that would recommend it to UK clinical psychology training courses. Naturally the USC materials needed modification to fit with UK curriculum requirements and were only ever expected to supplement rather than replace local contributions and face to face teaching. Our experience has been strongly influenced by a number of educational theories and the need to create UK-based materials and hence we are producing more original materials and learning activities than was originally envisaged. This has been a stimulating experience for all involved in this project. We are fortunate in having active support and participation from local PSIGE members, many of whom have joined an executive steering group to oversee the development of this course.

The project goal is to create a blended learning environment, one that includes both face-to-face and online learning, where the emphasis for trainees is on activity, integration of theory, practice and values. The project is currently in its first iteration as a supportive online environment, and the aim is have a fully integrated, blended course running by April 2005.

Trainees 'learn about the field by thinking like a member of that practice community' (Jonassen, 1998). The online course encourages self-reflection, collaboration and self-paced learning where professional responsibility for the development of trainees own competence and skills are emphasised. The trainees are encouraged to reflect on the gaps in their knowledge and to use the online materials to target their own needs, importantly we also encourage trainees to draw upon skills and knowledge from prior learning and experience. The online course materials are also available to local PSIGE members to enhance their own CPD. Establishing stronger peer networks enhances learning (Salmon, 2002; Reushle *et al.*, 1999; Herrington, 2000) and is a more naturalistic learning environment for trainees that equips them with better skills for continuing professional development post-qualification.

Institutional supports and e-tools

Edinburgh University has a Media and Learning Technology Service which offers assistance in developing IT skills, creating multimedia exercises and using the virtual learning environment software WebCT. The University also has an e-Library facility, which will allows us to provide journal articles to students and properly investigate copyright issues. We are using WebCT as our virtual learning environment as it is supported by the University and is compatible with most web browsers offering a variety of learning tools. Learning tools vary from simple reproductions of lectures and powerpoint slides (PDF viewers), to discussion boards, self tests, quizzes, and information databases. This allows trainees with different learning styles more opportunities to find the right style to suit their needs.

Online courses, provide a different experience from the classroom (Harasim, n.d.) and can be used to engage trainees in their own development. For this reason, the course focus is on creating integration of knowledge and experience through a collaborative, constructivist approach (Sternberg, 1998; Chickering & Gamson, n.d.)

Overall content has been split into topics that contain lectures, summaries and further resources (both print and online). We have included many 'mind tools', valuable cognitive tools for mapping the relationship between concepts and practicing essential professional skills, such as self tests, databases, internet activities, discussion boards and so on (Jonassen, 1998). The bigger picture of skills, knowledge and abilities is evident in each content item,

with useful placement tools and resources available in each topic (for instance, the topic on CBT includes practitioner manuals, useful practitioner forms and formulation examples and tutorials). *Activities are emphasised as the unit of learning* (Herrington *et al.*, 2000).

Each topic contains a number of illustrative cases, activities and exercises that facilitates the integration of key concepts consistent with Reigeluith's (1999) Simplifying Conditions Sequence in which we 'teach a simpler version of a task…before teaching progressively more complex versions'. We are developing two types of audio-visual case studies to enhance learning. These are illustrative cases which for example shows a client and therapist completing an activity in therapy, and conceptual case which are more complex and enhanced requiring the trainee to draw on information across a number of topic areas in order to successfully deal with issues raised in the case examples.

Evaluating the project

While it is important to evaluate the supportive online environment we have created for this year's cohort, we also need to evaluate learning materials in terms of future years cohorts. Evaluation occurs at a number of levels. We measure the trainees experience of the topic areas by asking them to complete a short survey, we also measure trainees use of materials and we also elicit feedback about needs from the placement and academic point of view. On a more global level we are also measuring trainees attitudes to ageing using a generic standardised measure developed with older people (Laidlaw *et al.*, 2003b).

Conclusion

This paper outlines a currently developing project looking at providing a supportive online training environment for trainees working with older adults. We have a number of aims that include changing the image of the speciality amongst trainees and raising the profile of the speciality generally. Given the move towards competence based training for clinical psychologists has been considered as having some challenges for the smaller specialities, our approach is one which trainees are provided with a constructive, valuing collaborative approach to learning which we hope is more realistically illustrative of the dynamic, creative and autonomous work of older adults specialists. As we are in the early stages of this project we would welcome comments and suggestions from our colleagues in PSIGE. We are happy to provide interested parties with a 'tour' of our online environment.

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Trainee clinical psychologists' attitude towards adults over the age of 65 and their interest to work with older adults – pre-teaching, post-teaching and post-placement

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Abstract

Care of the elderly will represent a significant proportion of the future practices of current trainee clinical psychologists and yet a reluctance to work with older people has been reported within the profession. Previous research has found that the two most powerful predictors of motivation to work with older adults were attitude toward psychotherapy for older adults and past professional experience in the field (Shmotkin, Nitza & Lomranz, 1992). Clinical psychology trainees' attitudes towards older adults and intention to work in the area were measured prior to and after their main teaching block on older adults and then six months later, either after an older adult placement or non-older adult placement. For those trainees who had at least a 'neutral' experience on an older adult placement, attitudes were significantly more positive post-placement compared to baseline and to the end of the teaching block. In addition, these trainees were more interested, or possibly interested, in working with older adults at the end of placement than at baseline. The stability of attitudes in the non-older adult placement group supported the hypothesis that favourable experience on an older adult placement is important in positively influencing trainees' attitudes towards this age group. The findings of this study were discussed in relation to previous research.

Introduction

The ageing population and current mental health services

A MAJOR PROBLEM CURRENTLY facing mental health service professionals is caring for the population of adults over 65 years and with increasing numbers of older adults[1]. These difficulties are likely to be magnified (Compton, 1989). Currently, figures indicate (e.g. Skelton-Robinson, 1995) that older people are under-represented amongst the clients of clinical psychology services, on the basis of the age distribution of the general population. Britton and Woods (1996) pointed out that: *'If the increased health needs and service use of older people as a group were taken into account, this proportionally low frequency of contact may be seen as virtually a neglect of the needs of older people for the services provided by clinical psychology'* (p.10).

Indeed, others have suggested that there is no reason to believe that older adults' need for mental health services is significantly less than that of other age groups (Kay & Bergmann, 1980), and that in fact the opposite may be true (Butler & Lewis, 1977; Greene, 1986). The problem of providing mental health care is set to escalate as the number of people over 65 is predicted to rise by 10 per cent in the next 10 years and the greatest increase will be among those over the age of 80 (Forget-Me-Not report, 2002). This report points out that the 'older' old will need the most help from services – a quarter of those over 85 will develop dementia, of which a third will need constant care or supervision.

High vacancy rates for clinical psychologists in the older adult specialty

According to a British Psychological Society briefing (1995) clinical psychologists have traditionally been

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[1] Throughout this report the terms older people/adults will be used to refer to people over 65 years of age. It is important to stress that the age of 65 is an arbitrary cut-off point commonly used within mental health services to determine which services people should access.

found to be less interested in working with older people than younger age groups and under-recruitment has been a recurrent problem. This finding is not limited to Britain, as Shmotkin *et al.* (1992) found that within a population of 190 Israeli students and practitioners of clinical psychology, there was 'lower motivation for treating older adults as compared with other age groups, with 55 per cent of clinical psychologists specifically expressing desire not to work with the elderly'.

Researchers have studied the problem from a variety of perspectives, examining the structural factors that make the work difficult and unappealing (e.g. Pursey & Luker, 1995). They have looked particularly at the societal and cultural roots of disparaging views of older people that form the context in which young people entering the health professions make their career choices.

Ageism
Gilleard *et al.* (1995), have suggested that much of the discriminatory practice in health services and the high vacancy rates for psychologists within the older adult (OA) specialty result from ageism. Butler (1969) described ageism as a 'deep-seated uneasiness on the part of the young and the middle-aged – a personal revulsion to and distaste for growing old, disease, disability and fear of powerlessness, 'use-lessness' and death'. He later defined ageism as 'a systematic stereotyping and discrimination against people solely on the basis of their old age' (Butler, 1975). Gerontologists have expressed concern that negative stereotypes of elderly people and of work in gerontology pervade our culture and that such stereotypes have affected recruitment of clinicians in all health care specialities (e.g. Scott, 1998).

Predictors of motivation to work with older adults
Shmotkin *et al.* (1992) found that the two most powerful predictors of motivation to work with older adults were attitude toward psychotherapy for older adults and past professional experience in this field.

Attitudes toward psychotherapy with older people
Mental health professionals have been described as 'reluctant therapists' with reference to working with older adults (Kastenbaum, 1963). Scepticism as to the value of psychotherapy with older people can be traced back to Freud (1953) and the psychoanalytic assumption that older people had character structures too rigid to permit change. Greene (1986) argues that Freud's legacy of pessimism with the validity and utility of psychotherapy for older adults has long influenced the delivery of psychiatric services for this population group. Knight (1996 in Laidlaw, 2003) noted: *'While those who do not work with older people may argue that older patients are unlikely to benefit from psychotherapy, practitioners in the field are more optimistic and enthusiastic about the range of benefits older people can derive from this approach'* (p.23).

Professional experience leading to more positive attitudes
Several researchers found that past professional experience with older adults was related to more positive attitudes in students (e.g. Paris *et al.*, 1997; Hawkins, 1996; Dooley & Frankel, 1991; Mount, 1994). Furthermore, studies examining change in attitudes found that information or teaching about this specialty or completion of a placement in older adults, resulted in more positive attitudes in psychology undergraduates students (e.g. Ragan, 2001; Angiullo, Whitbourne & Powers, 1996; Richardson, 1996).

In a study examining the factors determining trainee clinical psychologists' choice of first job, 'good experience in the specialty as a trainee' was one factor that was identified most frequently as significant in the choice of specialty (Lavender, 1993). It seems, therefore, that experience in the older adult specialty is important in terms of changing attitudes towards older adults and in terms of influencing choice of specialty.

Contact hypothesis and inter-age attitudes
The contact hypothesis (Allport, 1954; Caspi, 1984) is one theory that might help to explain the phenomenon, as noted above, that professional experience in the specialty can lead to attitude change and change in intention to work in the specialty. The contact hypothesis (Allport, 1954) states that: *'Co-operative contact with individual members of an out-group can lead to a general more positive attitude toward the out-group as a whole.'*

Results of several studies have confirmed that self-reported favourable *quality*, but *not frequency*, of contact was significantly related to more positive attitudes toward the elderly (e.g. Schwartz & Simmons, 2001).

Compulsory older adult placements vulnerable to be discontinued?
It is well known that there is considerable pressure to expand the training of clinical psychologists and, owing to difficulty providing placements in the older adult specialty, compulsory older adult placements may be vulnerable to be discontinued (Britton & Woods, 1996). Gilleard *et al.* (1995) argue, however, that *'whilst solving the logjam problem of too many trainees and not enough placements, such proposals will do little to increase the number of psychologists interested and experienced in working with an older adult client group'* (p.14). Britton and Woods (1996) suggest that although working with older people is often a less popular choice initially, good placement experience is effective in encouraging trainees that this area is worth a second look in terms of career choices.

Rationale for the current study
The need to establish attitudes of clinical psychology trainees to working within this specialty has been identified as an important issue to explore, given the growing number of older adults and previous difficulties with recruitment to this area. Given that attitudes

towards older people have been found to correlate with intention to work with older clients (Mount, 1994) and that intention to work with this age group tends to shift with education and professional experience, I planned to measure trainees' attitudes towards older adults and intention to work in the area prior to and after their main teaching block on older adults (16 days of training) and then after their placement (which immediately follows on from the teaching block).

Hypotheses
Re: Prior to teaching (baseline)
1. Trainee clinical psychologists will hold 'negative attitudes' towards older adults.
2. Trainees will not be interested in working with older adults.
3. Prior professional experience with older adults will be associated with more positive attitudes.
4. Current personal contact with older adults will be associated with current positive attitudes.

Re: Post-teaching
1. The attitudes of trainee clinical psychologists will be significantly more positive post-teaching compared to baseline
2. Trainee clinical psychologists will be more interested in working with older adults post-teaching compared to baseline.

Re: Post-placement
1. Trainees who characterised their placement contact as favourable will have significantly more positive attitudes toward older adults post-placement compared to:
   a. baseline;
   b. post-teaching;
   c. trainees who characterised their placement as unfavourable.
2. Trainees who deferred their older adult core placement will show no significant change in attitudes towards older adults over the six-month period post-teaching.
3. Trainees who characterised their placement contact as favourable will be more interested in working with older adults compared to those who did not describe their placement contact as favourable.

The study
Design and participants
This study was a repeat measures design, utilising a questionnaire, involving trainee clinical psychologists from one cohort (2001 intakes) in their second year of training. Of the 16 trainees, three were excluded because they had already completed their placements, out of synchrony of the teaching blocks. Of the 13 remaining trainees, all completed the questionnaire at baseline (T1) (prior to teaching), 12 then completed it after the teaching block (T2) (one person did not return the form at this stage) and 13 completed the question-

naire six months later (10 completed an older adult placement during this period) (T3). Three out of the 13 trainees postponed their placement until their third year of training. Out of the ten trainees who had completed an older adult placement, nine had only a half-time placement, i.e. two days per week on placement. 23 per cent of the trainees were male (*N*=3) and 77 per cent were female (*N*=10). The mean age was 29.9 years (SD=3.66), ranging from 25 to 34 years. One trainee had some experience of working with older adults (as a care assistant) prior to training.

A single questionnaire was designed to measure previous professional and current personal contact with older adults, contact quality, interest in working with older adults after graduation, and attitudes towards the elderly. Using two separate Likert scales, participants indicated the frequency and satisfaction of their contact with people over the age of 65. Implicit attitudes toward older men and older women were assessed using Polizzi's refined version of the 'Ageing Semantic Differential' (Polizzi, 1996). The attitude scale now consists of 24 traits stereotypically associated with elderly individuals, e.g. 'flexible/inflexible'. This can be seen in the Appendix.

The respondents were asked to mark each item in one of the seven blanks based on their evaluations of a man 70 to 85 years of age and a woman 70 to 85 years of age. Two forms of the instrument were administered, one with the man listed first and the other with the woman listed first, in order to prevent any possible order effects. The respondents were told to evaluate any man and woman that they knew fit the category of 70 to 85 years of age. No ageist descriptions or words (e.g. 'old' or 'elderly') were used at any time in the instrument or by the researcher in order to avoid any possible bias that those words might create. A total score of more than 96 indicated a 'negative attitude', less than 96 indicated a 'positive attitude' and 96 indicated a 'neutral attitude'.

The questionnaires distributed at the end of the teaching block were the same except they excluded questions about past professional and current personal contact with older adults. The questionnaire used at the end of placement (T3) was the same as that for the end of the teaching block (T2) but included an additional question on placement quality and whether the placement was a 'full-time' or 'half-time' placement. Questionnaires were distributed at the beginning of the older adults teaching block in second year and repeated post-teaching and six months later – after which time 10 out of the 13 trainees had completed a placement in the older adult specialty.

In analysing the results attitudes regarding male and female older adults were 'moderately' to 'strongly' correlated (Coolican, 1994) at all three time points. Therefore, the attitude scores for each gender were aggregated.

Results
Baseline (T1)

Prior to teaching, 10 out of the 13 trainee clinical psychologists held 'positive' attitudes towards older adults compared to three who held 'negative' attitudes, as measured by the Aging Semantic Differential scale.

Regarding interest to work with older adults, at this time point, six trainees were 'not interested' and six indicated that they 'did not know' if they were interested. One person did not respond to this question.

In terms of whether previous professional experience with older adults was related to current attitudes, only one trainee reported such experience. It was not, therefore, possible to answer this question.

Five out of the 13 trainees reported to have personal contact, at least once a month, with adults over the age of 65. All of these trainees indicated that this contact was 'very favourable', 'favourable' or 'neutral'. An independent samples t-test revealed that there was no significant difference between the attitudes of the group of trainees in regular personal contact with older adults and those who were not in regular contact (t(11)=0.213; p>0.05; NS).

Post-teaching (T2)

Twelve out of the initial 13 trainees completed the questionnaire at T2. A paired t-test revealed that there was no significant change in attitudes between baseline and the end of the teaching block (t(11)=0.234; p>0.05; NS).

At the end of the teaching block, five trainees indicated that they were 'not interested' in working with older adults, one trainee said that she was 'interested' in working with older adults, one person said that they 'possibly' might be interested in working with older adults and four people said that they 'did not know'. One trainee did not respond to this question.

Post-placement (T3)

Out of the 10 trainees who completed an older adult placement, nine reported that the contact that they had was 'very favourable', 'favourable' or 'neutral'. The one trainee who reported an 'unfavourable' experience on placement was excluded from the analysis of attitude change because the contact hypothesis emphasises the importance of *quality* of contact in influencing attitudes. Owing to the fact that only one trainee reported a negative experience on placement, it was not possible to statistically compare the effect of such an experience on attitudes towards older adults compared to that of a favourable placement.

Attitudes changed significantly from between baseline (T1) to end of placement (T3) for the nine trainees who experienced their placements as at least 'neutral' (t(8)=1.987; p<0.05) (paired t-test). There was also a highly significant change in attitudes between the end of the teaching block (T2) and end of the placement (T3) (t(7)=3.314; p<0.01) (paired t-test) (there was one less participant in this analysis because he did not return his questionnaire at T2).

An independent samples t-test revealed that there was no significant difference at T1 between the group of trainees who went on to complete a placement in older adults and the group of trainees who deferred their placement (t(11)=0.117; p>0.05; NS). For those trainees who had deferred their placements, there was no significant change in attitudes between T2 and T3 (t(2)=–0.014; p>0.05; NS) (paired t-test).

In response to the question regarding interest to work with older adults, at this time point, out of the ten trainees who had completed an older adult placement, nine trainees responded to this question of which only three trainees were 'not interested', one trainee was 'interested', four trainees said that they were 'possibly interested' and one trainee said that they 'did not know'. The trainee who had experienced an 'unfavourable' placement reported that she was 'not interested' in working with this age group and out of the three that deferred their placement in older adults, two 'did not know' if they wanted to work in this specialty and one person did not respond. It was not possible to statistically assess whether trainees who characterised their placement contact as favourable were more likely to be interested in working with older adults.

Discussion

Most of the clinical psychology trainees held positive attitudes towards older adults at baseline. No one, however, was interested in working with older adults at this stage although just under half said that they 'did not know'. For those trainees, however, who experienced at least a 'neutral' experience on placement, attitudes were significantly more positive post placement as compared to baseline and the end of teaching block. In addition, more trainees were interested or possibly interested in working with older adults at the end of placement than at the start. The group of trainees who deferred their placements did not have more negative attitudes towards older adults at T1 than the rest of the group but, importantly, their attitudes did not change between T2 and T3. The stability of attitudes in the non-placement group supported the hypothesis that favourable experience on an older adult placement is important in positively influencing attitudes towards this age group.

It was interesting that professional contact (in the form of a placement in older adults) had an impact on trainee's attitudes towards older adults whereas no significant difference was found between trainees who had regular personal contact with older adults in their personal lives and those who did not. This suggests that in order to positively influence trainee clinical psychologists' attitudes towards older adults and their intention to work with this age group, professional

experience within this specialty may be more effective than just general personal contact.

Even though the majority of trainees only worked a half placement in older adults, for those who had at least a neutral experience on placement, their attitudes were significantly more positive and trainees were more interested in working with older adults by the end of placement. It would have been interesting to have had a sufficient sample size of trainees who had completed a full placement as well as a group that had just experienced a half placement to be able to compare the two groups statistically. This analysis would have helped to provide evidence for or against the finding of several studies that self-reported favourable *quality*, but *not frequency*, of contact is significantly related to more positive attitudes toward the elderly (e.g. Schwartz & Simmons, 2001).

Overall, the findings of this study support previous research that has found that professional experience with older adults can have a positive effect on the attitudes trainee clinical psychologists hold towards older adults and their interest in working with this group. The contact hypothesis (Allport, 1954) seems to be supported in that good quality contact with older adults seemed to have been effective in improving attitudes towards this out-group. This is an important finding given the urgent need for more clinical psychologists, and indeed other professionals, to work in this area. The pressure of increasing the number of training places, at the expense of providing placements in this core specialty may be a false economy, at least in terms of attracting clinical psychologists to work with older adults. In terms of practical implications, it seems important that trainees should experience at least a half-time older adult placement.

In a recent article, Molinari *et al.* (2003) list the specific skills and/or knowledge needed to function as a general psychologist who provide some professional services to older adults and by more specialised experts in the field for practice and training. They attempted to delineate the types of competence needed for specific geropsychology activities at general and more advanced levels of competence. Their expectation is that this delineation of requisite knowledge and skills in geropsychology will be helpful to a wide range of health care professionals, including directors of training in professional psychology who wish to incorporate age-related topics into their curricula. Given the need to retain this core placement, this article may help to inform the content of the teaching and the minimum core experience for trainees on older adult placements.

Methodological problems and future research

The results of this study, however, should be interpreted with caution because this was a relatively small sample of trainees, from one intake and from one training course. The validity of the findings and their generalisability are limited, but the study was intended to be a first sketch only and does support previous research.

In hindsight, it would have been preferable to have used a Likert scale to measure interest in working with older adults, rather than a scale at the categorical level. This would have made it possible to use parametric statistics to analyse whether there was a link between attitude change and interest level.

Finally, it would have been interesting to have also measured attitudes towards psychotherapy for older adults[2]. Attitudes towards psychotherapy for older adults have been found to be the other main predictor of interest in working in this specialty. It may have been that the increase in interest in working with older adults at the end of placement compared to baseline was a result of a shift in attitudes towards psychotherapy as well as a change in overall attitudes.

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[2] Using, for example, The Psychotherapy with the Elderly Questionnaire (PEQ: Shmotkin *et al.*, 1992).

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Appendix

Part A
Refined version of the Ageing Semantic Differential (Polizzi, 1996).

Below is a list of 24 polar opposite adjective pairs on a seven-point scale. The middle block is neutral. Please place a check mark along the scale at the point that best represents your judgement about the person being rated. Make each item a separate and independent judgement. Don't be concerned about how you marked any of the previous items, and don't worry or puzzle over individual items. It is your first impression or immediate feeling that is most important. Please be sure to mark each item on the scale.

Firstly, please evaluate any WOMAN that you know that fits the category of 70-85 years of age:

WOMAN

N

Cheerful								Crabby
Unpleasant								Pleasant
Friendly								Unfriendly
Kind								Cruel
Sour								Sweet
Nice								Mean
Tolerant								Intolerant
Unco-operative								Co-operative
Fair								Unfair
Grateful								Ungrateful
Selfish								Unselfish
Considerate								Inconsiderate
Impatient								Patient
Negative								Positive
Calm								Agitated
Thoughtless								Thoughtful
Humble								Arrogant
Frugal								Generous
Inflexible								Flexible
Good								Bad
Hopeful								Despairing
Pessimistic								Optimistic
Trustful								Suspicious
Dangerous								Safe

*N denotes the neutral column

Secondly, please evaluate any MAN that you know that fits the category of 70 to 85 years of age:

MAN

N

Cheerful								Crabby
Unpleasant								Pleasant
Friendly								Unfriendly
Kind								Cruel
Sour								Sweet
Nice								Mean
Tolerant								Intolerant
Unco-operative								Co-operative
Fair								Unfair
Grateful								Ungrateful
Selfish								Unselfish
Considerate								Inconsiderate
Impatient								Patient
Negative								Positive
Calm								Agitated
Thoughtless								Thoughtful
Humble								Arrogant
Frugal								Generous
Inflexible								Flexible
Good								Bad
Hopeful								Despairing
Pessimistic								Optimistic
Trustful								Suspicious
Dangerous								Safe

*N denotes the neutral column

Perceptions of handwriting deterioration in older adults

Susan Baxter
Former Trainee Clinical Psychologist.

Introduction

HANDWRITING IS A tool for achieving communication and self-expression (Berninger & Graham, 1998; Suen, 1983). When teaching handwriting the aim is for the development of a personal style that can be used quickly while remaining legible (Bailey, 1988). Similarly, the two elements commonly examined in handwriting research have been speed and legibility. However, for decades the general aesthetic character of handwriting has also been considered an important aspect (Bailey, 1988).

Handwriting in older adults

There have been several studies to suggest that differences exist between the handwriting of older adults and that of younger adults. Contreras-Vidal, Telings and Stelmach (1998) found that deterioration in spatial co-ordination of finger and wrist movements affected aspects of handwriting in older adults; specifically, there was a reduction in the straightness of oblique strokes. Older adults were found to rely more on external visual cues while writing than younger adults leading to reduced fluency in handwriting movements (Slavin, Phillips & Bradshaw, 1996). Dixon, Kurzen and Friesen (1993) found older adults to perform more slowly than younger adults in several handwriting tasks; these age differences were more apparent in unfamiliar tasks. However, the authors found older adults to improve at a faster rate than the comparison group across trials, emphasising the importance of practice effects on handwriting.

Cornhill and Case-Smith (1996) found handwriting skill in children to correlate strongly with measures of eye-hand co-ordination and integration of visual and motor feedback. This suggests that deficits in visuospatial skills may lead to reduced handwriting skills. It is equally important to note the prevalence of sensory deficits on older people (Woods, 1999) and the effect this has on the use of visual feedback.

Older adults have an increased risk of a number of physical health problems. These frequently include illnesses affecting the muscular-skeletal system, such as arthritis or rheumatism which may affect an individual's mobility in the hand and consequently their handwriting. In addition, many older adults are on multiple medications, the side effects of which may affect handwriting, for example those which cause tremor. Older people are also at an increased risk of strokes (Skilbeck, 1996), which may prevent or restrict the use of the writing hand. After a stroke there may be deficits in handwriting due to cognitive impairment. Ardila and Rosselli (1993) describe several writing errors present after cerebral damage, including letter omissions and additions, inability to maintain horizontal writing and changes in handwriting style. These were ascribed to a number of neuropsychological deficits including constructional and spatial deficits, and perseveration.

The literature appears to indicate that many older adults will be unable to produce handwriting of the same standard as during earlier years.

Implications for clinical psychology

Previously the bulk of clinical psychology input for older adults has been psychometric assessment. It is now more common for clinical psychologists working with an older population to spend much of their time using therapeutic interventions (Woods, 1999). There have been several studies demonstrating the efficacy of psychological treatment of older adults (Gatz *et al.*, 1998; Scogin & McElreath, 1994). Cognitive-behavioural therapy has been shown to be of benefit for older adults with mental health difficulties including depression (Thompson *et al.*, 2001) and anxiety (King & Barrowclough, 1991). An important component of this type of treatment is the use of homework assignments. These allow the client to test out predictions and practise the skills acquired during therapy (Blackburn & Davidson, 1995). It provides an opportunity for skills to be generalised to the client's everyday life (Garland & Scott, 2002). Results of a meta-analysis found completion of homework assignment to correlate significantly with outcome in cognitive therapy (Kazantzis, Deane & Ronan, 2000).

A common component of therapy homework is the use of written tasks, such as thought diaries. This is often a feature of the middle phase of treatment. At the start of therapy, homework may focus on behavioural tasks. These serve to collect information on negative cognitions that can then be modified using thought records later on in therapy (Garland & Scott, 2002). Kirk (1989) notes the importance of identifying practical difficulties that may prevent homework completion. Deterioration in handwriting could be considered one such difficulty. It is essential for clinical psychologists to bear in mind possible deterioration in handwriting when assigning written homework tasks or diary keeping for assessment purposes. Preferably the therapist and client will agree jointly on a homework task as the session progresses, with the client taking on more responsibility for devising homework in later sessions (Garland & Scott, 2002).

Thoughts about handwriting may play a part in non-completion of homework tasks. For example, the client may worry that the therapist is negatively evaluating their handwriting if they complete written homework assignments (Garland & Scott, 2002). Cognitive theory hypothesises that mood disorders arise due to a disturbance in information processing, whereby events are interpreted with a negative bias (Beck, 1976). Several types of cognitive distortion have been described, such as selective abstraction and magnification (Wells, 1997). These types of errors may be present in thoughts about handwriting; for example, an individual may focus on the fact that their handwriting is less neat than before and ignore whether it serves its purpose, or exaggerate the consequences of poor handwriting.

Concern about deterioration in handwriting among older adults has implications other than within therapy. For example, anxiety about perceived handwriting may interfere with many activities of daily living, such as completing correspondence. Little research has been carried out examining the extent of anxiety about handwriting in an older adult population. Given the issues described above, it seems likely that a high proportion of older adults will have noticed a marked deterioration in their handwriting over time. However it is unclear to what extent this will be a cause for concern. Laidlaw, Thompson and Gallagher-Thompson (2002) emphasise the importance of considering cohort beliefs when working with an older adult population. It is possible that older adults are currently at more risk of distress due to handwriting deterioration, as more importance was placed on handwriting at school. Older adults are also less familiar with information technology, leading to a greater reliance on handwriting (Laidlaw, Thompson & Gallagher-Thompson, 2002.

The present study is a preliminary exploration of older adults' thoughts about their handwriting. The study explores whether concerns about handwriting are present in a non-clinical older adult population.

In particular, this study examines the aspects of legibility and neatness. Legibility is considered more vital in adult day-to-day handwriting than speed (Suen, 1983) yet the aesthetics of handwriting are often also considered (Bailey, 1988).

Aims of the study

The aims of this study are as follows:

1. To identify what proportion of an older adult sample have identified deterioration in their handwriting over time.
2. To explore the perceived reasons for any deterioration.
3. To identify whether older adults report a higher degree of self-consciousness about their handwriting than younger adults.
4. To identify what health factors are present which may contribute to deterioration in handwriting.
5. To identify whether older adults score less than younger adults for neatness and legibility on self-report and observer-rated measures.
6. To compare views on handwriting of older and younger adults.

Method

Participants

The participants in the older adult group were recruited from attendees at a local day centre. The sample consisted of seven men (26.9 per cent) and 19 women (73.1 per cent). The age of participants in this group ranged from 60 to 92 years (mean = 79.8, standard deviation =7.5). Only one of the sample was left-handed (3.8 per cent).

The participants in the younger adult group were recruited from hospital staff attending a multidisciplinary meeting, and attendees at a psychology special interest group meeting. The sample consisted of seven men (21.9 per cent) and 25 women (78.1 per cent). The age of participants in this group ranged from 21 to 59 years (mean = 38.3, standard deviation =11.2). Three of the sample were left-handed (9.4 per cent). All participants had learnt to read and write.

Measures

The older adult participants were interviewed at the day centre using a brief semi-structured interview schedule (see Appendix). Participants were asked to mark their current handwriting for neatness and legibility on a visual analogue scale. The end points of the scale were 0 and 100, where 0 was not at all neat or easy to read and 100 was extremely neat or easy to read. Participants who had difficulty with this were asked to rate their handwriting out of 100 using the same anchor points. Participants were then asked to do the same for their 'previous handwriting'. No specific time period was given to allow participants to identify for themselves when deterioration had begun. If this was queried, participants were asked to rate their usual handwriting during their adult life.

Participants were asked if they thought their handwriting had deteriorated over time and what they attributed this to. They were asked to name any physical conditions that might affect their handwriting and were asked specifically whether they had any of the following; arthritis, tremor, uncorrected visual impairment or previous stroke.

Participants were asked if they ever felt self-conscious about their handwriting. They were also asked to identify situations that triggered self-consciousness and what their specific concerns were.

Questions were included regarding the importance placed on handwriting during participants' school-days, and by themselves currently.

Participants were asked to copy a sentence in their usual handwriting. They were also asked for any additional comments.

The younger adult group were asked the same questions as above, except they were asked to rate only current handwriting. As this group were co-workers of the researcher, the younger adult group answered the questions by completing a written questionnaire for confidentiality reasons.

Results

Deterioration in handwriting

Twenty-three (88 per cent) of the older adults reported deterioration in their handwriting. The reasons given for this deterioration are given in Table 1. Some participants identified more than one reason.

Anxiety about handwriting

Three (11.5 per cent) of the older adult participants reported that they were self-conscious about their handwriting a lot of the time compared with one (3.1 per cent) of the younger participants. Fifteen (62.5 per cent) of the older group and 19 of the younger participants (59.4 per cent) reported that they were not at all concerned about their handwriting. Figure 1 (below) illustrates the distribution of responses.

Table 1: Deterioration in handwriting.

Reason	Number	Percentage of those who reported deterioration
Lack of practice	7	30%
Ageing	5	22%
Stroke	4	17%
Arthritis	4	17%
Shakiness	3	13%
Weakness/poor mobility in hand	3	13%
Lack of patience	3	13%
Operation	1	4%
Medication	1	4%
Anxiety	1	4%
Vision	1	4%

Figure 1: Self-consciousness about handwriting.
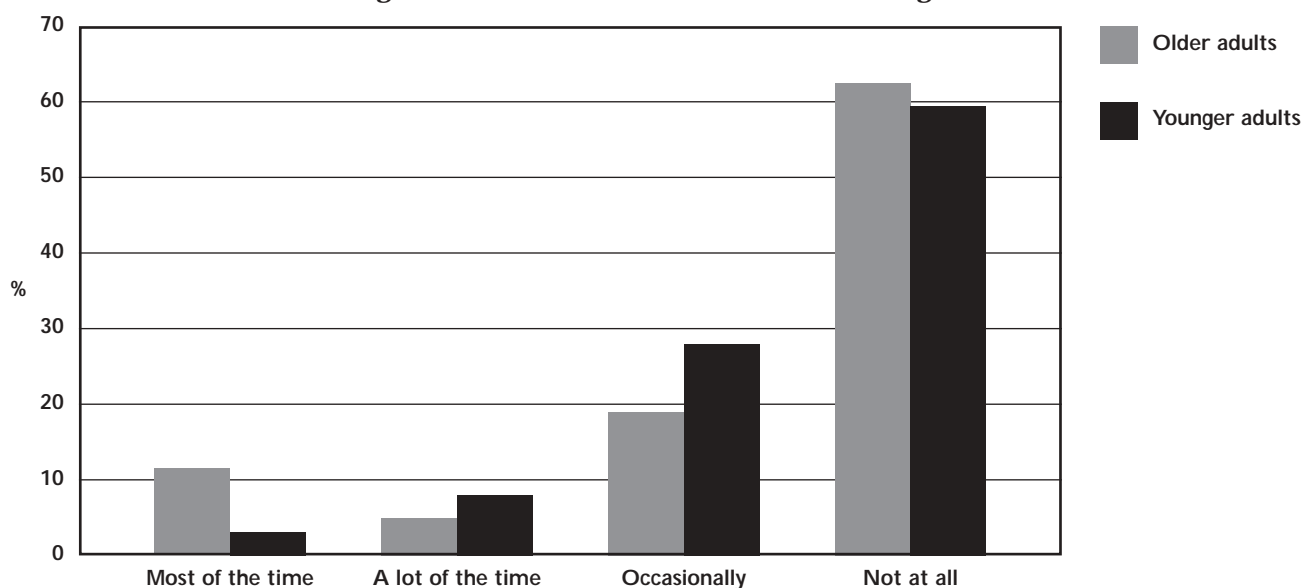
Situations mentioned by participants as ones in which they felt self-conscious about their handwriting are given in Table 2. Older adults reported particular concerns about writing in front of others.

Physical health factors
Only three (11.5 per cent) of the older adult group reported having no physical health problems that might affect their handwriting, compared with 31 (96.9 per cent) of the younger participants. The factors mentioned are given in Table 3.

Some participants identified more than one health factor. It should be noted that participants with cognitive impairment were excluded for the sample; therefore the effects of stroke described were physical symptoms. The definition of visual impairment included only deficits not corrected by wearing glasses.

Rating of handwriting
Participants were included in this analysis if they were able to copy the whole of the test sentence ('the quick brown fox jumps over the lazy dog'). This included all 32 of the younger adult group and 23 of the older adults. The excluded participants were unable to copy the sentence due to visual impairment.

Self-report
Table 4 gives the mean and standard deviation for each group for self-report rating of neatness and legibility. Younger adults rated their current handwriting higher for both neatness and legibility. The difference for neatness was shown to be significant at the .05 level using the Mann-Whitney (unrelated) test (p=0.04) but not for legibility (p=0.30).

Independent rating
The written sentences were shown to two independent raters. They were asked to rate each sample for neatness and legibility from one to 100. Correlations between raters 1 and 2 were significant at the 0.01 level for neatness and legibility. Correlations between self-report ratings and raters 1 and 2 were significant at the 0.01 level.

Table 4 shows that the mean ratings for neatness and legibility were higher for the younger adults for both raters. Mann-Whitney (unrelated) tests showed this difference to be significant at the 0.05 level for rater 2 neatness ratings only (p<0.001). The difference approached significance for rater 1 neatness ratings (p=0.083).

Table 2: Situations where participants felt self-conscious about their handwriting.

Situation	Frequency – Older adults (%)	Frequency – Younger adults (%)
Writing in front of people	5	1
Writing letters	2	2
Writing cheques/credit card slips	2	1
When people can't read writing	0	2
Filling in forms	0	1
Writing legal documents	0	1
Reading it at a later date	0	2
If not written for a while	0	1
If people reading it	0	1
If I don't have glasses	0	1
If writing medical notes	0	2

Table 3: Physical health problems that might affect handwriting.

Health Factor	Frequency – Older adults (%)	Frequency – Younger adults (%)
Arthritis	12 (46.2%)	0 (0%)
Poor vision	10 (38.5%)	0 (0%)
Stroke	5 (19.2%)	0 (0%)
Tremor	4 (15.4%)	0 (0%)
Osteoporosis	1 (3.8%)	0 (0%)
Lost tip of finger	1 (3.8%)	0 (0%)
Neurosurgery	1 (3.8%)	0 (0%)
Poor circulation	0 (0%)	1 (3.1%)

Table 4: Mean ratings for neatness and legibility.

Variable	Group	Mean	Standard Deviation	p
Self-report neatness	Younger Adults	51.5	22.4	0.004
	Older Adults	37.8	22.2	
Self-report legibility	Younger Adults	56.6	23.7	0.303
	Older Adults	53.4	22.3	
Rater 1 neatness	Younger Adults	80.5	12.5	0.083
	Older Adults	71.3	17.8	
Rater 1 legibility	Younger Adults	79.4	15.6	0.122
	Older Adults	73.5	14.6	
Rater 2 neatness	Younger Adults	79.2	13.7	0.000
	Older Adults	62.0	15.4	
Rater 2 legibility	Younger Adults	81.3	14.6	0.186
	Older Adults	74.2	18.4	

Importance of handwriting

Nineteen (76.0 per cent) of the older adult participants reported that handwriting was considered very important when they were at school compared with 13 (40.6 per cent) of the younger participants. Figure 2 (below) illustrates the distribution of responses.

Eight (30.8 per cent) of the older adult participants reported that they considered handwriting very important now compared with seven (21.9 per cent) of the younger participants. Four older adults (15.4 per cent) considered handwriting not to be at all important and no younger adults. Figure 3 (overleaf) illustrates the distribution of responses.

Discussion

The results suggest that the majority of older adults experience some deterioration in their handwriting. This is in line with previous research (Contreras-Vidal *et al.*, 1998; Slavin *et al.*, 1996; Dixon *et al.*, 1993). The reason given for this deterioration by almost a third of participants was lack of practice, while over a fifth attributed the deterioration to ageing. Several older participants gave specific health problems as perceived reasons for their own handwriting difficulties. Over 10 per cent of older participants reported feeling self-conscious about their handwriting most of the time, compared with only three per cent of
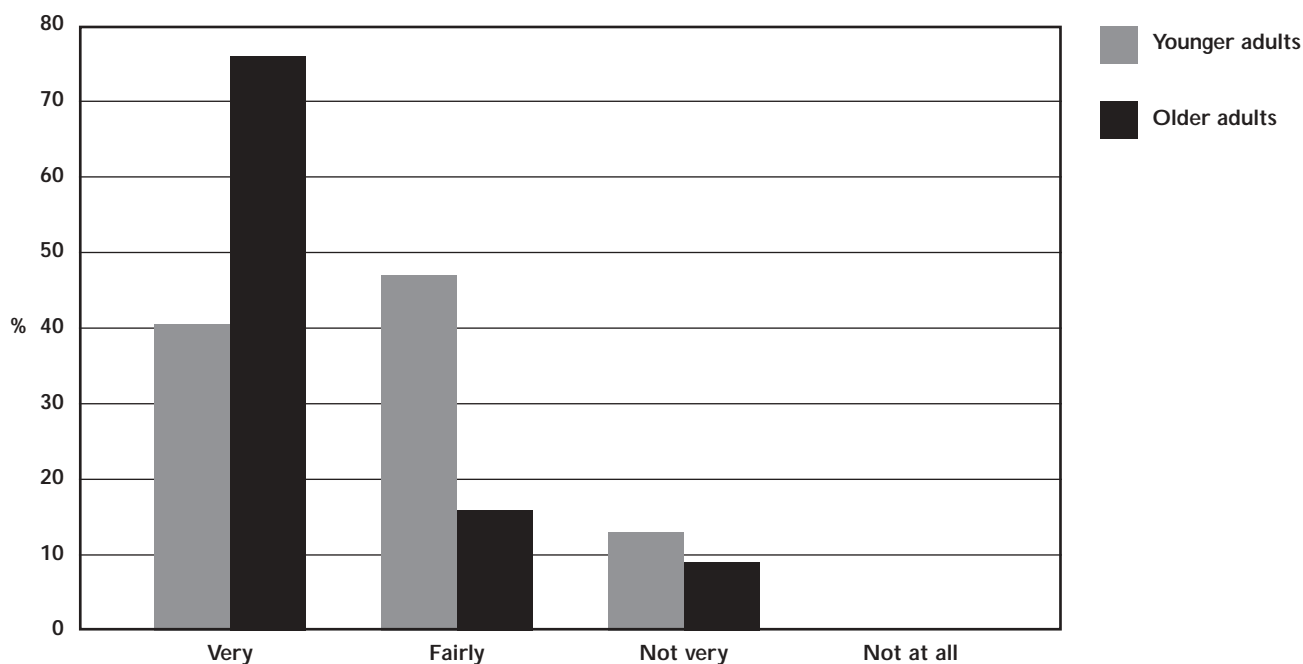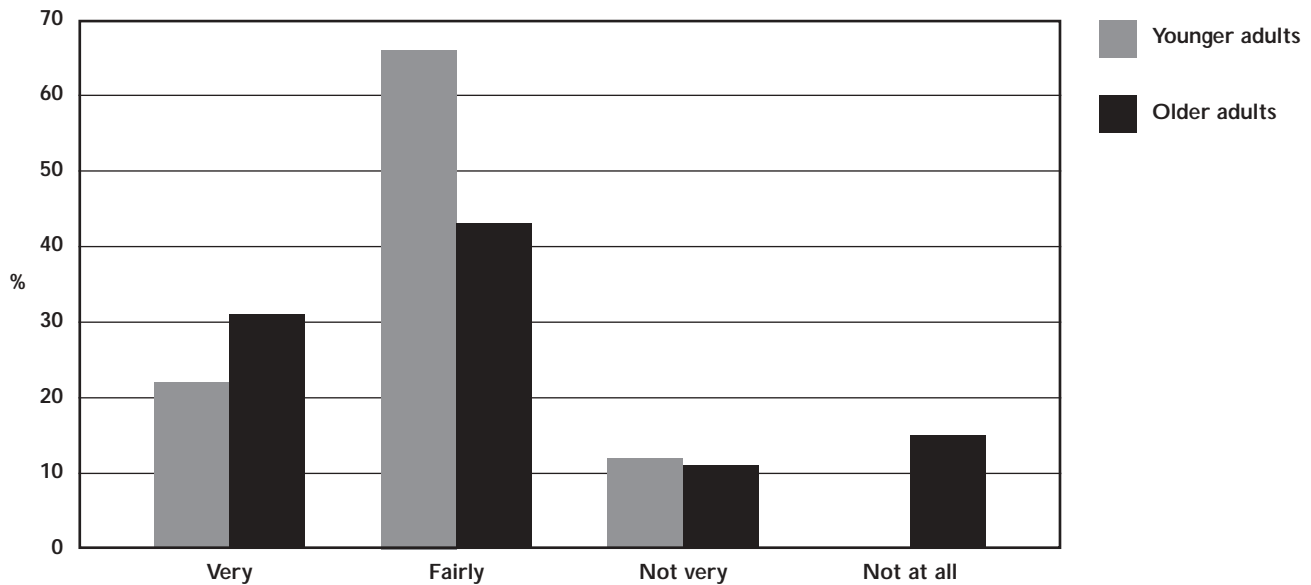
Figure 2: Importance at school.

Figure 3: Importance now.

younger adults, however, a greater proportion of older adults reported that they were not at all self-conscious. This result should be interpreted with caution, as several older adults reported that they never felt self-conscious because they rarely wrote anything, seeking the help of family for written tasks where possible. This would probably not have been the case in the younger group as all had occupations requiring them to write in medical notes.

The situations reported as those where participants were self-conscious about their handwriting appeared to differ between groups. Older participants appeared to be concerned about others watching them write, while younger participants reported concern about others seeing their handwriting at a later date. This may reflect the different usage of handwriting between groups. There is a strong emphasis on communication to other professionals via casenotes for the younger participants. Alternatively it may reflect the reduction in speed found in older adults' handwriting (Dixon *et al.*, 1993). It is of note, however, that none of the older participants reported reduced speed as a concern.

The results showed a clear difference between the two groups in the extent of physical health factors that may affect handwriting. Almost all of the older adults reported relevant factors, while around 10 per cent of the younger age group did so. There are several reasons why inferences may not be drawn from these figures. The older adults were attending a day centre. This means that the proportion of health problems may be higher than in a normal older adult population. In addition, the younger group may also not be a representative sample as all participants were in employment. This suggests that there may be a lower proportion of health problems than in the general population.

The older participants gave themselves significantly lower ratings for neatness than the younger adults. They were also rated significantly lower for neatness by one of the raters. This suggests that older adults are accurate in perceiving deterioration in their handwriting in terms of its aesthetic character. However, there are not significant differences in legibility. If handwriting is considered a tool for communication (Berninger & Graham, 1998), this function appears to remain in later life.

There were differences between younger and older participants in the importance placed on handwriting at school, with three-quarters of older adults reporting that handwriting was considered very important compared with around a fifth of the younger group. During the interviews several older adults reported that they spent a great deal of time on handwriting at school and faced harsh punishment if they were not up to scratch. A higher proportion of older adults considered handwriting to be very important now than in the younger adults, although several older adults considered handwriting not at all important compared with none of the younger adults. This is possibly due to the more frequent use of writing in the younger age group. It could be argued that, with the increased use of computers, communication is facilitated without the need for handwriting. However, older adults are currently less likely to use such technology. This may be due to erroneous beliefs such as 'you can't teach an old dogs new tricks' which can be a feature of an individual's attitude to ageing (Laidlaw *et al.*, 2002).

Further research

This research highlights a number of important points and areas for future research. It would be interesting to replicate the study with both healthy populations, to factor out the effect of physical disability on handwriting and clinical populations. The use of objective measures of handwriting would be advantageous and training of raters in assessment measures, for example of neatness and legibility. Longitudinal studies might clarify the extent to which individuals in general report changes in their handwriting and the influences of specific cohorts, for example, in the use of I.T. and emphasis placed on handwriting at school. Furthermore, it would be helpful clinically to determine the extent to which older people avoid writing by hand.

The role of speed might be further explored; it is noteworthy that no respondents mentioned concerns about writing more slowly. The consensus is that legibility is more vital than speed in adult day-to-day handwriting.

In terms of clinical practice these results suggest that it might be beneficial to make some adjustments, for example, thought sheets could be drawn up with larger boxes for writing in. Expressed anxiety about handwriting may also be a valuable part of assessment, for example, alerting the professional to the possible presence of anxiety in general or increased pen pressure in the context of perceived deterioration. This might further the assessment of physical health complaints and activities of daily living.

Conclusion

Cohort influences and physical health may influence the perception of handwriting. Exploring a person's view of their handwriting may aid assessment in general and the role of handwriting taken into account when devising recording methods for older clients.

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Dementia Services Development Centre

THE DEMENTIA SERVICES DEVELOPMENT CENTRE at the University of Stirling recently moved to a purpose-built dementia-friendly building on the campus – The Iris Murdoch Building. Amongst some of its special features are a memory wall which contains individually-sized windows with deep sills which provide alcoves to hold objects or artwork that are familiar or might trigger memories. Also colour contrast has been used to aid orientation to important rooms such as the toilets. There are stained glass panels which have been especially made by a group with dementia from a English long-stay NHS ward and outside is a mosaic of fishes, reflecting Dame Iris Murdoch's love of water and swimming. The Centre holds Open Days which provide tours of the building. For information about these, or more general information, the Centre can be contacted on www.dementia.stir.ac.uk or telephone 01786 467741, e-mail: dementia@stir.ac.uk

An audit of clinical psychology referrals and provision for older adults in the Scottish borders

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Abstract

Patients over the age of 64 and those under 65 referred to a Psychology Department in the Scottish Borders were compared in terms of referral rates, differences in attendance behaviour and service received. Routinely collected departmental data and NHS demographic data were utilised. Results showed that older adults were proportionally less likely to be referred to psychological services than those under 65. The older group also generally had less time to wait for an initial appointment, and were more reliable attendees. However, they were more likely to decline contact before their initial appointment. Implications of these findings are discussed in the light of recent recommendations by the Scottish Executive concerning services for older people in the NHS.

Introduction

THE PUBLICATION OF THE White Paper *Our National Health* (Scottish Executive, 2000) identified key areas for change and investment within the National Health Service in Scotland. Many relate directly to mental health services for older people, and include issues regarding: equality of access to services; local delivery of care; reduction in waiting times; better care for older people; and tackling poor mental health. A working group was established to specifically look at services for older people in Scotland. Their findings and recommendations were published in *Adding Life to Years* (Scottish Executive, 2002). With regard to improving mental health in older people, these included that: 1. 'NHS Boards should work to raise awareness of older people's mental health issues, and promote recognition and treatment of problems at an early stage; 2. NHS Boards and Local Authorities should assess population needs for dementia and other mental health services and plan appropriate capacity at all levels; 3. NHS Boards should ensure there are services to provide rapid assessment of cognitive impairment,

with appropriate access to modern drug treatment and follow-up.' These are prime areas for clinical psychology involvement, not simply in treating the older population, but also in shaping services. Other relevant recommendations in this document addressed issues of fairer access to services and ageism within the NHS.

The Audit Commission (2000) recently reported that Primary Care teams working with older people often lack mental health expertise in dealing with the non-medical factors of health care. Britton and Woods (2000) have emphasised the importance of psychological formulation in guiding interventions with older patients, identifying this approach as a valuable contribution in the formulation of care plans and packages.

Despite the clear role for clinical psychology within older adult services, a recent survey suggests that its provision in Scotland falls well short of recommended levels (Boddington & Kirtley, 2002). These authors cite several sources for guidelines on psychology service provision within older adult services, and provide information on actual psychology provision. Although Boddington and Kirtley's data are incomplete, as not all geographical areas responded to their survey, they note that their figures show quite large discrepancies within regions, with rural areas tending to have less clinical psychology provision than urban ones. This is the case in the Scottish Borders where current clinical psychology provision falls well below Boddington and Kirtley's average, as well as recommended levels. This is particularly concerning as Scottish Health Statistics (NHS in Scotland, 2000) show that the population is ageing more rapidly in rural areas, and that although over-65s currently account for less than 20 per cent of the population nationwide, this rises to 22 to 24 per cent in the Borders, Dumfries and Galloway, Highland, Orkney, and the Western Isles. These figures call into question how well we are meeting recommendations outlined in the *Adding Life to Years*

document, not just in terms of psychological input but also in terms of equal access to services and issues concerning ageism.

The present study

As already noted, specialist clinical psychology provision for older people in the Borders is very low. Most referrals to this service come from the Mental Health for the Elderly Team (MHET) and tend to contain a high proportion of requests for neuropsychological assessments. Older adults who are referred for intervention with more functional difficulties are often referred to, and seen by, the adult service. The present study sought to use previously collected departmental data to identify discrepancies in the clinical psychology service older and younger adults receive in the Borders.

The main aims were to compare referral rates for over 64s and under 65s, against demographic data for the area to determine if a significant difference existed between the proportion of older and younger adults being referred. It was hypothesised that referral rates would be proportionally lower for over 64s than under 65s. A second aim was to identify differences, if any, in the service received by these two groups. Differences in waiting times and number of contacts between the two groups were examined for this purpose. It was hypothesised that waiting times would be shorter for over 64s due to referrals from the MHET usually being picked up quite quickly. The average number of contacts for over 64s was hypothesised to be fewer than for under 65s as a significant proportion of older adults are referred for neuropsychological assessment which require fewer sessions than those being seen for functional difficulties.

Method

Routinely collected departmental data for the year 2001 was utilised. This included patient identification details (i.e. name and date of birth), length of time on waiting list, the name of the therapist seen, total number of contacts, DNA and CNA rates, whether patients decided not to be seen, and inappropriate referrals. Most of those included in this data set were closed cases. This provided a more accurate picture of the number of contacts people had with psychology services than more recently collected data.

Demographic data collated in July 2002 for the area were collected from Borders Primary Care NHS statistics on the numbers of patients and age groups registered at GP surgeries in the Borders.

Results

Differences in referral rates

Demographic information showed that there were a total of 109,347 people registered in GP practices in the Borders in July 2002. Of these 88,722 were under 65 and 20,625 over 64. The departmental database showed a total of 526 referrals to combined adult and older adult clinical psychology services during 2001. Fifty-one were over the age of 64 and 475 under the age of 65 (see Table 1). As can be seen from Table 1, proportionally, referrals for those over the age of 64 are less than referrals for those under 65.

These data were analysed using a chi-square test. This revealed that over 64-year-olds were significantly less likely to be referred to psychology services than under 65s (χ^2=28.806, df=1, p=0.001).

The proportion of referrals made to the department at specific ages can be seen in Figures 1, 2 and 3. These graphs can be compared to a graph showing population figures for Scotland (from *Adding Life to Years*) for the year 1991 (Figure 4). This data suggests that referral rates are not proportional to population size within age groups in general, as there appears to be a greater discrepancy between referral rates at different ages than the population at different ages. This is particularly evident at either end of the age spectrum and suggests that we may need to be aware of ageism at other stages in people's lives other than just in later years.

Table 1: Comparison between referral rates to psychology services and numbers registered with GP surgeries.

	Number of referrals	*% of referrals*	*Number of people registered with GPs*	*% of people registered with GPs*
Over 64 years	51	9.7%	20,625	18.86%
Under 65 years	475	90.3%	88,722	81.14%
Total	526		109,347	

Figure 1: Distribution of all referrals.
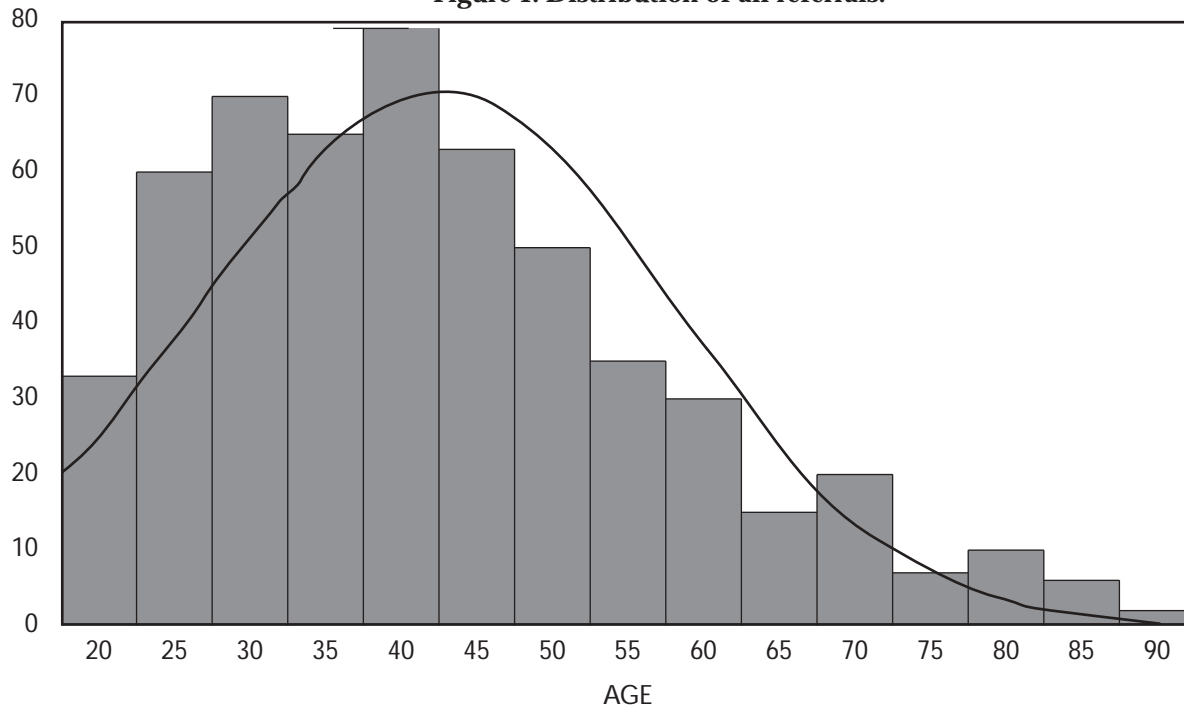
Figure 2: Distribution of male referrals.
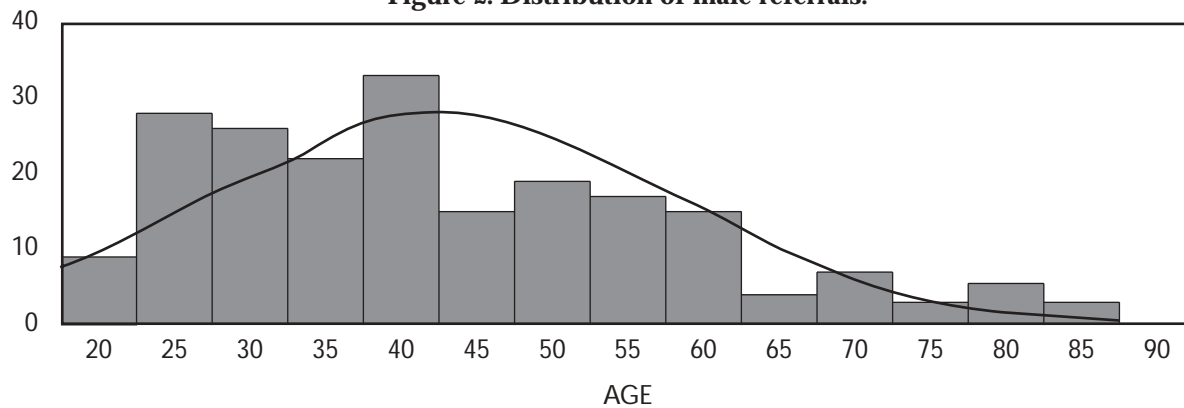
Figure 3: Distribution of female referrals.
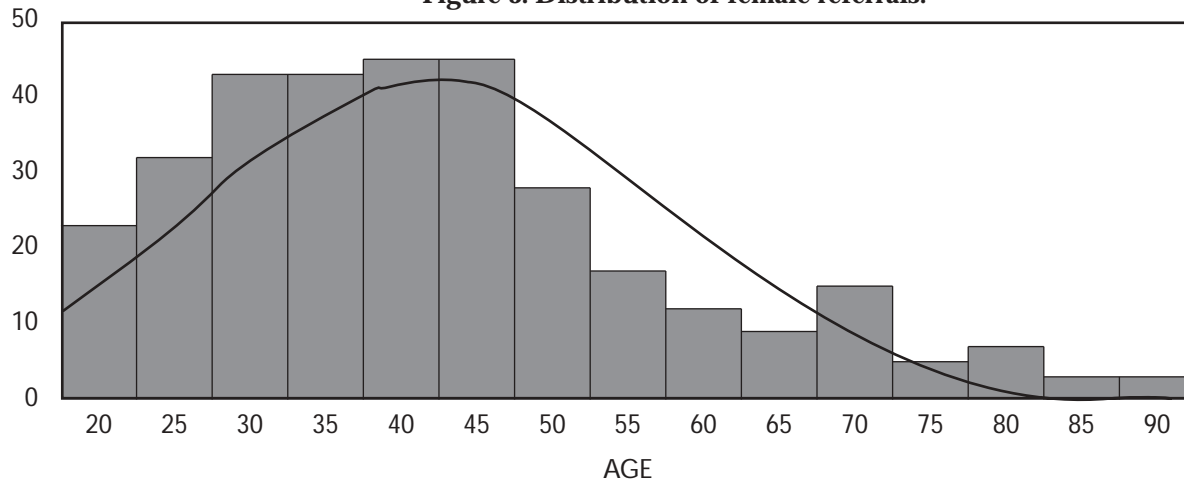
Figure. 4: Scotland's population in 1991 (from Scottish Executive, 2000).
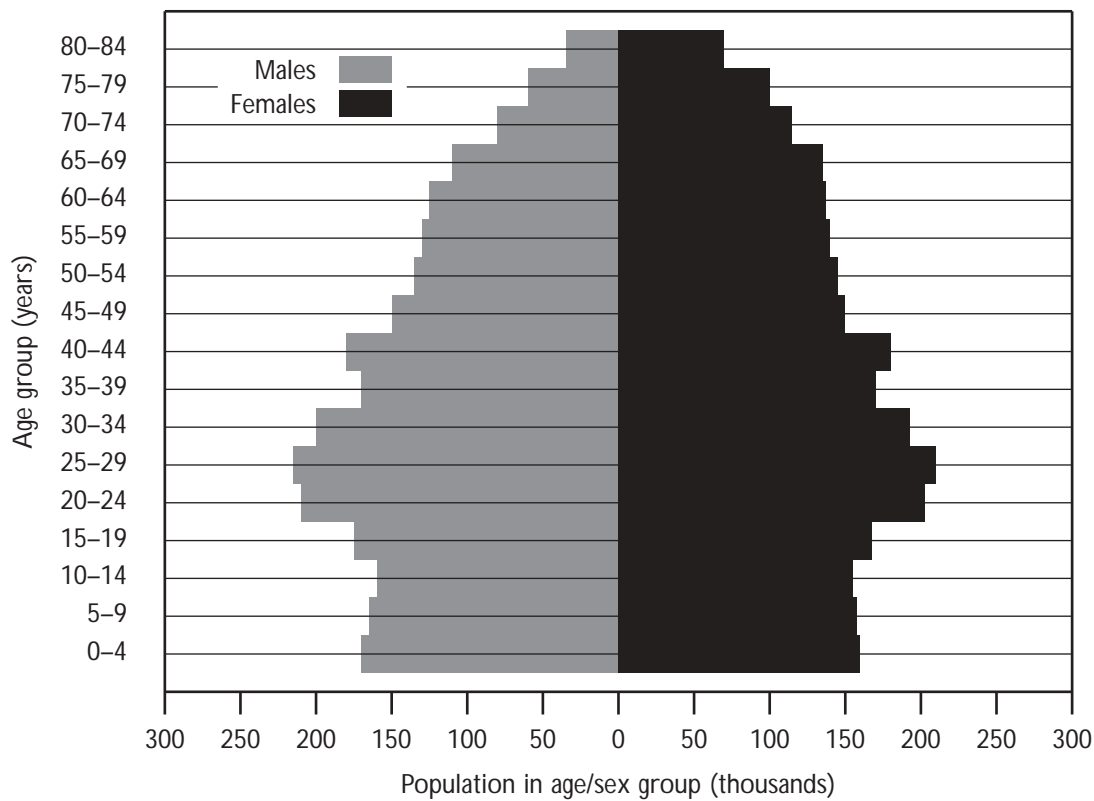
Table 2: Results comparing what happens to patients in the two age groups once they are referred to psychology services.

	Number over 64 years (percentage)	*Number under 65 years (percentage)*	*Total (percentage)*
Number of inappropriate referrals	0 (0%)	7 (1.5%)	7 (1.3%)
Number of patients who voluntarily withdrew from service	4 (7.8%)	88 (18.5%)	92 (17.5%)
Number of patients still being seen	1 (2%)	35 (7.4%)	36 (6.8%)
Mean waiting time until initial appointment	12.45* weeks	30.09* weeks	28.25* weeks
Mean number of contacts	4.96**	5.31**	5.27**
Number of patients who failed to turn up for at least one appointment	7 (14.9%)*	146 (38.4%)*	153 (35.8%)*
Number of patients who cancelled at least one appointment	12 (25.5%)*	141 (37.1%)**	153 (35.8%)*

* This figure does not include individuals who were inappropriate referrals or were withdrawn, as these people did not have first appointments.

** These figures do not include individuals who were inappropriate referrals or were withdrawn, as these people were never seen. It also excludes those are still being seen as data for this set of people was missing.

Differences in other areas

Further results were obtained regarding what happened to patients once referred. These are summarised in Table 2.

Results of chi-square tests identified that over 64s were significantly more likely to attend appointments; their DNA rate being much lower (χ^2=10.07, df=1, p=0.002). Significant differences were not found between age groups for numbers of inappropriate referrals; number of patients still being seen; cancellation rates or withdrawal rates.

The Mann-Whitney test was used to examine younger and older adults' different experiences of waiting times and number of sessions with their therapist. No significant difference was found between age groups for number of contacts, but differences in waiting times were significant at the 0.001 level, older adults generally having to wait a shorter length of time (see Figure 5 below).

Discussion

The above results suggest that an adult over the age of 64 is less likely to be referred to psychological services than a younger adult. Most psychology referrals to adult services in the Borders come from GPs although in older adult services a fair number come from psychiatry and the MHET, especially where there is concern regarding cognitive decline. It seems therefore that GPs are not referring older patients. There are a number of reasons why this may be the case.

Scottish Health Statistics (2000) state that the most common reason recorded for female patients, and the fourth most usual for males, across all ages, to consult their GP is depression. Anxiety is recorded as the fourth most common for women. For the age group 45 to 65 both depression and anxiety are rated amongst the top five recorded reasons for consulting a GP for both sexes. However, for the age group 65 to 74 these have disappeared from the top five problems presenting for men and for the age groups 75 and over they do not appear for women either.

It is possible then, that the reason for lower clinical psychology referral rates for older people is that this age group does not experience the same level of psychological distress. However, other research does not necessarily support this view. It has been suggested that rates of depression in residential care for the elderly are high (Ames, 1991) especially for those with dementia, and that community population samples vary greatly, possibly because some exclude those in residential care (Woods, 2000). The prevalence of dementia in later life would thus suggest that a greater level of psychology intervention would be useful to this age group, if not for neuropsychological assessment and follow-up then treatment for associated depression. Dementia is rated as the third most common reason for GP consultations in the over 85-year-old age group.

Another possible reason for low referral rates to psychology could be the prevalence of physical problems in older adults. Woods (2000) points out the difficulties involved in untangling the interaction between physical problems and affective disorders in the older population. Depression can be mistaken for physical difficulties and vice versa, possibly leading to older people being treated for physical difficulties instead of being referred for psychological intervention, where it might be useful.

Figure 5: Relationship between age and wait.
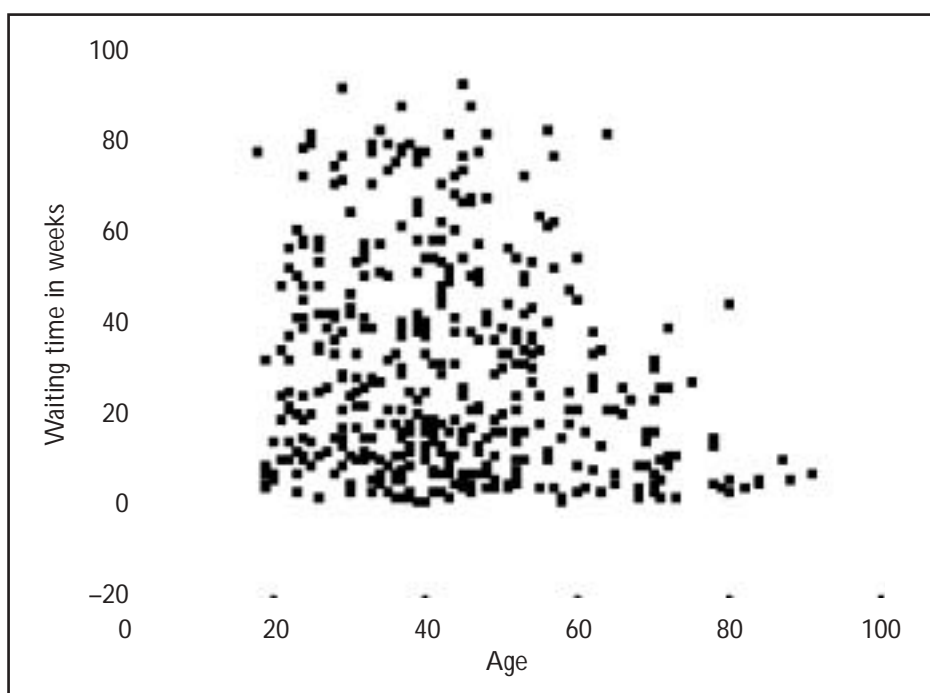
This is not suggesting that an emphasis on physical symptoms is solely coming from those making referrals, it is quite possible that this could be the patients' perception as well. The current cohort of older people were brought up in a time when psychological ways of thinking about problems were less common and when mental health problems carried more of a stigma than they do today. They may, therefore, be less likely to want to view their difficulties psychologically and thus present them in such a way. There is also a tendency for old age in our society to be viewed as burdensome (Warnes, 1993), leading to attitudes in both patient and professionals that difficulties are expected and not much can be done about it.

Recent research within the Borders' Psychology Department found that GPs identified long waiting times and minimal psychology service as their main reasons for not referring patients to the adult psychology service. These factors are likely to also be affecting their referral rates to older adult services. There is currently very limited input to older adults, a situation which is unlikely to change in the near future. Despite this older adults were generally seen sooner than younger adults. This was probably due to referrals from the MHET team being picked up quickly. Once seen, contrary to expectations, older and younger adults have a similar number of contacts with a psychologist. This could reflect the fact that contact data was missing for those still being seen. The highest proportion of whom were amongst the younger adult group.

Another finding of the present study was that when the older group are seen, they more reliably attend appointments than younger patients. This again could reflect cohort attitudes towards the importance of keeping appointments.

The Borders psychology service does seem to be going some way to meeting the Scottish Executive's recommendations for rapid assessment of cognitive decline. However, it is not doing so well on meeting other recommendations such as appropriate capacity for population needs. This lack of service in itself may mean we are not promoting awareness of psychological aspects of illness in the older population simply by not having time to liaise with other services for this group. This raises issues regarding recommendations about equality of access to services and ageism.

Conclusions

The above study highlights the low level of clinical psychology services available to older people in the Scottish Borders, in comparison to recommended staffing levels. Referral rates to clinical psychology services for the over 64s are found to be significantly lower than those for the under 65 population.

The reason for this is unclear, although it is possible that patients' and professionals' attitudes to ageing and mental health problems, confusion of functional difficulties with physical problems, and a limited service to refer to are affecting referral rates.

If patients are referred to psychology services, older patients do not generally have to wait as long to be seen as younger ones and tend to be more reliable attendees. Older patients were found to have a significantly smaller number of contacts with the therapist, although this finding may have been a result of the data set being incomplete for final number of contacts.

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Management of psychological difficulties in later life: A survey of general practitioners

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Abstract

This paper reports on a survey of general practitioners (GPs) in North East Edinburgh. It investigates their management of a range of psychological needs in older people as well as their attitudes towards a psychological approach to treatment. Their knowledge of psychological services available for people with dementia is also assessed. Fifty-five per cent of those contacted responded to a postal questionnaire. Results suggested that although referral of older adults with mental health needs to psychiatry or a Community Psychiatric Nurse (CPN) was not uncommon, referral rate to psychology was low. Low referral rates appeared to be due to lack of awareness of services available, uncertainty regarding appropriate referral criteria and inaccurate beliefs regarding waiting times. The findings suggest that providing GPs with accurate information and education about the psychology service, and management of psychological needs in older adults, may improve access for these individuals to such a service.

Introduction

MENTAL HEALTH PROBLEMS are a significant consideration in the over 65 population, with prevalence rates estimated across studies from around 10 per cent to 40 per cent (Watts, Bhutani, Stout, Ducker, Cleator, McGarry & Day, 2002). However, these figures are likely to be underestimates as detection of mental health problems in this group is limited (MacDonald, 1986; Jenkins & MacDonald, 1994). Even when needs are identified only a minority of older adults are referred onto specialist psychiatric services or psychotherapy (Gallo, Ryan & Ford, 1999; Landerville, Landry, Baillargeon, Guerette & Matteau, 2001; Shah, McNiece & Majeed, 2001). Indeed, the proportion of individuals receiving treatment from a mental health professional is reportedly lower in the over 65s than for any other adult age group (Landerville *et al.*, 2001). This discrepancy cannot simply be explained by reduced prevalence of mental health problems within this population.

A British study by Watts *et al.* (2002) investigating GP management of mental health problems in older adults found that although mild depression and/or anxiety were the most common problems detected by them, identification *per se*, rarely resulted in a decision to either treat, or refer the patient on. The GPs examined tended to defer the decision to treat, choosing instead to monitor their patients' progress. Watts *et al.* (2002) conclude that the low treatment/referral rates suggest that potentially large numbers of psychologically distressed patients in primary care are not receiving appropriate services which could ameliorate their condition.

Within the literature, reasons expressed by referring agents for not referring people with detected mental health problems for psychological intervention include GPs considering medication to be a more acceptable treatment (Landerville *et al.*, 2001), and psychological treatments to be ineffective with older adults (Gallo, Ryan & Ford, 1999); or believing that depression is an expected and understandable consequence of later life (Blanchard, 1996).

The White Paper *Our National Health: A plan for action and change* (Scottish Executive, 2000) identified the health of older people as a national clinical priority. Key objectives of the Executive's national programme for improving health included providing early identification, early intervention and ready access to services and supports for at risk groups, including older people. Following a review of older people's health care, a further Executive paper *Adding Life to Years* (2002) identified a number of areas for improvement and made recommendations on how services should work to promote and support good health and well-being in older people in Scotland. Amongst these were measures to help promote and improve mental health ensuring provision for early diagnosis of mental health problems, effective support, and treatment, tailored to individual circumstances. In addition the report recognised the importance of enhancing awareness in NHS staff of

mental illness in older people, and the need for training of clinical staff to facilitate access to supports and services that could benefit both the individual and their carers. This paper also identified ageism in the NHS in Scotland as a possible factor hindering access for older people to various treatments and interventions.

A recent, influential, paper published by Alzheimer Scotland – Action on Dementia (2000) *Planning Signposts for Dementia Care Services* outlined the multi-disciplinary approach that they considered should be offered to people with dementia, and their carers. It also noted the need for emotional support and specialist counselling for individual patients and their carers, thus underlining the importance for psychosocial as well as medical interventions with this client group. As GPs have a central role in the lives of people with dementia and their carers, being the health professional with whom they are most likely to come into contact (Downs, 1996), it is important that they are aware of services available to their patients. However, previous research suggests that GPs are generally ill prepared to manage the problems associated with dementia and are often unaware of support services available (Downs, 1996).

The local picture
In view of the above it is important to ensure that the service we provide is being appropriately and adequately utilised. The motivation for this study arose following a recent audit of the referrals received by the North East Edinburgh Older Adult Clinical Psychology service in the year following its set up. This was carried out by the Clinical Psychologist with responsibility for the service (Dr Pauline Thomson). Her post was requested, and funded by the Local Health Care Co-operative (LHCC) with part funding dedicated to developing a dementia service. The results of the audit revealed that despite the post being LHCC funded, direct referral rates from GPs was low and only a small subsection of GPs (12 of approximately 70) within the sector were making referrals. These were mainly for problems associated with anxiety and depression. Few people with a primary diagnosis of dementia were referred.

GPs hold a key role as gatekeepers to services, therefore, their knowledge of, and attitude towards, available services is a critical factor in the services individuals under their care receive. Subsequently, it is of central importance that they have an accurate understanding of the interventions available and the services provided by mental health professionals to ensure that their patients receive the optimal level of care available. The audit showed that the Older Adult Clinical Psychology service was underused. It is important to investigate the reasons for this in order to develop the service, and to ensure that older people are not prevented from accessing potentially beneficial psychological input. It was also considered important to assess whether GPs were clear about when to refer

to the psychology service as opposed to other mental health professionals, as a small group of GPs had sought clarification on this.

It was anticipated that the survey would highlight areas of misunderstanding and misconceptions that could then be openly addressed with GPs. It was also hoped that GPs awareness of the specialist older adult clinical psychology service would be increased. This study was interested in the management of a variety of psychological needs in the older adult population differing from previous research that concentrated largely on cases of anxiety and/or depression.

Aims
The aims of the study were to investigate GPs' current management of detected mental health problems in older adults; their attitudes towards psychological approaches with older adults; their knowledge of psychological interventions available to people with a diagnosis of dementia; and to assess how confident they felt about making a decision to refer an individual to psychology as opposed to another mental health professional. It also aimed to educate GPs about potential areas for input with dementia patients.

Method
A postal survey of the 71 GPs based in north-east Edinburgh was conducted using a one-page questionnaire (Appendix 1). Responses were anonymous, and stamp-addressed-envelopes were provided. The items on the questionnaire were developed specifically to examine:

Item 1 GPs' current management of a number of mental health problems experienced by older adults.

Item 2 Possible reasons for non-referral to psychology.

Item 3 GPs awareness of psychological interventions for people with a diagnosis of dementia, and their current and possible future referral of such cases.

Item 4 GPs confidence in differentiating between which mental health professional to refer to.

Item 5 What GPs would consider might help them in deciding which mental health professional to refer to and any additional qualitative information they wished to provide.

Results
Responses were received from 39 (55 per cent) of GPs. Table 1 shows respondents first-line management of identified mental health needs. The percentage of respondents who endorsed each preferred course of action is detailed. These results highlight that aside from identification of a psychotic illness, detection of these mental health needs in older adults, generally does not initially result in a decision to treat or refer. GPs prefer to initially monitor and re-assess.

GPs were asked to indicate if they would consider a variety of options in their management of mental health problems within their normal course of action and therefore to indicate whether they would consider referral to a mental health specialist and to psychology. Results are shown in Table 2. In all but one of the identified cases (carer stress associated with dementia) the majority of GPs indicated that they would consider referral on to a mental health specialist within their normal course of management. Though a much lower percentage indicated that this would be to psychology.

Forty-four per cent of respondents indicated that referral to psychology would never be considered within their normal course of management for any of these difficulties.

Table 3 shows the percentage of agreement amongst respondents to statements relating to reasons for non-referral of older adults to the psychology service. One respondent failed to appropriately respond so their data is excluded from analysis.

These results suggest that the main reasons respondents would not refer on to the older adult psychology service were due to beliefs that long waiting lists existed as well as being unsure as to what would constitute an appropriate referral. Seventy-four per cent of respondents believed that the older adult psychology service had a long waiting list and just over half (51.3 per cent) were unsure what would be an appropriate referral. One respondent considered depression to be an expected and understandable consequence of old age and psychological treatments to be ineffective with the older adult population.

The analyses then turned to GPs knowledge of interventions and their management of difficulties specifically associated with dementia. Firstly, this addressed GP's awareness of possible interventions offered to people with dementia by clinical psychologists. A number of respondents failed to appropriately complete this question. Results are, therefore, based on appropriately completed responses (*N*=29). Analysis of these results is shown in Figure 1.

Table 1: GPs first-line management of identified mental health needs as a percentage of responses.

	Depression	*Anxiety*	*Psychosis*	*Complex Grief Reaction*	*Psychological symptoms associated with physical illness*	*Carer Stress*	*Memory Problems*
Monitor and re-assess	74.4	82.1	10.3	76.9	82.1	74.4	59.0
Prescribe medication	25.6	12.8	10.3	5.1	0	0	0
Refer to CPN	0	0	2.6	7.7	2.6	10.3	0
Refer to psychiatrist	0	0	74.4	2.6	2.6	2.6	38.5
Refer to psychologist	0	0	0	0	10.3	0	2.6
Missing data	0	5.1	2.6	7.7	2.6	12.8	0

Table 2: Percentage of GP respondents who would consider referral to a mental health specialist and to psychology for identified mental health problems.

	% of GPs	
	Consider referral to Mental Health Specialist	*Consider referral to Psychology (n)*
Depression	66.7	15.4
Anxiety	61.5	23.1
Psychosis	97.4	2.6
Complex Grief Reaction	74.4	17.9
Psychological consequences to physical illness	74.4	35.9
Carer Stress associated with dementia	46.2	5.1
Memory Problems	89.7	12.8

Table 3 GPs views regarding possible reasons for non-referral of older adults to psychology.

	% of GP respondents	
	Agree (N)	*Disagree (N)*
You consider that psychological treatments are not effective with the older adult population	2.6 (1)	94.9 (37)
You consider that medication would be a more acceptable treatment for older adults	12.8 (5)	84.6 (33)
You believe that the older adult psychology service has a long waiting list	74.4 (29)	23.1 (9)
You are unsure what would be an appropriate referral	51.3 (20)	46.2 (18)
You consider that depression is an expected and understandable consequence of old age	2.6 (1)	94.9 (37)
You believe that psychologists have nothing to offer people with dementia	17.9 (7)	79.5 (31)

Results for four out of the five interventions speci-fied, show that less than half of respondents were aware of the psychological interventions that are available for people with dementia. Fifty-eight per cent were aware of psychological interventions for co-morbid anxiety but less than 40 per cent were aware of interventions available for individuals experiencing difficulty adapting to their diagnosis, or for those displaying challenging behaviours.

This lack of awareness of available interventions is reflected in the current referral practices of GP respondents. Figure 2 clearly highlights that current referral rates for people with a diagnosis of dementia to the psychological services available are very low. Again, results are based on appropriately completed responses (*N*=37).

However, the analysis suggests that low referral rates may be due, in part, to lack of awareness of services as significantly more GPs indicated that they would refer such cases in the future.

GPs were asked whether or not they felt that they knew when to refer an older adult to a Clinical Psychologist as opposed to another mental health professional. Seventy-seven per cent of respondents were not confident about this.

Figure 1: GP awareness of psychological interventions for people with dementia (% respondents).
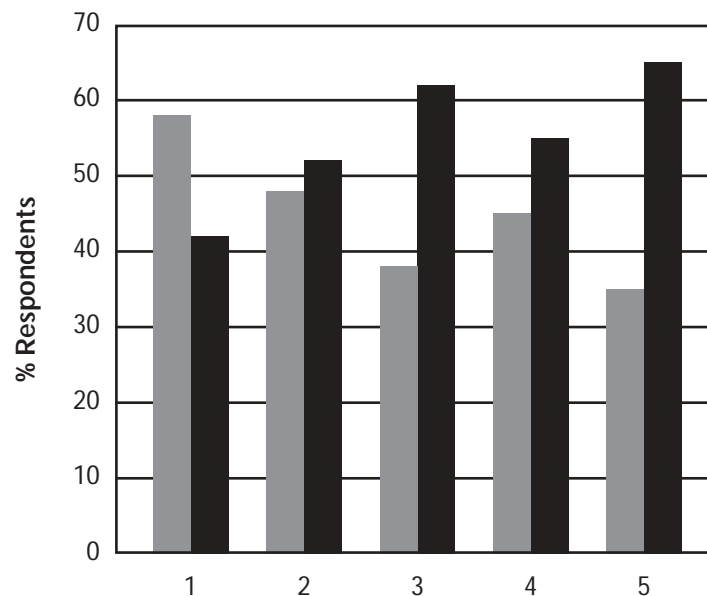
	1	2	3	4	5
Aware of intervention	58	48	38	45	36
Unaware of intervention	42	52	62	55	65

Psychological intervention

Numbers on the x axis correspond to interventions available for: *1 Co-morbid anxiety; 2 Co-morbid depression; 3 Difficulty adapting to diagnosis; 4 Developing aids and strategies for cognitive problems; 5 Challenging behaviours.*

Figure 2: Percentage of respondents who currently refer for psychological intervention for people with dementia and percentage of GP respondents who would do so in the future.
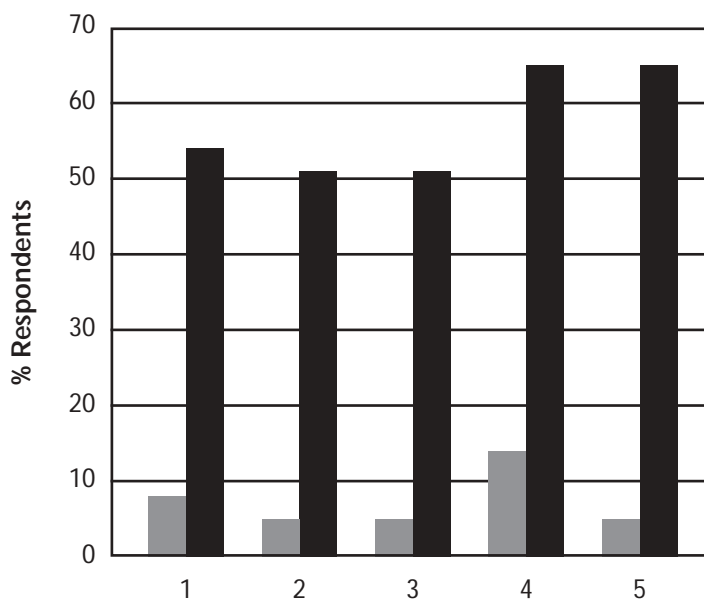
	1	2	3	4	5
Currently refer	8	5	5	14	5
Would refer in future	54	51	51	65	65

Psychological intervention

As outlined previously, the study was designed to gather both qualitative and quantitative data. An open question was included in the questionnaire to enable respondents to suggest ways in which the psychology service could help GPs to feel more confident in their referral decisions. Those who responded to this question tended to ask for referral guidelines and more information on psychological interventions available. Requests were made for education regarding appropriate referrals via either written guidelines or practice visits. A number of respondents indicated that their practice was to refer to the Community Mental Health Team, rather than to an individual professional, assuming that cases would then be allocated to the appropriate service. Two GPs responded that they were not aware that direct referral to psychology was available. A number of respondents again emphasised that they believed waiting times to be a problem, and commented that they would not consider psychology as there was such a sparse service.

Discussion

This study aimed to investigate the current management of mental health problems in older adults in primary care as well as to investigate GP's attitudes towards psychological approaches with this population. It also assessed their knowledge of psychological interventions available to individuals with a diagnosis of dementia. A response rate of 55 per cent, although adequate, immediately introduces a bias to the results as those who responded were perhaps more interested in psychology services than non-responders. Nevertheless, the results provide important information regarding GPs attitude towards, and management of, older people with identified mental health needs in north-east Edinburgh. Although the results cannot be generalised directly, they may provide an insight into more widely held GP beliefs and practices.

Consistent with previous research, GPs initial response to identified mental health needs in this age group tended to be to monitor and re-assess rather than to treat or refer on. This may indicate awareness by GPs of spontaneous remission in some individuals (Watts *et al.*, 2002) and this practice may avoid large numbers of inappropriate referrals to secondary services. However, there is also the possibility that, as discussed in the Scottish Executive paper *Adding Life to Years* (2002), a decision not to treat or refer may be indicative of an ageist attitude resulting in blocking access to services for older people.

Generally GPs in this study were willing to consider referral on to a mental health professional within their normal course of management but this tended to be a psychiatrist or CPN as opposed to a clinical psychologist. In fact, 44 per cent of respondents indicated that they would never consider referral to psychology for older adults with the psychological needs specified on the questionnaire. Their reasons for this were contrary to previous research that suggested that low referral rates to

psychology were due to lack of GP optimism regarding the effectiveness of psychotherapy, or beliefs that depression is an expected and understandable consequence of old age, or that medication is a more acceptable treatment for older adults (Gallo *et al.*, 1999; Landerville *et al.*, 2001). In fact, the vast majority of GPs in this study disagreed with these statements. However, the fact that even one may agree is concerning. The majority of respondents in this study indicated that low referral rates were largely due to the erroneous belief that a long waiting list existed when in fact there currently is none for the older adult service. Uncertainty regarding what would constitute an appropriate psychology referral was a further reason. In addition a large number of respondents (77 per cent) were unclear about when to refer to a psychologist as opposed to another mental health professional. The fact that a number of GPs practice is to refer to a CMHT assuming cases are allocated to the appropriate service suggests they are seeking these teams to make this decision for them. Currently no multi-disciplinary team allocation meetings take place in north-east Edinburgh and GP referrals would be direct to the psychiatric of CPN services. Decisions to refer on to psychology would be taken by these individuals. This does result in some indirect referrals to psychology but is not an ideal situation as it clearly relies on these individuals' knowledge of available psychological services being good.

When given the opportunity to detail in what way GPs felt we could assist them in making the decision about when to refer an older adult to psychology, respondents asked for written guidelines, referral criteria and practice visits. Interestingly, when the psychologist took up the post the previous year, she contacted all GPs individually in the sector, providing them with detailed information regarding the service and offering to visit. Only one practice took up this offer, and the study results would suggest that guidelines given have either been discarded, lost, or considered unhelpful.

The current study also found that a significant proportion of GPs awareness of psychological interventions for people with dementia was poor. This supports Downs' (1996) finding that GPs are often unaware of support services available for those with dementia and may partly explain the low referral rate of this client group. This is clearly a concern as dementia can cause significant problems for the individual, their carers and families, yet psychological services, which could benefit them are underused.

Throughout the analysis of the results of this study, the overriding indication seems to be that there remains confusion in GPs about the referral process to the Older Adult Psychology service and uncertainty about what we can offer to this population, and what constitutes an appropriate referral. The responsibility for clarifying these issues lies firmly with us. To facilitate ready access to psychological services, this study highlights the need for clinical psychologists to provide accurate information to referring agents regarding psychology services available as well as explicitly attending to referral routes to these services. As GPs tend to be the gatekeepers to services for those under their care, it is important, as this study outlines, to examine the factors which are blocking access to services and to address these in order to remove any obstacles to appropriate care for those who may benefit from it. Perhaps on the back of this study, an opportunity has been created to provide education and information to GPs about access to, and availability of, psychology services at a time when awareness of the service has been highlighted. The study results suggest that greater awareness of interventions for people with dementia increased GPs' consideration of referral to psychology. Therefore maximising information provision at this time may facilitate access to psychological services for older adults with psychological needs in the future. Although current rates of referral to dementia support services, available from the psychology service, are very low, estimates of future management indicate a considerable increase in referral for these services with over 50 per cent of GP respondents indicating that referral would be a consideration in the future.

In light of research that has emphasised the under detection of psychological problems in the older age group, (MacDonald, 1986; Jenkins & MacDonald, 1994) it is important to consider that the results obtained in this study only represent management of those cases that have been detected. This suggests that even larger numbers of individuals could be suffering distress and impairment that could benefit from a psychological approach to intervention. The importance of training for GPs and other primary care staff to improve recognition of mental illness in older adults has been noted by Crawford, Prince, Menezies and Mann (1998) and was recommended in the Scottish Executive's paper *Adding Life to Years.* This may be an area for our input also.

Finally, within a service framework it is important to consider the consequences of disseminating information to GPs and other referring agents. Although, no waiting list is currently in operation in north-east Edinburgh, a huge influx of referrals from freshly well-informed referrers would soon jeopardise this position. There is already a shortage of psychologists working within the older adults specialty Lothian wide. The situation is likely to worsen in the future with demographic studies predicting a rise in the proportion of the total population aged over 65, particularly in those over 80 (Kinsella & Velkoff, 2001). Therefore, it is important to consider that knowledge and awareness are futile without adequate service provision.

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Appendix 1: GP's Questionnaire.

1. When you see older adults with the following mental health problems what would be your normal course of action? If you would usually pursue more than one of the following options, please indicate in which order you would do this.

	Monitor & re-assess	*Prescribe Medication*	*Referral to: (please specify)*		
			CPN	*Psychiatrist*	*Psychologist*
● Depression					
● Anxiety					
● Psychosis					
● Complex grief reaction					
● Psychological symptoms associated with physical illness					
● Carer stress associated with dementia					
● Memory problems					

2. Would any of the following be reasons why you would not refer to psychology? Please tick to indicate yes.

You consider that psychological treatments are not effective with the older adult population. ☐

You consider that medication would be a more acceptable treatment for older adults. ☐

You believe that the older adult psychology service has a long waiting list. ☐

You are unsure what would be an appropriate referral. ☐

You consider that depression is an expected and understandable consequence of old age. ☐

You believe that psychologists have nothing to offer people with dementia. ☐

3(a). Clinical Psychologists can offer interventions to people with dementia for the following problems. Please indicate: (a) whether or not you were aware of such interventions by ticking either Yes or No; (b) if you would currently have considered referring such cases to a Clinical Psychologist; (c) having now been made aware of these interventions would you refer such cases in the future.

	(a)		*(b)*	*(c)*
	Yes	*No*	*Currently Refer*	*Would refer in the future*
● Co-morbid anxiety				
● Co-morbid depression				
● Difficulty adapting to their diagnosis				
● Developing aids and strategies for cognitive problems, e.g. memory				
● Challenging behaviours, e.g. wandering, verbal/physical aggression, soiling, etc.				

3(b). If you would still not consider referring such cases please specify why not?...

....

4. Do you feel you know when to refer an older adult to a Clinical Psychologist as opposed to another mental health professional?   Yes ☐   No ☐

5. Is there anything you feel that we could do that would help you make this decision? Please state.

....
....
....

Please add any other comments that you may have (continue on another sheet if necessary).

....
....
....
....
....

Thank you very much for your time.

Flexible training arrangements for clinical psychology

Ken Laidlaw and the University of Edinburgh/East of Scotland NHS Course Executive Team

RECENTLY ACROSS THE east coast of Scotland there has been interest in developing a new 'flexible' approach to training. Partly this interest and consequent development of a new mode of clinical training has come from the NHS areas in the east coast of Scotland and the funding agency for training in clinical psychology in Scotland, NHS Education for Scotland, NES. In response to this demand, and the availability of funds for an expansion of trainee places, a flexible 1 + 4 years modular, flexible training scheme was developed. A training cohort of 20 additional trainees to our 20 recruited for the three-year fixed training scheme were recruited to start their training in October 2003. Further recruitment of flexible trainees has occurred for October 2004.

The new 'Flexible Training Scheme' retains all of the main components of the current fixed-term modular training scheme but increases flexibility since the configuration and duration of training can be negotiated in response to service need, individual factors and local circumstances. It is this feature that may be of particular interest to PSIGE members as some departments may choose to recruit trainees to older adult flexible training posts as a way of helping an older adult service grow. The service is assured of someone in post for up to five years and developing and gaining specialised knowledge during their time training and contributing to the service. Given that smaller specialist services such as older adults are often vulnerable to the mobility of trained staff this sense of having someone interested in older adults in post for a prescribed period of time can be attractive and can lead to long-term forward planning. While a service cannot and should not make any demands that training leads to an expectation that an individual trainee will stay on in a service after their training has been completed, it is, of course, up to the service to ensure that their service is attractive enough that individuals do not want to leave.

The main components of the flexible training scheme are as follows:

- Trainees complete a modified first-year training in Adult Mental Health and Learning Disabilities.
- At the end of the first year, trainees are expected to continue with training in addition to providing a local service contribution.
- Each trainee is provided with an Individual Training and Development Plan that sets out the elements of their training on a timescale that can extend up to five years.
- The Flexible Training Route retains the same overall ratios of supervised experience, self-directed study and academic teaching for the total time spent in training. Irrespective of the duration of Individual Training and Development Plans (e.g. four or five years), the total time spent in training is three years in total.
- The quality assurance checks (accreditation procedures overseen by the Committee of Trainers in Clinical Psychology) apply equally with the flexible training scheme (1 + 4 years).

THE 2005 PSIGE CONFERENCE
IS THE 25th ANNIVERSARY
(SILVER JUBILEE) CONFERENCE
AND THE ORGANISING COMMITTEE IS SEEKING:

● PHOTOS   ● PROGRAMMES

● VIDEOS   ● ANECDOTES

ABOUT CONFERENCES

1980 – 2004

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Editors' Note: Please let us know of any changes or errors.

A one-day conference run in collaboration with **PSIGE** (Psychology Specialist Group in Older People) and **NIMHE** South West (National Institute for Mental Health in England).

AGEISM IN MENTAL HEALTH
Affirming our work with older people

Friday October 8th 2004
Fee: £90   **Venue: Hilton Hotel, Bournemouth**

Programme

9.30am -	Coffee and registration
10am -	Chairman's welcome
10.10am-	Ageism in the general hospital setting – Dr Vaughan Pearce, Consultant Physician – Care of the Elderly - Exeter
10.30am-	NSF for Older People – Dr Roger Bullock, Academic Secretary, Faculty of Old Age Psychiatry, Royal College of Psychiatrists
10.50am-	Ageism – a carer's view - Mrs Hartnell-Beavis
11.10am-	Religion, spirituality and ageing - Professor Peter Coleman, Professor of Psychogerontology, University of Southampton
11.30am-	Questions from the floor
11.45am-	Coffee
12pm -	**Keynote presentation: Ageism: an interpersonal understanding** Dr Laura Sutton – Consultant Psychologist, Ipswich & Dr Jason Hepple – Medical Director, Somerset Partnership
1-2pm -	Lunch
2pm -	Workshops - Dr Jane Pearce - Consultant Old Age Psychiatry, Oxford Dr Mim Prins - Consultant Neuropsychologist, Somerset Partnership Madeleine Jevon – CAT therapist, Somerset Partnership Dr Shelagh Axford – Associate Specialist - Norfolk
3.30pm -	Tea
4pm -	Plenary
4.30pm -	Close

The aim of the day is to explore the pervasive nature of ageism and particularly how this affects older people with mental and physical health problems in the NHS.

The morning's speakers will contribute perspectives on ageism which should lead to some lively discussion. The Key Note speakers will re-frame ageism as an interpersonal phenomenon and use this perspective to challenge traditional models of working with older people.

In the afternoon there will be 4 parallel workshops offering experience of affirmative ways of working covering systemic, neuropsychological and psychotherapeutic themes.

Further information: Janet George, Secretary to Dr Hepple, Magnolia House, 56 Preston Road, Yeovil, Somerset BA20 2BN
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