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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 Editors

Sinclair Lough & Penny Fooks

THERE IS A major change to the Editorship from this issue onwards. We are now in a handover year to the prospective next editor, who will hopefully take up office at next year's AGM. We are treductivated that Penny Fooks has very kindly offered to pick up this role. Penny will shadow me over the next few issues, taking

on an increasing responsibility. Since we both work in the same region this arrangement makes good geographical sense. Ian has, therefore, stepped down. I am sure all of you will join me in thanking Ian for all the efforts he has made on behalf of the *Newsletter* over the past four years.

Letter from the Chair

Nicky Bradbury

THE AGM AT THE Chester conference in July formally ended my two-year term of office as Chair of PSIGE. The time seems to have flown past. Although the responsibility of the role could, in theory, be daunting, the support, energy and commitment of the rest of the committee ensured that, in practice, it didn't feel that way.

I now have one year as outgoing Chair. This is a role designed to provide support for the new incumbent (although I'm sure Steve Boddington will be an excellent successor). It gives me a seat on the committee without any official responsibilities – an opportunity to continue to play a part in the interesting bits for a little longer!

Returning to driving after a stroke: Development of an assessment process

Jane Barton & Kate Lipka

Background

ALARGE PART OF stroke rehabilitation in Sheffield is undertaken in the community, by a multidisciplinary community rehabilitation team. Rehabilitation is goals led, and over time we became aware that increasing numbers of clients entering our service identified returning to drive as their main therapy goal. This raised a number of issues for us:

- The occupational therapists had traditionally used the Stroke Driver's Screening Assessment (Nouri & Lincoln, 1993) to assess for fitness to return to driving. However, there were a number of occasions where they felt that, even where some clients had successfully passed this screening test, in their clinical opinion there were other, executive type of issues, that were indeed a problem for the client, and that these had not been adequately formally assessed.
- Referral to our regional mobility centre for an on-road driving assessment entailed a lengthy wait (up to nine months at the start of this project).
- Information regarding legal requirements and DVLA regulations was inconsistently given to clients across our care pathway.
- Communication between primary and secondary care, and indeed between services within sectors, was poor. This often resulted in, for example, GPs informing clients that they were fit to return to driving, while therapists within the community rehabilitation teams had concerns, primarily regarding deficits in cognitive functioning.

The project

A project group of occupational therapists and a clinical psychologist, from across the whole of the stroke care pathway (i.e. secondary, primary and intermediate care), was set up to address these concerns.

Four aims were identified:

- To update and standardise client information, and to make this uniform across the care pathway.
- To develop a comprehensive cognitive assessment battery.
- To facilitate faster and more timely access to on road assessments, preferably while the client is still receiving rehabilitation.
- To develop better systems of communications between the services treating the clients, and the medics who make the decisions regarding fitness to drive.

Section A: Client and clinician information

An information leaflet was developed, *Driving after stroke*, giving details on: how the stroke might have affected you, driving regulations from DVLA, procedures to follow regarding DVLA and informing insurance companies, and useful contact details for mobility centres and DVLA. This leaflet is now posted on the Stroke Association website (www.stroke.org.uk). The leaflet is now distributed to all clients in our services, who were drivers prior to their stroke, both when in hospital, and also when entering community rehabilitation services.

Drawing on the guidelines from DVLA, an information sheet for occupational therapists was developed, giving details of legal obligations regarding duty of care to the clients, and actions to be taken. Included is information regarding ethical issues, such as

when to break confidentiality, or when to seek advice from the Trust solicitor. These guidelines are used by all occupational therapists in our stroke services.

Section B: Cognitive assessment

Two important publications helped to shape the development of our battery. McKenna (1998) highlighted the importance of adopting an approach to assessment, which is focussed on assessing neuropsychological skills that are known to be important in driving behaviour. These were identified as those of the visuo-perceptual system, the praxis system, and the executive system. This approach is in contrast to more traditional approaches which have tended to use intelligence based batteries to assess fitness to drive. In 2001, the British Psychological Society published an important document, *Fitness to drive and cognition*, which reviewed the evidence base for the relationship between neuropsychological test performance and driving behaviour. While the document cannot make clear recommendations regarding which test materials to use for clinical assessment, at least the document is a starting point from which to think about which tests (or subtests) might work better in helping to assess the different neuropsychological functions that are known to be essential for driving.

On the basis of these two documents, a preliminary battery of tests was put together. However, other considerations influenced our choices as well. For example, as our assessments were to be administered by occupational therapists (under supervision by clinical psychologists), tests only licensed for use by psychologists were excluded. The use of some tests by OTs requires them to undertake formal training with the publishing test company. Money was sought, and an arrangement for the test company to visit Sheffield, in order to train 35 of our OTs in the use of these tests. Training on administering and interpreting the whole of the battery was delivered by clinical psychologists.

The individual components of our battery reflects the overall structure identified by McKenna (1998), and is detailed below.

A: The ability to monitor cognitive processes and behaviour (the executive system)

As part of daily living it is necessary to constantly adapt responses in order to function effectively in a range of situations. This includes the ability to anticipate, plan ahead, self-monitor and make decisions. Adequate executive functioning is important for this self-regulation of behaviour. The executive system is known to be heavily subserved by structures in the frontal lobes. Following injury to the frontal lobes, impulse disinhibition and socially inappropriate behaviour may be present. Loss of impulse control may lead to outbursts of verbal and physical aggression, with little or no provocation. The resulting deficits can often produce poor judgements both intellectually and socially, and can impair safety on the road. Whilst driving, it is necessary to integrate behaviour, and to respond appropriately and instantaneously to changing situations. Assessment of executive function in relation to driving is, therefore, of paramount importance. (Extracts taken from *Fitness to drive and cognition*, BPS, 2001.)

Lundqvist (2001) argues that information processing speed is important for driving performance. The driver has to handle multiple simultaneous stimuli, selecting what is relevant and filter out intrusive stimuli. All has to be processed during a very short time. Although driving is largely an automatised process, there are times when something unexpected will happen, and the driver needs to respond, i.e. controlled processing. Thus, shifts between automatised and controlled processing are continuously demanded during driving, depending on the traffic situation and the driver's experience. Controlled processing is required when the routine reactions are not sufficient. Then, a central executive is required. It serves to maintain directed driving behav-

our and to execute attentional control, which is necessary for efficient driving.

Research indicates that there is some correlation between individual tests of executive functioning and in-car performance, but no consistency with which test correlates with driver safety. The following tests were chosen to assess the neuropsychological functions identified:

(a) Planning, monitoring and organising

Three subtests from the Behavioural Assessment of the Dysexecutive System (BADS) (Wilson *et al.*, 1996) were selected to assess these functions.

(i) Key search

This task draws on planning and monitoring one's own performance, and devising an effective strategy.

(ii) Zoo map

This test assesses spontaneous planning ability when structure is minimal versus ability to follow a concrete externally imposed strategy when structure is high. Subjects are required to monitor their own performance to minimise errors, and to modify their performance accordingly.

(iii) Six elements

This test assesses how well a person can organise them self, and monitor their own performance. It also taps into prospective memory. It requires the person to be able to switch between tasks.

(b) Selective, divided and switching attention

Three subtests from the Test of Everyday Attention (TEA) (Robertson *et al.*, 1994), as well as the Trail Making Test (Army Individual Test Battery, 1944) were selected to assess the following functions:

(i) Map search and telephone search

These subtests are sensitive to a visual selective attention deficit, reflecting a difficulty in ignoring irrelevant information and picking out the targets in complex visual arrays.

(ii) Telephone search while counting

This test assesses divided attention (the ability to do more than one thing at once). However, it also loads onto sustained attention. It may be that sustained attention is an important factor in dual task performance (e.g. remembering to attend to a second task while engrossed in the first). This test is sensitive to the ability to handle the complex demands of everyday life. Some people attempting this subtest simply cannot do both tasks at the same time: they may stop the telephone search whenever they have to count, or they may even ignore the counting task. This will be apparent in their final decrement score, but it is also useful to observe how subjects respond to competing demands, as this may provide pointers for teaching them strategies to manage information overload in everyday life.

(iii) Trail making test

This is a test of complex visual scanning with a motor component. It is a dual task involving visual conceptual and visuomotor tracking. It also requires the monitoring and switching of attention between two tasks.

(c) Information processing

One subtest from the Adult Memory and Information Processing Battery (AMIPB) (Coughlin & Hollows, 1985) was selected.

(i) Information Processing Task (Form 1, Task A)

This task involves a rapid but repetitive mental activity and places relatively little load on memory, reasoning or visual perception. It is possible to assess separately motor speed and mental activity.

B: Analysis of the visual world

There is much evidence to indicate that two distinct systems can be differentiated which can be selectively impaired following cerebral pathology. These are shape perception, and perception of spatial relationships between objects and oneself in the visual fields. It has been difficult to identify tests

that assess only one aspect of visual functioning. For example, assessing three dimensional location in space whilst minimising the role of other systems has proved difficult. Research evidence is weak for the distinctive contribution to be made by assessing *shape perception*, but stronger for the role played by assessing *visual spatial perception*. Assessment of the latter requires careful consideration of the test to be used, as deficits in motor skills will inevitably impair performance on visuo-constructional tasks.

Tests of neglect which are used clinically tend to be based on paper and pencil cancellation tasks which do not cover extrapersonal space beyond the physical reach of an individual, which is the most salient dimension in driving. Assessments to detect neglect should encompass different types of neglect, though our understanding of how visual neglect fractionates into particular syndromes is still evolving. As with many other complex cognitive functions, there is a strong inter-relationship between the presence of neglect and performance on other tasks, e.g. reading, visuo-spatial ability, visual memory and executive functions. Therefore, studies which examine the relation between these tasks and driving should either partial out the effects of visual neglect or exclude clients with neglect. (Extracts taken from *Fitness to drive and cognition*, BPS, 2001.)

The following subtests from the Visual Object and Space Perception Battery (VOSP, Warrington & James, 1991) were chosen.

(i) Incomplete letters

When the perceptual clarity of a letter is degraded it becomes more difficult to identify. Neuropsychological studies have established that clients with right hemisphere lesions may have a selective deficit reading degraded letters, notwithstanding the fact that dysphasia is associated with left hemisphere lesions. Research has shown that in this group, subjects experience a degradation of their visual vocabulary such that more distinctive features must be in view for the object to be identified. This test is of object

perception of graded difficulty, and provides a degree of difficulty, rather than a pass or fail score.

(ii) Position discrimination

For normal subjects the capacity to perceive the relative position of objects in two-dimensional space is good. Using this subtest, a misalignment of much less than 1° of visual angle can be detected, and such deficits are often seen with right hemisphere lesions.

(iii) Cube analysis

It has been suggested that the interpretation of three-dimensional space in two-dimensional representations may involve the perception of more complex forms of spatial relationships than are tapped by tests of discrimination of location. This is a measure of the perception of complex spatial relationships, and deficits are seen with right hemisphere lesions.

Section C: On-road assessments

An arrangement was made for two registered driving assessors from our regional mobility centre to come to Sheffield one day a month, in order to provide on-road driving assessments. These assessments were for our clients undergoing community rehabilitation, who had already had the cognitive assessment provided by the occupational therapists, the results of which are to be used to feed into the on-road assessment. Overall results of the on-road assessment are then fed back to the client's GP.

This arrangement with the regional mobility centre unfortunately no longer stands. Alternative arrangements have now been made with an independent registered driving assessor to provide on-road driving assessments. In addition, for those clients where no concern is raised regarding their ability to return to driving, recommendations are made to undertake a two-hour return to driving lesson with the British School of Motoring. In all instances clients are advised to independently have a peripheral vision assessment by a registered

optician, and the results be made available at the time of the on-road assessment.

Section D: Communication with primary care

A system has been developed whereby for all clients entering the community rehabilitation services, who were driving prior to their stroke, a letter is automatically sent to their GP, informing them that the client is undergoing rehabilitation, and that as part of that, there will be the option to assess for fitness to drive. The results of this assessment will be fed back to the GP, who will then be able to use these to make more informed decisions as to a person's fitness to return to driving. This system has been slow to establish, but there have been a number of examples where the GP has commented on the usefulness of this system, and has even delayed making such a decision until these results have been available. A standardised proforma has been developed which gives detail on the cognitive functions assessed, tests used, and compensatory strategies and recommendations made, so that individual client test results can be easily incorporated into a personalised report.

Section E: Challenges and future directions

Undertaking this sort of work with clients can be extremely challenging. The importance of driving for many people can mean that the threat of not driving can be an extremely emotional issue. While occupational therapists are not actually in the position of making decisions as to whether clients are able to return to driving or not, they are nonetheless often in the position of delivering disappointing news, e.g. feeding back of cognitive assessment test results. Training in relation to working with difficult emotions, and in 'breaking bad news' has thus been undertaken.

The extent to which the cognitive assessments undertaken can reliably predict safe driving behaviour remains questionable. The current process does not purport to reliably make this assessment, but rather can highlight where clients may have difficulties with aspects of cognitive functioning which we know from the research literature is fundamentally important for driving behaviour. Our next step is to compare the results of the on-road driving assessments with the individual cognitive assessment results, in order to help to determine the validity of these assessment measures.

The situation remains that this driving assessment 'service' is entirely optional for patients, and only available for those stroke patients within our community rehabilitation services, and not for other stroke patients who fall outside of this service. This reflects where the limited clinical psychology provision is placed within the stroke care pathway.

Summary

This project has started to address some of the complex issues that we often face with clients wanting to return to driving after a stroke. We have attempted to standardise, and routinely administer, the information that we give to clients across our care pathway. We have also made attempts to provide more comprehensive cognitive assessments for clients, which we hope will contribute towards making more informed decisions regarding capacity to drive. Finally, we have attempted to make the assessment process more timely, by addressing the issue of returning to driving while our clients are undergoing rehabilitation, where there is the opportunity to address any remedial problems that are identified.

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Accessing views of client and carer satisfaction within a memory clinic service

Victoria Molyneux, Clare Punshon & Jane Nowlan

Previous literature exploring satisfaction with services for individuals with dementia has mainly focused upon the opinions of carers (Drebing et al., 2004), staff members (Harper, 2000) or GPs (Gardner et al., 2004). This is a result of the stereotyped belief that individuals with dementia are unable to provide useful information about their experiences (Kane et al., 2003). Van Hout et al. (2001) have attempted to address this issue through the use of the Dementia Care Satisfaction Questionnaire. The current study used an adapted version of this survey to access the opinions of 20 client/carer dyads. The discrepancies between the opinions of clients and their corresponding carer were explored. The results suggested that on most aspects, clients and carers expressed similar opinions. Client and carer opinions were more varied concerning the need for additional support. The findings of the current study were discussed in relation to previous research.

GROWING AWARENESS OF dementia disorders, particularly within the public domain, has led to an increase in the need to assess such symptoms and provide early diagnoses (Philpot & Levy, 1987). The National Service Framework for Older People (Department of Health, 2001) highlighted the importance of single assessment, ease of access, early recognition and management of mental health problems. In order to meet the increase in demand, memory clinic services were developed.

The first clinics emerged in the UK in the 1980s following successful application in North America in the 1970s. Initially, these clinics were designed to facilitate research into disorders such as Alzheimer's disease (Wright & Lindesay, 1995). However, more recently their role has evolved and now includes a much broader remit (Phipps & O'Brien, 2002). Currently, no single definition of role or function of memory clinics exists (Phipps & O'Brien, 2002). In their review of the literature, Lindesay *et al.* (2002) suggest that most memory clinics operate a multi-disciplinary model involving assessment, investigation, diagnosis and information giving.

Literature assessing the strengths of memory clinics has suggested that they attract

clients who are younger than traditional Old Age Psychiatry services and that clients assessed with dementia at memory clinics are, on average, two years earlier in the progression of their illness (Luce *et al.*, 2001). Clinical governance and quality improvement in the NHS have had a direct effect upon the development of memory clinics. The National Institute for Clinical Excellence (NICE, 2001) and the National Service Framework for Older People (Department of Health, 2001) have shaped the contribution of memory clinics in the care of individuals with dementia. As part of this process, the Department of Health (1992) stated that everyone who provides or purchases services has a duty 'to consult users and their carers in the drawing up and monitoring of community care plans'. This document also added 'they will need to ensure that service users are enabled to define their own health and social care to the maximum of their ability' (Department of Health, 1992). Many researchers have highlighted the importance of assessing patient satisfaction as a marker of quality of care in healthcare services (Donabedian, 1988; Berwick, 1994; Fitzpatrick, 1991).

Contrary to the ideas stated in these policies, research into satisfaction with services of individuals with dementia has

been very limited (Sperlinger & McAuslane, 1994). Some authors have attempted to explain this through statements such as '[Subjects with Alzheimer's disease] cannot comprehend questions or report on subjective states' (Albert, 1998) and 'Elderly patients with dementia are not always able to contribute usefully to satisfaction surveys' (Simpson *et al.*, 1995). Beliefs such as these have led to a large majority of researchers focussing upon the satisfaction of carers of individuals with dementia (Simpson *et al.*, 1995; Townsend & Kosloski, 2002; Wald *et al.*, 2003; Drebing *et al.*, 2004), staff members (Logsdon *et al.*, 1999; Harper, 2000) or the satisfaction of General Practitioners (Gardner *et al.*, 2004).

In an attempt to address this underdeveloped area of research Sperlinger and McAuslane (1994) used qualitative methods to highlight the importance of exploring the experiences of the person with dementia. They assessed client satisfaction with a day centre service. This study attempted to use insight from work on satisfaction in individuals with learning disabilities in order to access client views. The study involved using an interview structure with open-ended questions. They concluded that many individuals were able to provide relevant information and, even for those who were unable to provide specific answers, a general sense of overall level of satisfaction was obtained.

Kane *et al.* (2003) suggested that the stereotyped belief that cognitively impaired individuals are unable to provide useful information was inaccurate. This study utilised interviews to elicit the opinions of Nursing Home Residents both with and without cognitive impairment on their Quality of Life. Using Likert-type response options wherever possible, they concluded that quality of life could be measured in a valid way using self-report with cognitively impaired residents. These conclusions on quality of life have been supported by findings from other studies (Logsdon *et al.*, 1999; Terada *et al.*, 2002; Van-de-Water *et al.*, 2003).

Boyer *et al.* (2004) attempted to explore concern surrounding the reporting of factual information by individuals with dementia. They assessed the level of agreement between reports on health status of individuals with dementia and proxy reports (from family and caregivers) by administering the 38-item Nottingham Health Profile Questionnaire to each. They found that family proxies reported lower functioning compared to individuals with dementia on a range of items (for example, energy and social isolation). Carers reported lower functioning on estimates of physical mobility. The authors concluded that results based upon proxy reports of health for individuals with dementia should be interpreted with caution.

All of these studies have provided support for the changing focus from aiming literature and support services at carers to realising that individuals with dementia (particularly in the early stages) are able to share their experiences if they are given the opportunity (Yale, 1995).

In recent years, researchers have become more interested in the satisfaction of service users of Memory Clinic services. Hill *et al.* (1995) provided one of the first studies attempting to explore this topic. They used a questionnaire design in order to elicit the expectations of users of a memory clinic. However, they decided that clients and carers should complete the questionnaires jointly as there was variability in clients' ability to complete the questionnaire. The study found that less than half of the participants thought the visit to the memory clinic had been adequately explained and 15 per cent felt unable to ask any questions they wanted to. Also, 30 per cent of the participants were unable to state the diagnosis they had received. Overall, 50 per cent stated that they were satisfied, 12 per cent were not satisfied and 38 per cent provided answers suggesting mixed satisfaction. One of the major weaknesses of this study was that clients and carers filled in the questionnaire

jointly. This led to uncertainty about whose views were actually represented by the results.

Following on from this research, Van Hout *et al.* (2001) completed an observational study looking at satisfaction with memory clinic services. They took a wider view of the term 'service user' and included individuals with dementia, their carers and their general practitioners. This study involved interviewing clients and carers using a Dementia Care Satisfaction Questionnaire. The questionnaire involved 23 statements on experiences of care and were rated on a five-point Likert Scale. GPs were given self-constructed questionnaires. Response rates were 30 per cent for clients, 96 per cent for carers and 96 per cent for GPs. Results reflected users satisfaction with the way diagnoses were communicated, the attitude of clinicians and the usefulness of the diagnostic service. Areas of dissatisfaction included vagueness of diagnostic information for clients and carers and insufficient nature of information for carers and GPs. The study also found that the opinions of clients, carers and GPs were not related, suggesting differing service needs.

Foreman *et al.* (2004) also used the Dementia Care Satisfaction Questionnaire (Van Hout *et al.*, 2001) in order to access user views of satisfaction. This study utilised postal administration of the questionnaire and achieved an overall response rate of 33 per cent (193 caregivers and 45 clients). The results suggested that there were differences between factors rated as most important for carers and clients. For carers, they were more likely to be satisfied with the service if they felt the staff had supportive and caring attitudes. For clients, their satisfaction was linked mainly to the appropriateness of diagnostic information received. However, one difficulty with postal questionnaires is in determining who has completed them and consequently whose opinions have been expressed.

In light of the background literature described here, the aims of the current study

were:

- i. To access the views of clients and carers on satisfaction with a memory clinic service.
- ii. To compare the views of clients and carers – to explore similarities and differences in perceived experiences of the service.

Method

Participants

Participants included all attendees to follow-up appointments at the memory clinic during a four-week period. Twenty clients with a diagnosis of Alzheimer's disease completed the questionnaire. For each client, the carer who attended with them also participated. Clients who attended the memory clinic for an initial assessment appointment, hence possibly receiving a diagnosis, were not included in the present study. This decision was based on ethical considerations, that is, clients and their carers may have received potentially distressing information and taking part in the study could have prolonged their distress. An overall response rate of 64 per cent was achieved.

Fifty-five per cent of the client participants were female and all were over 65-years-old. Seventy per cent of the carer participants were female and 50 per cent were over 65-years-old. Forty-five per cent of clients attended with their spouses, 35 per cent with their children and 20 per cent attended with someone other than these.

Measures

The questionnaire design was based upon the dementia care satisfaction questionnaire (van Hout *et al.*, 2001). The questionnaire consisted of 14 questions and was adapted in order to take into account issues most relevant to the local service. The questionnaire was piloted on six individuals in order to assess suitability of layout and content. Eleven of the questions required the participant to use a five-point Likert scale (where 1=Strongly Disagree and 5=Strongly Agree)

in order to answer. One question about contacting support services had only three options (i.e. Yes, No and Intend to). Two of the questions were open-ended and invited the participants to comment upon the service they had received. The questions covered topics including satisfaction with assessment and diagnosis, information and advice provided by the service and future developments. Client and carers each received a copy of the questionnaire to complete. The questions were exactly the same for both sets of participants. The questionnaires were coded in order to allow for comparison of satisfaction ratings between the data sets whilst retaining anonymity.

Consent

Alzheimer's disease is recognised to affect an individual's decision-making capacity (National Bioethics Advisory Commission, 1998). In order to address concerns over obtaining the informed consent of clients, the present study requested consent separately from both the client and their carer. The use of additional proxy consent was deemed appropriate due to the minimal risks and potential benefits of the current study.

Procedure

The questionnaires were administered in a private interview room. Where possible, the questionnaire was completed solely by the individual. The facilitator was present to provide assistance as required. When support was required it was provided in a standard format, that is, the questionnaire was used to conduct structured interviews. Facilitators were able to monitor that the views being expressed were those of the individual and were not biased by others. None of the participants showed any signs of distress and the small percentage who were unable to complete the questionnaire were sensitively supported by the researcher.

Results

Satisfaction

As shown in Table 1, overall, 95 per cent of

participants reported a high level of satisfaction with the treatment received at the memory clinic.

Findings from clients and carers indicated a number of positive aspects of the memory clinic service. They reported that:

- What they had to say was taken seriously.
- They had been told everything they wanted to know.
- They understood the diagnosis.
- They were happy with the procedure of conducting home visits.
- They would know who to contact if they needed help.

Clients and carers reported some areas for future improvement. They indicated that:

- Some clients did not know what to expect from the memory clinic.
- A small amount did not receive information on support services. Approximately half of the participants had not contacted any support services.
- Client and carers were divided over whether additional support both on the day of diagnosis or in the weeks following diagnosis would be useful.

In addition to the above findings, the qualitative data produced from the open-ended questions further confirmed these results.

Discrepancy

The purpose of using discrepancy scores to analyse the data was to identify differences of opinion within the client/carer dyads. The maximum possible discrepancy score was 4 (this would occur if one individual said that they strongly agreed to a statement while their partner strongly disagreed). The minimum possible discrepancy score was 0 and this would be achieved if both partners expressed identical views. Discrepancy data for appropriate questions is displayed in Table 2.

As shown in Table 2, in the majority of cases there was little or no discrepancy on each item. This suggested that, in most cases, the opinions expressed by clients and carers were similar.

Question 10, concerned with opinions

Table 1: Combined data for client and carer ratings of satisfaction (percentages).

		Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Q.1	I knew what to expect from the memory clinic	12.5	33.3	31.3	16.7	6.3
Q.2	I understood the diagnosis	16.7	70.8	12.5	0	0
Q.3	I felt that what I said was taken seriously	45.8	50	4.2	0	0
Q.4	I was happy to be visited at home	31.3	56.3	6.3	6.3	0
Q.5	I am happy with arrangements for collecting medication	21.1	47.4	10.5	10.5	10.5
Q.6	I was told everything I wanted to know	23.4	72.3	4.3	0	0
Q.7	I received information on support services	9.1	63.6	13.6	11.4	2.3
Q.8	I would know who to contact for help	28.9	48.9	17.8	2.2	2.2
Q.9	I am satisfied with overall treatment	37	58.7	4.3	0	0
Q.10	More support on the day of diagnosis would be useful	4.4	35.6	15.6	31.1	13.3
Q.11	More support in the weeks following diagnosis would be useful	4.7	32.6	11.6	41.9	9.3

Table 2: Discrepancy data for client and carer opinions of satisfaction (percentages).

		0	1	2	3
Q.1	I knew what to expect from the memory clinic	40	40	20	0
Q.2	I understood the diagnosis	65	35	0	0
Q.3	I felt that what I said was taken seriously	45	50	5	0
Q.4	I was happy to be visited at home	0	75	25	0
Q.5	I am happy with arrangements for collecting medication	54	46	0	0
Q.6	I was told everything I wanted to know	63	37	0	0
Q.7	I received information on support services	44	44	12	0
Q.8	I would know who to contact for help	41	53	6	0
Q.9	I am satisfied with overall treatment	33	67	0	0
Q.10	More support on the day of diagnosis would be useful	28	33	28	11
Q.11	More support in the weeks following diagnosis would be useful	59	29	12	0

regarding the usefulness of additional support on the day of diagnosis, received a discrepancy score of 3 for 11 per cent of participants. This suggested a large discrepancy between the opinions of these clients and carers. On further exploration, it seemed that the clients were more likely to disagree that additional support would have been useful.

Discussion

The present study genuinely accessed the views of clients and carers regarding the service they had received at the memory clinic. The majority of service users reported that they were very satisfied with the overall service received at the memory clinic. Service users also identified a number of areas for possible future development. In response to open-ended questions, clients in particular commented that they had appreciated their opinions being valued and having the opportunity to comment on the service they had received.

The present study was in many ways a pilot. The very real contribution of clients as well as their carers suggested that the study was successful. Furthermore, it has allowed the memory clinic to plan future service development around those needs identified by its clients and their carers. The current study has supported the view that clients with dementia should be encouraged to express their opinions. It is also in line with Department of Health guidance (1992) stating that service users should be encouraged to define their care as far as possible.

The current study has further refuted the view that individuals with dementia cannot contribute to satisfaction surveys (Simpson *et al.*, 1995). Rather, it has added support to findings of Kane *et al.* (2003) who suggested that individuals with cognitive impairment are able to meaningfully engage in a satisfaction survey.

The results of the present study reflect those reported by previous studies in that individuals with dementia were able to complete satisfaction questionnaires

regarding services (Van Hout *et al.*, 2001; Foreman *et al.*, 2004). However, these studies suggested that clients with dementia provided different levels of satisfaction from their carers. Discrepancy scores in the present study have shown agreement within client/carer dyads on the majority of questionnaire items. This lack of differential satisfaction has suggested that the memory clinic service in question was able to adequately meet the needs of both clients and carers.

Limitations of the current study

The present study was an attempt to address the inherent difficulties of accessing the views of individuals with dementia. A facilitated questionnaire design was chosen so that support could be provided should participation cause distress. However, using a questionnaire design limited the information provided by the participants to ratings on a Likert scale. The benefits of using this data collection method included the provision of a structure for answers rather than requiring spontaneous response. Indeed, this seemed to be the case in the current study as individuals with dementia were less likely to complete the open-ended questions.

It is important to consider the possibility that client views were somehow affected by the carer views. Whilst it was important for clients and carers to complete the questionnaires in the same room (in case of distress), the researcher was present in order to ensure that the client was able to express their views and was not asking the carer what they thought. This was highlighted in the information sheet at the beginning of the meeting and if the client requested help it was provided by the researcher not the carer. Given this arrangement, it is difficult to see how the views expressed by clients could have been affected by the view of carers.

The present study administered questionnaires in the Memory Clinic building, to service users still in contact with the service. This decision was made because there were many ethical issues with the alternatives. However, it is recognised that such a situa-

tion may have inflated participant's satisfaction scores (LeVois *et al.*, 1981). Many of the responses received from participants in the current study were positive about the services provided by the memory clinic. However, the mixed results obtained concerning further support suggested that participants were able to criticise aspects of the service.

Summary

In summary, the present study has accessed the views of clients with dementia and their carers regarding satisfaction with the memory clinic service. The results have supported the idea that the opinions of individuals with dementia should be considered in the future development of services.

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Does age influence the perception of age?

Stephane Duckett

HOW DO WE define ourselves? According to Symbolic interactionism (G.H. Mead) we do so through our involvements with others – it is only in assuming the role of the other that we begin to perceive ourselves as others see us. From this process self-consciousness, empathy and ‘moral’ engagement arises.

Cooley (1969) later refined this into his ‘looking glass theory of self’ which argues that we define ourselves through the way in which others respond to us. With this in mind, what does it mean to be an ‘older adult’?

I have always found it interesting to note how few of my older clients ever think of themselves, or refer to themselves, as older adults. Most people only recognise that label as a product of some external agency indentifying them as such, such as receiving their Freedom Pass from London Transport or upon retirement. David Smail has, of course, eloquently described the myriad of ways we all remind ourselves who is elderly and who isn’t. We, of course, think of it as a biological category, but the fact is that it is, I would argue, wholly a social construct and as such the perception of ‘old age’ has as much to do with the perceiver as it has to do with the perceived. The following is a simple investigation which sought to explore this issue.

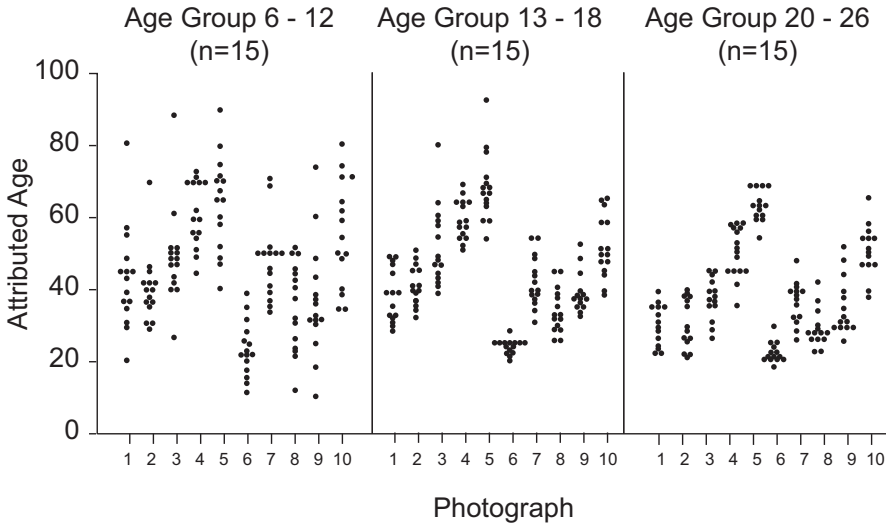
I showed three groups of subjects photographs from the Rivermead Behavioural Memory Test Faces sub-test and asked subjects to estimate the age of the individuals portrayed in the photograph stimulus cards. My subjects ($N=45$) were divided into three groups: prepubescent (6–12), adolescent (13–18) and young adult (20–26). I then interviewed a smaller sample from each group to enquire how and why they made their choices.

All subjects were recruited through friends, neighbours and colleagues.

Principle findings

1. There appeared to be more conceptuality the older the subjects became.
2. Older subjects rated the photographs of more mature adults as younger than younger subjects.
3. There appeared to be more agreement the closer the photograph reflected the subject’s age.
4. A minority of subjects appeared to be very bad judges in all three groups.
5. Better judges in younger children appeared to be formed from direct contact within the family of varying age groups (as seen with photo No. 3), however, I could not determine whether the reverse was true; that is, whether poor judges appeared to have a limited exposure to varying, particularly, older age adults. This point appeared to show itself in two ways. The first through my interview, having on-going contact with an older relative does appear to lead to less extreme assessments of age. However, it also, with the younger children showed itself with respect to card No. 3 which portrayed a woman whom I believe would probably more accurately reflect the age of the children’s mothers than any of the other cards. This may make sense given that from a child’s point of view learning to decode your mother’s facial expressions is probably a useful skill.
6. Younger children appear to rely in identifying older people more on facial hair, hairstyling, glasses and clothing as well as whether the subject is more formal in their dress or better groomed. Older subjects, however, report relying more on skin, posture and the manner or behaviour, but not exclusively. They are

Figure 1: Age Ratings.



far the quicker to discount such features if there are contradictory indicators.

7. Older groups recognise that some people may look younger than they are. They are, as a result, less certain and more circumspect with certain photographs. Whereas, adolescents appear to be more certain in some of their judgements.

Discussion

It would appear that children make judgements about age based on individual factors, particularly around the subject's presentation, ie. such as grooming, hairstyle, the presence of facial or grey hair whereas the older we become, in some respects, we become more circumspect in our judgements, particularly when the subject is closer to our own age. The Austrian philosopher, Ludwig Wittgenstein posed the question 'How is it that I can recognise two members of a particular family when neither may share a single facial feature'? His answer was that families may have a pool of characteristics (family resemblances) from which individual expressions may be drawn. It is from these elements that we make judgements on whether they are or are not members of a particular group. Thus, as we move away

from childhood to adulthood we become less reliant on single factors, but rather draw from a pool of factors in assessing the whole.

It is in this sense that we can say that the perception of age – old age in particular – is not an absolute, but a construct based upon and modified by the experience of the perceivers.

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Prevalence of cognitive impairment in medical rehabilitation settings for older people

Helen Wain & Ian Kneebone

This paper considers findings with respect to the frequency with which cognitive impairment occurs in physician led community hospital rehabilitation service settings for older people. Particularly in light of the relevant National Service Framework this has implications for staffing, staff training and liaison psychiatry access with respect to these services.

PREVALENCE ESTIMATES OF cognitive impairment within older people are relatively high. Dementia affects five per cent of those aged 65 and over, and 20 per cent of those aged over 80 (Department of Health, 2001). This has been found to increase among primary care settings, hospitals, and nursing homes (Adolffson *et al.*, 1981; Erkinjuntti *et al.*, 1986). Additionally age is a major risk factor for stroke and a substantial number of hospital beds are assigned to older stroke patients, a population it is recognised can exhibit cognitive difficulties including problems with memory, language, perception, attention and executive tasks such as reasoning and planning (Lincoln & Tyson, 1989; Wade *et al.*, 1986). In addition, older people within in-patient medical rehabilitation services frequently have multiple health problems. This raises the likelihood of cognitive deficits. Even when age, neurological impairment and psychiatric symptoms are controlled for, cumulative illness predicts cognitive deficits (Patrick *et al.*, 2002). In the only study we have found reporting them, prevalence rates of significant cognitive impairment were found to be 31 per cent in persons over 65 in acute medical wards and 71 per cent in hospitals specialising in the continuing care for the elderly, of these 46 per cent were severely impaired (Hickey *et al.*, 1997). Unfortunately this study specifically excluded patients in rehabilitation units.

The National Service Framework for Older Adults stresses the 'need for specialist care for people suffering from behavioural and psychological symptoms of dementia' (Department of Health, 2001, p.100) and recognises that older people require specialist care in hospital, including attention to 'cognitive impairment' (Department of Health, 2001, p.54). The first step in service provision is awareness, so it was felt it would be beneficial to know approximately how many patients had cognitive impairment within our own services. We report the findings of our brief survey here, as there is a paucity of such statistics.

Method

Our consultant-led community medical rehabilitation services for older people includes four day hospitals ($N=53$) and six in-patient rehabilitation wards ($N=100$). All patients participating in day hospitals and in-patients, at a specific time for each service, over a three-day period, were involved. A nominated staff member at each site completed a brief prevalence of cognitive impairment questionnaire for each patient, with the support of an Assistant Psychologist. In the majority of the hospitals Sisters and Staff Nurses completed the questionnaires, although a Doctor and Physiotherapist (day hospital manager) were also involved. The prevalence of cognitive impairment questionnaire assessed the number of patients with a cognitive impairment and the likely

cause of the problem. Cognitive impairment was clarified as memory problems, perceptual, attention/concentration difficulties, disorientation, and problems with planning and reasoning. No direction as to method of determining impairment was given and this varied between personal experience of the patient, to consulting notes to establish patients scores on tests of cognitive functioning, such as the MMSE (Mini Mental State Examination) (Folstein *et al.*, 1975).

Results

As displayed in Table 1, approximately 43 per cent of patients participating in our consultant led community medical rehabilitation services for older people had some form of cognitive impairment identified, and a further six per cent 'may have' cognitive problems. A greater percentage of in-patients had cognitive impairment

compared to day patients (50 per cent and 28 per cent respectively; $\chi^2(2, N=153) = 7.35, p < 0.05$). The lower prevalence of cognitive impairment among day patients appeared relatively consistent across three day hospitals (ranging from 13 to 24 per cent). The fourth centre, however, identified 60 per cent of day patients as having some form of cognitive impairment. While fewer day patients appear to have cognitive impairment it should be noted an overall prevalence of around one in four is still high.

Table 2 displays the likely reason for cognitive impairment. Dementia, closely followed by stroke, was identified as the primary cause. The cause of the problem being recorded as 'unknown' was also relatively frequent (18 per cent). Diagnoses did not appear to differ between in-patients and day patients.

Table1: Number and percentage of patients with cognitive impairment in consultant-led community medical rehabilitation services (in-patients, day patients and total).

Cognitive impairment		In-patients	Day patients	Total
Yes	N (%)	50 (50.0)	15 (28.3)	65 (42.5)
No	N (%)	46 (46.0)	33 (62.3)	79 (51.6)
Maybe	N (%)	4 (4.0)	5 (9.4)	9 (5.9)
Total	N (%)	100 (100)	53 (100)	153 (100)

Table2: Likely diagnosis responsible for cognitive impairment.

Diagnosis		In-patients	Day patients	Total
Dementia	N (%)	22 (40.7)	10 (50.0)	32 (43.2)
Stroke	N (%)	21 (38.9)	6 (30.0)	27 (36.5)
Unknown	N (%)	10 (18.5)	3 (15.0)	13 (17.6)
Dementia and Stroke	N (%)	1 (1.9)	1 (5.0)	2 (2.7)
Total	N (%)	54 (100)	20 (100)	74 (100)

Discussion

The presence of cognitive impairments among patients served by our consultant led community medical rehabilitation services for older people is substantial at 43 per cent. Dementia emerged as the predominate reason for cognitive impairment. This is unsurprising as among older people dementia is the most likely cause of cognitive impairment (Callahan *et al.*, 1995). A number of beds within these community hospitals are also assigned to stroke patients, and therefore it is again unsurprising that this diagnosis is prevalent in the sample. For 18 per cent of the sample the reason for cognitive impairment was unknown. This raises the question whether further assessment is required to establish cause and if additional referral/treatment was required. Of course further assessment may have been pending for these patients. Identification of a greater number of older people with cognitive impairment as in-patients compared to day patients is consistent with the finding cognitive impairment is associated with in-patient hospitalisation (Hickey *et al.*, 1997). The increased rate of cognitive impairment in one day hospital is unsurprising as there is currently no day service for people with mental health problems in that service's geographic catchment area.

This audit provides a brief snapshot of the prevalence of cognitive impairment in consultant led community medical rehabilitation services for older people. Although the methodology served this purpose, a number of methodological improvements would have created a more comprehensive assessment. All community services were not considered in this survey. For example intermediate care, the community stroke service and out patient services were not included. Had these services been involved a more complete picture would be allowed. The Sister at one day hospital mentioned that the number of patients with cognitive impairment had been substantially greater in the morning session, than the afternoon (when the evaluation took place), although for no

specific programme-related reason. This information highlights the variability in patients who use these services and the problems with a 'snap shot' methodology. A standard appropriate measure of cognitive impairment administered to all patients in a consistent fashion would also have removed the subjective element of the decision as to cognitive impairment. While we are cautious not to underestimate the value of clinical opinion we are aware this is fallible (Macniven *et al.*, 2005) and even well accepted measures such as the MMSE may not be adequate for some of our sample (e.g. people who have had a stroke) (Nys *et al.*, 2005)

On a given day our consultant-led older people community rehabilitation services are dealing with 65 people with cognitive impairment, primarily due to dementia and stroke. In light of the National Service Framework for Older Adults (specifically Standard 4: General Hospital Care) (Department of Health, 2001) it is pertinent to consider whether the needs of these patients are being met. Individuals with dementia and cognitive impairment require a range of services to aid their rehabilitation/management. For instance currently there is no specialist in cognitive impairment (a dedicated neuropsychologist) employed by our health care trust. It follows, therefore, that patients may not be receiving the specialist care they need. The association of cognitive problems with behavioural difficulties (Mace & Rabins, 1981) also raises questions about access to clinical psychology and liaison psychiatry as well as staff training issues. Most of our nursing staff for instance, don't have mental health training or certification.

This survey has highlighted the extent of cognitive impairment within our services. It is appropriate we follow up with consideration of how these impairments are best assessed and managed. It also provides the first statistics on prevalence that may be of use to other service providers/planners. We doubt the prevalence, or its implications, is unique to our own service.

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An evaluation of a Memory Remediation Group: Do carer's benefit?

Alison James & Neil Sabin

CARING FOR A family member with dementia poses significant challenges, and many studies report considerable psychological and physical morbidity among caregivers compared to age-matched controls (Dunkin & Anderson-Hanley, 1998). For example, there are consistent reports of high levels of strain, distress and depression among carers (Knight *et al.*, 1993; Donaldson *et al.*, 1997; Haley *et al.*, 1987), thus interventions are needed to aid carers to cope with their challenging role.

A model predicting a simple positive linear relationship between burden and patient impairment, such that caregivers caring for the most impaired patient would report the greatest degree of burden, has not been supported by the literature (Hadjistavropoulos *et al.*, 1994). Pruchno and Resch (1989) propose that although caregivers may feel burdened when memory problems initially reach a level that necessitates their assistance (i.e. during the mild-to-moderate stages of dementia), this burden later abates as supporters adjust to these demands. Thus patients with mild dementia may cause heavy strain on family carers, and a range of interventions is required at all stages of dementia. The focus of this study is to examine how a memory group intervention can aid carers of individuals with mild memory problems.

Memory Group interventions can offer a form of cognitive rehabilitation, a term which can apply to any intervention, strategy or technique which enables clients and their families to live with, manage, reduce or come to terms with memory difficulties (Clare, 2003). Such programmes typically incorporate information and education about cognitive problems, introduce suitable strategies or aids and provide an opportunity

for members to support and encourage one another, and perhaps develop friendships and social contacts (Clare, 2003). Moniz-Cook (2001) described how a memory group where families were taught early memory management crisis preventative strategies maintained mood in patients, reduced the impact of poor memory on day-to-day problems and reduced associated caregiver burden six months following the group. This suggests that memory group interventions may be beneficial for carers, although it is not clear in this study whether the results are due to the increased nurse contact or due to the intervention (Moniz-Cook, 2001).

Results of a randomised control trial of an intensive group intervention programme for dementia caregivers indicated that the intervention was able to reduce psychological morbidity in caregivers (Brodaty & Gresham, 1989). Positive benefits on caregivers mood and stress levels have also been reported for reality orientation interventions (Greene *et al.*, 1982), psycho-educational approaches (Toner, 1987), cognitive-behavioural family interventions (Marriott *et al.*, 2000), support groups (Touseland *et al.*, 1992) and cognitive stimulation programmes (Quayhagen & Quayhagen, 1989), thus demonstrating the importance of targeting interventions to carers in order to improve their well-being.

However, there are some criticisms of Memory Group interventions with carers. Reviews of memory-aid groups have reported high drop-out rates, difficulties in maintaining gains and excessively optimistic expectations of outcome (Scogin, 1992). Despite initial positive results on measures of patient memory and carer well-being, six-months following a memory management intervention experimental carers were more

depressed than controls, suggesting some interventions can have a negative impact on the psychological state of the carer (Moniz-Cook *et al.*, 1998). However, the data did not allow examination as to whether experimental and control groups were equivalent in well-being at baseline.

Zarit *et al.* (1982) also report negative effects on carers following group memory training for the person with dementia. They suggest that it was active involvement in memory training had focused experimental carers on their relative's deficits, which had exacerbated their feelings of loss and consequent depression (Moniz-Cook *et al.*, 1998). Another explanation could be that the intervention required more time to impact on carer mood (Moniz-Cook *et al.*, 1998). Thus, more research is needed to determine how interventions aimed at aiding those with memory difficulties may have the potential to improve well-being for the carer.

Based on research emphasising the importance of intervention techniques during the mild stage of impairment, the Newcastle Memory Remediation Group was set up in 1999 in order to meet the needs of patients with early memory difficulties. The group takes the form of a seven-week course, and one follow-up session three months later, with each session lasting an hour-and-a-half. The group covers a range of issues relating to memory and also aims to assist clients and carers to develop a prosthetic home environment, by educating them to various external memory aids. It also aims to develop supportive, therapeutic relationships with the presenters and members of the group. To date, 113 patients have participated in the group, most of whom have attended with a partner, relative or friend. Caregiver responses on scales of stress, strain and coping were measured in order to evaluate change as a result of the Memory Group intervention.

Method

Participants

Data was collected from 14 carers (nine females, five males) who were invited to

attend two separate Memory Groups with their partner/relative with mild memory problems. Ten carers were spouses, three were daughters, and one was a nephew. Of the initial sample, two carers failed to return their questionnaires post-group, whereas eight failed to return the questionnaires at follow-up.

Measures

The Memory Awareness Rating Scale – informant version (MARS; Clare *et al.*, 2002) was used to measure perceptions of relative/partner's memory abilities.

The Carer's Stress Scale (Pearlin *et al.*, 1990). Derived from Pearlin *et al.*'s model of caregiver stress, the following items were used to investigate stress: cognitive status, problematic behaviour, loss, role captivity and family conflict.

The General Health Questionnaire (GHQ; Goldberg, 1978) was used to measure strain.

The Coping Response Inventory (CRI; Moos, 1990) was used to measure coping strategies.

Procedure

All patients that were referred to the Memory Group and met inclusion criteria (mild memory difficulties, MMSE of 24 or above, acceptance of memory problems, and keen to participate in a group setting) were invited to attend the Memory Remediation Group. All participants completed questionnaires pre-group, post-group and at three months follow-up. Questionnaires were distributed during the session and completed at home, which were either returned during the following session, or returned via post.

Results

All data was entered into SPSS and a series of repeated measures *t*-tests were performed to determine if the Memory Group produced any significant changes on the questionnaire responses. The main findings were as follows:

Carers report that their relative/partner seems to have significantly more cognitive difficulties at follow-up compared with post-group ($t=4.302$, $df=5$, $p=0.008$).

Carers ratings of problem behaviour are significantly higher at follow-up than at post-group ($t=25.072$, $df=5$, $p<0.001$) or pre-group ($t=17.074$, $df=5$, $p<0.001$).

Carers report significantly more conflict with other family members at three months follow-up than at post-group ($t=307.379$, $df=4$, $p<0.001$) or pre-group ($t=16.816$, $df=4$, $p<0.001$).

Carers report a significant change in their role at post-group compared to pre-group ($t=11.453$, $df=5$, $p<0.001$).

The total stress score on the Carer's Stress Scale (a combined measure of stressors including cognitive status, problematic behaviour, loss, role captivity and family conflict) is significantly higher pre-group than at post-group ($t=9.544$, $df=11$, $p<0.001$).

Carers are significantly more likely to report feelings of strain, as measured by the GHQ, post-group rather than at three months follow-up ($t=5.571$, $df=5$, $p=0.003$) and are significantly more likely to report strain at pre-group compared to follow-up ($t=3.956$, $df=5$, $p=0.011$).

Carers are significantly more likely to use active cognitive coping techniques (e.g. considering several solutions to the problem) when dealing with their partner/relative with memory problems at post-group than at pre-group ($t=4.329$, $df=11$, $p=0.001$). This is not maintained at follow-up, as carers are significantly more likely to use active cognitive coping techniques at post-group rather than at follow-up ($t=3.420$, $df=5$, $p=0.040$).

Carers are significantly more likely to employ active behavioural coping techniques (e.g. talking it over with someone) post-group rather than at three months follow-up ($t=2.755$, $df=5$, $p=0.040$).

Discussion

The aim of this study was to examine if caregivers stress, strain and coping techniques altered as a result of the Memory Group intervention. The caregivers rating that cognitive problems and problem behaviour are higher at three month's follow-up could simply be a reflection of the degenerative nature of the patients' disease. It could also suggest that patients are no longer using the strategies recommended during the intervention. This is consistent with Scogin's (1992) criticism of memory groups, which they have difficulties in maintaining gains and that individuals have excessively optimistic expectations of outcome. This suggests that ongoing support and follow-up is needed in order to ensure maintenance of strategy use.

Carers reported a change in their role after the group compared to pre-group. This may be a reflection that active involvement in memory training had focused carers on their relative's deficits and they are now required to be more active in implementing the recommended strategies. Similarly as Pearlin *et al.* (1990) suggested, there is often a marked constriction of social and recreational life as care giving responsibilities escalates, thus change in role may reflect change in functioning within the patient.

Carers reported that they experience more conflict with other family members at follow-up than during the intervention. Zarit *et al.* (1982) also reported negative effects on carers following memory group training for the person with dementia. Russell and Proctor (1989) suggest that caregivers who attend support programs learn the full implications of caring for a relative and realise that the caregiving situation is likely to worsen. Thus, family members who do not attend may not be aware of the implications of the condition. This disparity may be the cause of some conflict. Pearlin *et al.* (1990) suggested having a close relative who needs care can reawaken old grievances and create new ones. Conflict may arise due to beliefs about the seriousness of the illness and

disagreement over the amount of attention that is required (Pearlin, 1990); this may be particularly relevant to patients with mild memory problems. Increased conflict may also be related to withdrawal of support. Support from the trainers and fellow members of the group during the intervention may have allayed some concerns over the changing role and progressive problem. Carers may have sought similar support from their families, and been disappointed with the response. Conflict with family members may also be a reflection of the change in role of the main caregiver, and future groups may benefit from emphasising the role of the wider family.

Carers report less strain (anxiety with regard to caregiver role) at follow-up rather than at post-group. Similarly, Moniz-Cook (2001) reported decreased strain at follow-up following a memory group intervention. This may be due to the emphasis on practical solutions to memory problems, or due to specific content of some sessions. For example, the final session provides information about other agencies that can provide ongoing support to the patient and carer. This advice may have prepared carers with resources to cope with their situation. Overall this demonstrates a positive long-term benefit on psychological status following the Memory Group.

Carers report significantly less total stress following the intervention; similarly Marriott *et al.* (2000) found significant reductions in distress and depression following a family intervention group compared with control groups at post-treatment. This could simply be a reflection of the benefits of social support or a reflection of the intervention providing the group with strategies to help them deal with a challenging time. This explanation is supported by the finding that carers report they are more likely to use coping behaviours post-group rather than before the group. Mittelman *et al.* (1993) suggested that caregiver interventions improved caregiver knowledge, decreased family burden, and improved coping skills,

although it is not clear whether the changes are attributable to the intervention. Price (2002) evaluated the Newcastle Memory Group and also found significant differences in coping between the intervention group and waiting list controls at follow-up. Following the intervention, carers are more proactive about employing techniques to cope with their situation, thus suggesting that the advice and recommendations as part of the group are effective in the short-term.

Limitations

Due to ethical considerations of delaying treatment in degenerative diseases, no control group was included in this study. Thus, it is not clear if the change in caregivers responses was a result of the intervention or natural course for carers of mildly impaired individuals. Nor is it clear what the mechanism of change for any of the differences demonstrated, whether it is the content of the course, the peer support, trainer support or other factors.

A further limitation of the study regards the length of time to follow-up, in that only a three month follow-up was conducted. Mittelman *et al.* (1995) noted that the effect of family counselling and support on carer mood only became significant eight months following entry in the study. Therefore it is not possible to comment on longer-term influence of the intervention.

Due to small sample size it was not possible to compare the responses of carers with different relationships to the patient. It is possible that spouses and children may experience different types of stress, and may need different emphasis in the intervention.

Implications for the Memory Group

The Memory Group places an emphasis on carers and patients discussing and implementing strategies at home. As Scott *et al.* (2002) suggest, individual sessions may help to facilitate this process and provide an opportunity to explore whether participants were using any of the techniques discussed in the course. This may ensure that the use

of strategies are maintained, which may also impact on carer stress.

Reports of family conflict increased following the group, possibly due to role changes in the main carer, or lack of awareness of the problems by family members. Thus, an open session in which other relatives could attend may be useful, in order to explain about problems people with mild memory difficulties experience, and to recommend strategies that may help.

Following the intervention, carers reported significant changes in their role. Moore *et al.* (2001) suggest the caregiver must be willing and capable of committing to procedures, and share responsibility with the patient. They should be aware this may be time-consuming and involve patient-caregiver interaction. This should be explained from the outset, that carers are not passive companions to the Group but it is their role to support the client, re-read session outlines, and facilitate the implementation of strategies. The carers role at home should also be clarified, for example, Hepburn *et al.* (2001) include a brief 'role clarification' element as part of their carer support intervention. This emphasises the caregiver's role in terms of assuring the security and comfort of the patient alongside continuing activities he/she enjoyed. Although carers with need of support can attend a carer support group, some do not feel they need that level of support when their partner/relative has still relatively mild problems. They may, however, benefit from a brief emphasis on their role during the Memory Group.

Summary

In summary, the results suggest that carers experience a number of short-term improvements following the Memory Group, for example, carers reported less stress and improved coping. As a result of the intervention, changes in roles and family conflict also occurred. Improvements on levels of strain were also demonstrated at follow-up. Qualitatively, carers reported benefits of discussing issues with other members and with staff, feeling that there were others in a similar situation, learning about specific aids, and ways to cope. This suggests the group serves as a positive experience for carers, but some revisions to the Group format may need to be employed to reduce some levels of conflict, and to ensure maintenance of any benefit.

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Letters to the Editors

Dear Editors,

Can anybody provide me with a copy of the executive function screening test developed by Donald Royall called EXIT 25 used in a growing number of interesting studies? I have written to the author but received no reply.

Royall, D.R. & Shillerstrom, J.E. (2004). ECF impairment is common. *Age and Ageing*, 33, March, 206–207.

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Dear Editors,

I was looking through one of the local magazines here in Spain and came across some Will Rogers' quotes which I would like to share with the readership.

About growing older

- 1 Eventually you will reach a point when you stop lying about your age and start bragging about it.
- 2 The older we get, the fewer things seem worth waiting for.
- 3 Some people try to turn back their odometers. Not me. I want people to know 'why' I look this way. I've travelled a long way and some of the roads weren't paved.
- 4 When you are dissatisfied and would like to go back to youth, think of Algebra.
- 5 You know you're getting old when everything either dries up or leaks.
- 6 I don't know how I got over the hill without getting to the top.
- 7 One of the many things no one tells you about ageing is that it is such a nice change from being young.
- 8 One must wait until evening to see how splendid the day has been.
- 9 Being young is beautiful, but being old is comfortable.
- 10 If you don't learn to laugh at trouble, you won't have anything to laugh at when you are old.

Interesting thoughts, don't you agree?

Una Holden

Dear Sinclair

Sorry, I turned off too soon. Just in case you forgot I am happier called Una Holden than Cosgrove!!!! Sadly it will prove too complicated here in Spain to remove that name!

Hope all my friends are well and happy and that the present Conference goes as well as usual

PSIGE

(Faculty for Psychologists working with Older People)

Training clinical psychologists to work competently with late life issues: Building confidence for all supervisors offering placement experience with older clients

Leader: Steve Davies, Deputy Course Director, University of Hertfordshire D.Clin.Psych. training course.

Thursday 2 December 2005 – 10 am to 4 pm

BPS Offices, 33 John Street, London WC1N 2AT.

This event is open to all Applied Psychologists who provide supervision to psychologists in training, on clinical work with Older People, whether as the overall supervisor or in a specific area of work.

The aim is to provide information about the expected capabilities to work with the client group, to enhance supervisors' confidence and competence to provide such supervision and to provide a reflective space to consider particular issues that arise in clinical work with Older People.

There is no charge for the day.

Places will be allocated on a first-come basis,
maximum 30 people.

To book a place please contact Catherine Dooley, Barnes Hospital, South Worple Way, London SW14 8SU.

E-mail: catherine.dooley@swlstg-tr.nhs.uk

**Advance notice – Wednesday 15 February 2006
Assessing Capacity Day Workshop**

Book Review

CANE: Camberwell Assessment of Need for the Elderly

Martin Orell & Geraldine Hancock

Gaskell: London, 2004.

ISBN: 1-904671-06-3. 280 pp. £80.00.

The CANE is a carefully developed and extensively validated assessment of need for older people across a wide range of physical, psychological, social and environmental domains. It is based on the Camberwell Assessment of Need (CAN). In adapting it for use with older people, its relevance was ensured through consultation with focus groups of older people and professionals working with them. There are 23 areas of potential client need assessed:

- Accommodation;
- Looking after the home;
- Food;
- Self-care;
- Caring for someone else;
- Daytime activities;
- Memory;
- Eyesight/hearing/communication;
- Mobility/falls;
- Continence;
- Physical health;
- Drugs;
- Psychotic symptoms;
- Psychological distress;
- Information;
- Deliberate self-harm;
- Inadvertent self-harm;
- Abuse/neglect;
- Behaviour;
- Alcohol;
- Intimate relationships;
- Money/budgeting;
- Benefits;

and two additional areas of potential carer need:

- Carer's need for information;
- Carer's psychological distress.

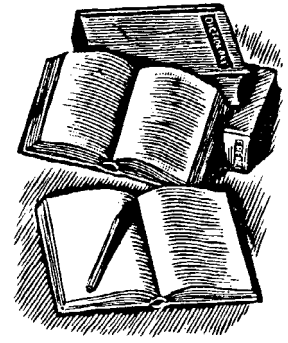
The measure is designed to assess different perspectives of the individual's level of need, including that of the older

person, their carer and a member of staff supporting them as well as the rater. The triangulation of data which recognises assessment of need as a value-laden process is one of the most attractive features of the CANE. Information is sought about the presence or absence of need in each domain, the extent to which any need is met and the amount of help from informal or statutory sources which is given in relation to this potential need. Informants are asked to rate the perceived appropriateness of any help received. Thus, for each domain of need five ratings are given:

1. Level of need (0=None, 1=Met, 2=Unmet);
2. Level of help received from friends/relatives (0=None, 1=Low level, 2=Moderate, 3=High);
3. Level of help received from services (0=None, 1=Low level, 2=Moderate, 3=High);
4. Appropriateness of help received (0=No, 1=Yes);
5. User satisfaction with help (0=Unsatisfied, 1=Satisfied).

Given that each of these ratings is made by four people (other than user satisfaction), full administration of the CANE yields a rather unwieldy table which may be of limited usefulness in itself. However, the process of collecting the information required is likely to identify areas of need which could be remedied by intervention

A short form of the CANE, the CANE-S is also provided which consists of ratings of the level of need only by the different informants for each of the 24 domains (0=No need, 1=Met need, 2=Unmet need).



In the final section for each domain of need, the rater is instructed to collect information regarding the older person's strengths and their cultural and spiritual expectations. The authors highlight the importance of collecting this information in developing a person-centred care plan for the older person and suggest that deriving a numerical score is only a secondary aspect of the CANE. However, there is relatively little space available on the record sheet and no specific guidance is given for this final section. This means that there is a potential risk of the assessment leaning towards being a deficit-driven quantitative exercise and the principles of person-centred care advocated by the authors being diluted. Training for raters on the aims of the CANE as a person-centred tool and the need to collect information on the older person's strengths and their heritage could presumably address this potential concern.

The CANE is administered as a semi-structured interview and its breadth of coverage makes it particularly suited for use by different members of multi-disciplinary teams as part of a 'single assessment process'. Administration is straight-forward and a set

of training overheads are provided to ensure reliable administration across raters. The measure is said to take between 10 and 30 minutes to complete with each informant, which could make it too lengthy for routine clinical practice within busy CMHT settings. However, studies have demonstrated the CANE to be reliable, valid and applicable across a number of settings. The manual provides accounts of studies which demonstrate the feasibility and applicability of the measure in primary care, continuing care, sheltered housing, day hospitals and liaison psychiatry settings. Data are also presented which support the utility of the CANE as a research tool and its cross-cultural usefulness, including its validation in Spanish and German populations. Case examples and guidance on scoring are also provided. The scale can be photocopied freely by purchasers of the manual.

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

Notes for Contributors

Articles

Contributions in the form of short articles on any aspect of psychological theory or practice with older people are always welcome. As the *Newsletter* aims to cover a broad cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication.

Articles should be submitted three months before publication (January, April, July, October).

Research Updates

The *Newsletter* is particularly keen to publish contributions concerning ongoing research.

These can reflect any stage in the research process, e.g. ideas for discussion or early stage results, which are not ready for formal publication. Try to keep them below 500 words.

The Editorial Board reserves the right to make minor changes to any submissions.

Where major editing is necessary, the authors will be informed. All contributions must be typed.

Submission Procedure

Where possible, please submit articles as a Word file via e-mail to

sinclair@ltshelford.freemove.co.uk. If this is not possible please send an electronic version on disc to the postal address below. Language should be inherently respectful to older people and consistent with the British Psychological Society's guidelines.

Letters to the Editors

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

All contributions should be sent to:

E-mail: sinclair@ltshelford.freemove.co.uk

or

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