



The  
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Psychologists' Special Interest Group  
Working With Older People

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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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# Guest Editorial

Jan R. Oyeboode & Caroline Sincock

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**C**LINICAL PSYCHOLOGY IS THRIVING in the West Midlands as a result of growth of quite a number of departments that started as single-handed B grade services. We have quite large services in North Warwickshire, where staff are known for their range of psychotherapeutic approaches; in Birmingham, where specialisation includes a whole time post in the Working Age Dementia Service as well as staff with expertise in systemic and psychodynamic approaches. Our medium-size services are in South Warwickshire and in North Staffordshire where both services have staff in physical as well as mental health care; in Coventry where an appointment has recently been made in intermediate care; in South Staffordshire where there is particular expertise work with challenging behaviour; in Worcestershire where, despite a small department, a generic service is provided countywide and in Wolverhampton where the service includes bereavement counselors as well as psychologists. We still have our share of single-handed pioneers in Sandwell, Walsall and Herefordshire where lone Consultant staff continue to plough a brave furrow. The Sandwell psychologist with three sessions per week for older people has successfully used consultancy as a means of service development. We have clinical psychologists with older people on the staff teams of two of our three local ClinPsyD courses (Birmingham, Coventry and Warwick), giving good opportunities for trainees to research in the field. And finally, we still have areas such as Shropshire and Dudley where there are no psychology posts

for work with older people, so there is still fundamental development work to do.

The West Midlands' PSIGE meets six times a year at Birmingham University. A core group of qualified psychologists attend regularly, with fluctuating numbers of trainees and assistants attending, all valuing the opportunity to discuss professional issues, development of clinical work and matters relating to Clinical Psychology training.

In addition to having a clinical presentation slot at each meeting, the group has hosted two study days in the last year. In March 2005, Dr Drew Alcott provided a stimulating day on neuropsychological assessment and differential diagnosis, and in May 2005 Dr Dawn Brooker held a half-day workshop looking at recent developments in person-centred care.

Provisionally, events planned for 2006, include an update on Fronto-temporal dementias, assessment and therapeutic interventions; CBT approaches with older people and IPT.

The papers in this issue of the *PSIGE Newsletter* reflect the varied areas of work being undertaken around the West Midlands region. Work ranging from questioning, and exploring models of service provision, group work in the context of CMHTs and in partnership with users and carers; the ongoing commitment to provision of services to a high quality be it through staff training or being informed of the latest theoretical models, and a tribute to our 'local' professor, Professor Dawn Brooker.

We hope you enjoy the West Midlands edition of *PSIGE Newsletter*.

**Jan Oyeboode & Caroline Sincock**

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**Editor's Note:** Thanks very much to Jan and Caroline for marshalling together an excellent West Midlands edition, despite Caroline blanching at the prospect back in Chester. Thank you to all contributors and to Nicky Bradbury for the next instalment in the NSF saga. Artwork in this edition has been produced through the Artscope project, a joint venture between older people attending Age Concern Birmingham and professional artists.

# Dawn J. Brooker

Professor of Dementia Research and Practice

Jan R. Oyebode

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**D**AWN NEEDS NO INTRODUCTION. Her contribution to dementia care in the UK and beyond is well known and has been deservedly recognised by Bradford University this year in their award to Dawn of a Chair in Dementia Research and Practice. Prior to her move to Bradford, Dawn's work contributed in different ways to a number of services in the West Midlands, so we feel she is 'one of us'. This brief reflection celebrates Dawn's contributions and success. So Dawn, feeling a bit like Eamonn Andrews, I can invite you to join us and say: 'Dawn, this is your (West Midlands) life!'

Dawn trained at the University of Birmingham course and went on to work for her first couple of years post-qualification in Sandwell. Dawn, you were already encouraging others to come into clinical psychology and your words of encouragement had an impact as remembered by Theresa Powell, who is now an experienced consultant clinical psychologist working in brain injury rehabilitation and co-director of the Birmingham University ClinPsyD course. *'I think of Dawn's advice to me before going for my clinical interview. Her advice was 'just be yourself'. It worked.'*

From there she went on to join the mental health service for older people that was being set up in Central Birmingham Health Authority based at John Connelly hospital. This was a time of growth and innovation in services for older people and Dawn made sure that clinical psychology was at the centre. One of the ways I remember being very impressed in those days of single-handed services, was that Dawn managed to establish several posts in addition to her own. Dawn focused on the assessment ward, there was an A grade psychologist in the day hospital and an Assistant on the continuing

care ward. The presence of clinical psychologists as full-time members of multi-disciplinary teams made a tremendous difference to the impact of psychological thinking on service provision and this concern with ensuring psychology is integrated into wider practice was, even then, a hallmark of Dawn's work.

In the early 1990s, a post was established providing psychological services for older people in a physical health setting at Moseley Hall Hospital and Dawn moved into this specialist post, to which she brought her characteristic focus on disseminating good psychological practice, through providing training and support to ward staff. The post also allowed her to spend about half her time at Birmingham University. In her role at the University she ensured that teaching about work with older people had a fair share of time in the curriculum, and inspired a fair few trainees along the way. Wonder Dawn if you can guess who this is: *'Work with an older adult, that's not for me. Well, that is what I initially thought, back in 1991 as a trainee on the Birmingham clinical course. Then I met Dawn Brooker. Full of energy, passion and enthusiasm and, well, it rubbed off on me.'* (Julie Heaton, Clinical Psychologist with Older People, Birmingham)

From there back to mental health services for older adults, but this time into a quality manager role in South Birmingham Mental Health Trust with a couple of sessions for continuing clinical psychology practice. I remember Dawn saying that although a manager by title, in practice she was still every inch a clinical psychologist. Dawn used the skills she had built up in working with staff and systems to great effect. She influenced the basic values of the Service, consulting widely on a mission state-

ment; she worked with other disciplines to set and check standards and introduced a five-day multi-disciplinary training course to ensure that all appreciated the nature of dementia and the basics of individually tailored care. Also at this time Dawn introduced Dementia Care Mapping and in true Dawn style did it thoroughly, embedding it in the service, ensuring that it did not remain the province of psychologists and that staff had full away days to consider maps of their units. So here, Dawn, is another voice for you: *'It was a fantastic experience for me working with such an effective team where real positive impact was made and could be observed as directly benefiting vulnerable older clients with dementia. Dawn, I experienced as very committed and passionate about her work. She helped me to develop enormously in a professional capacity. She was clear and constructive in her guidance as a supervisor and still remained very 'real' as a person. A good laugh could be had by all whilst getting down to some really hard work.'* (Marie Payne, Clinical Psychologist, Sandwell)

In addition to all this, Dawn continued to supervise and support (and challenge) clinical psychologists. *'I remember on my very first day in post after qualifying, Dawn sat down with me to discuss the post and amongst other things, she asked me almost casually whether I had come to terms with my own mortality, saying this was essential to me being able to work effectively with the older people in the Service.'* (Andrea Evans, now Consultant Clinical Psychologist with Older People, Pembrokeshire)

Then a move out of the big city to rural Herefordshire to take up a B grade post and once more to develop a service, bringing her usual mix of leadership, dissemination and inspiration. So Dawn, more words from a former Assistant of yours: *'She was an inspiration to me as a budding psychologist and a superb*

*teacher. Her enthusiasm and passion for working with people with dementia was infectious to the point where I now work within the Older Adult Specialty which I owe to those two years with her as an assistant! She showed me the positive impact that psychologists can have with this client group whilst remaining down-to-earth and fun to be with.'* (Louise Price, Clinical Psychologist with Older People, Worcestershire)

And after all these voices, let me add an anecdote of my own that illustrates the way Dawn champions psychology with older people. This relates to the rejection of a paper reporting work evaluating interventions for dementia by a mainstream journal on the grounds that it was of minority interest. Where most of us might have shrugged with resignation at this degree of ageism, Dawn was not defeated but wrote back to the journal pointing out the error of their ways – they accepted the paper.

In April 2001, Dawn moved on again to bigger and better things at the Dementia Development Centre in Oxford and then the Bradford Dementia Group. But I hope this piece shows her work has contributed a great deal to the West Midlands. So Dawn, we are very proud that you have become a Professor and what more can I say to sum up than quote Julie's thoughtful words: *'Professional, yet down to earth with a great sense of humour and a wonderful way of communicating and being with people. Quite awe inspiring too!'* Enjoy being a Prof – I am sure you will go on making a difference!

### **Jan R. Oyebo**

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# The 7th International Conference on Grief and Bereavement in Contemporary Society

Jan R. Oyebo

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THE PSIGE CONFERENCE PROVIDES an annual injection of validation and renewed enthusiasm for my clinical psychology work with older people. But this year I missed the jubilee due to its clash with the 7th International Conference on Grief and Bereavement in Contemporary Society. Back in 2000, when the West Midlands geographical group planned the millennium conference we found that we had many more offers of papers about dementia than about other issue. Yet the fact that in the developed world death has become an old age issue, combined with the far reaching consequences of bereavement, make understanding of the psychology of facing death and bereavement key issues for clinical psychologists working with older people. The opportunity to present a paper and attend a conference on this important topic, especially one with so many big names from the field was too good to miss. This brief report aims to pass on to you an account of some of the highlights.

Every day of the conference included one or two plenary addresses by eminent speakers, interspersed with eight parallel streams of papers. The line up of plenary presenters read like a who's who of bereavement research. They included Colin Murray Parkes, who has contributed in so many ways to bereavement services and research including most recently his work on cultural influences on grief; Henk Schut, one of the co-editors of the well-known *Handbook of Bereavement Research: Consequences, coping and care*; Robert Neimeyer, who has put forward a social constructionist perspective on the human need to make meaning from

bereavement; Leila Gupta, who has undertaken pioneering work helping children to recover from the trauma of war; William Worden, well known for his writings on the four tasks of grief work; Holly Prigerson, who has done painstaking work to establish criteria for a diagnosis of complicated grief; and David Kissane, who has undertaken a whole programme of work to develop and evaluate family focused grief therapy.

Unfortunately I had to leave before David Kissane's session but was lucky enough to hear all the other key speakers. Their talks and those of the other contributors are available on the Cruse bereavement care website (web address below) for people who would like to know more. Some key points included the importance of inter-disciplinary respect and collaboration and the need to be open to new ideas yet not to hastily throw out the old (Colin Murray Parkes); also the need for reciprocity between research and counselling in the field (Henk Schut). This latter point was conveyed in the context of the lack of evidence that routine bereavement counselling is helpful, yet continues to be provided in many hospice services. Henk Schut also described his own research which shows no evidence that emotional expression following bereavement is systematically linked with levels of distress. His conclusions were that we need to ensure continuing interaction between practitioners and researchers and that research needs to focus on what works for whom.

Alongside the plenary speakers there was a tremendous choice of talks. I found the symposium on bereavement in China with talks given by Cecilia Lai Wan Chan and Amy

Yin Man Chow very interesting in demonstrating some different cultural influences on grief. I also listened to a fascinating account of a qualitative study of women's experience of bereavement of a sister. My own talk was about work done by a trainee clinical psychologist, Andy Dunn, on the emotional aspects of continuing bonds after spousal bereavement.

The conference took place at King's College just a week after the London bombings. The nationwide two minute silence, in memory of those killed or affected, brought us all out onto the pavement from where we could hear Big Ben chime 12. This coincidence seemed to underline the importance of our meeting and sent us back into the conference hall with a renewed sense of purpose in relation to understanding and providing appropriate care for those suffering bereavement.

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<http://www.crusebereavementcare.org.uk/intlconf/>

# Principle-based design – a practical approach to changing and improving Health Services

Michael Church

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**W**HEN I REJOINED THE NHS, after a 10-year gap, it quickly became apparent that the repeated re-organisations and change that started in the 1980s, with the introduction of general management (The Griffiths Report), continue unabated. None of us would argue against the need to continuously improve services, however, re-organisation and change brings with it a significant risk. For example, business research (from which most of the ideas upon which modern NHS management is drawn) shows that less than 50 per cent of businesses that re-organise three or more times over a five-year period subsequently raise their profits (*The Economist*, 1994). There is no reason to suppose, given its complexity, that the risk is any less for NHS.

This risk is well summarised by Russell Ackoff (1981) who wrote: *‘When you get rid of what you don’t want, you do not necessarily get what you do want, and moreover you often get something you want even less.’* (p.231)

With a few moments reflection, I wonder how many of you reading this article have personal experience of ‘getting something you want even less’ from a service change in the NHS?

The aim of this article is to introduce a *principle-based* approach to the design of services, enabling us to better manage the risk inherent in attempts to improve services. Although I have not formally used this principle-based approach in the NHS, my own experience (in the re-organisation of large businesses) suggests that the kind of mistakes made when reorganising in the NHS are similar to those made in business.

The commonest mistake is what might be called the ‘back to front’ problem – when those involved move straight into defining how the service will be improved (specific solutions), without having a clear or shared understanding of *what* the service should be able to do (the *principles* of that system). The back-to-front approach means that those funding the service don’t even know what they want, let alone what they might get!

Principle-based design can be used to redesign complete services (e.g. dementia, stroke or intermediate care service, etc.) or particular part or process with a service (e.g. a memory clinic; or a stroke carers’ education and support system, or a community stroke rehabilitation team, etc.).

## The initial step – stakeholder identification

The initial step to getting started is for the ‘project group’ (those committed to making a change) to identify the stakeholders. By ‘stakeholders’ I mean all those *who influence* or *are influenced by* the change. Once identified, you can ensure stakeholders’ participation and involvement in the design process and thereby:

- Gain consensus about, ownership of, and commitment to the change (much better than coming up with an idea, however wonderful, and then trying to sell it others).
- Capture creative ideas and valuable information to inform the design of the system from key stakeholders such as service users (including relatives), and service providers.



## Principle-based design – three-stage process

The process of principle-based design seeks to achieve more effective change and redesign of services by getting stakeholders to share in the identification of an *ideal desired future state* (rather than simply criticising the existing service). As such it tends to expand rather than narrow the conception of what can be implemented and allows a holistic view to be developed.

Principle-based design can be divided into three main stages:

### 1. Why?

The different stakeholders involved in the design process are likely to have widely differing knowledge, understanding, and *perception* of the reasons for the service change. For example, what might be the reasons given by patient/relatives versus senior managers for changing the service? Therefore, the first step in the process focuses on developing a shared understanding about why is the change desirable. This is achieved by identifying:

- Top down drivers of the change i.e. the social, political, cultural, economic, technological environment trends and implications for the local service.
- Bottom-up drivers for change, i.e. the reality of the existing service including: experiences of services users and providers, local need (based on local demographics and geography), etc.

Preparing for this step in the process usually involves agreeing and scoping key topic areas (for example, an illustrative list of areas that might be considered is shown in Table 1). Then speakers must be found who can deliver brief pre-prepared presentations on the key topic areas. A programme that mixes some presentations with small group work can be devised (which may be one hour or half-a-day depending on the scope of the service to be redesigned). If time is scarce then a simple brainstorm for one hour, without formal presentations, can be used to develop a quick picture of the context and drivers of the change being envisaged.

### 2. What?

As was noted earlier, it is all too easy to think of examples of services that appear to be designed without the planners being clear about what the service should be able to do. It is easy to get it wrong even in the apparently straightforward design of physical systems, as the wheelchair bound older adults found out, when the window placement (too high) prevented them seeing out of one newly-built ward.

The aim of this part of the principle-based design process is to produce a detailed specification of the ideal system. This takes the form of 15 to 30 statements or principles, which provide a detailed answer to the question 'what should be the purpose of the system?'. This may be more challenging than it appears at first sight. It is helpful to follow four rules:

- The list should be prefaced by the statement: The ... system/service will:
- Each principle should begin with an active verb. Avoid vague aspirations. Which of the two principles A or B shown better defines *what* one purpose of a Dementia Care Service (DCS) should be?
  - A. The DCS will: be adequately resourced.
  - B. The DCS will: proactively seek and secure equity of funding for people with dementia and their families.
- Principles should avoid talking about the means or how an outcome is to be achieved (which is the next stage in the design process!). Thus, the DCS will: 'run pre-assessment/diagnosis support groups for the person with dementia' is too specific as it is only one of the means by which the more general principle the DCS will 'give access to pre-assessment/diagnosis advice and guidance for the person with dementia', might be achieved.

Some examples of possible design principles for an ideal Dementia Care Service (based on a brief one hour exercise at Midlands PSIGE) are shown in Table 2. This list is not meant to be comprehensive, only illustrative. Looking at this, you might like to ask your-

**Table 1: Examples of variables in the societal environment that influence Health Services.**

Sociocultural	Economic	Technological	Political-Legal
Age distribution trends; Ethnic group distribution; Conurbation verse rural locality; Birth rates and life expectancy trends; Prevalence of illnesses; Consumer activism and litigious behaviour; Changing family structures; Prevalence of illness.	GNP trends and NHS funding; Public verse private finance; Disposable and discretionary income.	Best practice in medical, psychological and social care; NICE guidelines; New treatments; Evidence-based practice; Impact of IT: new tools, integration and automation on practice.	NSF framework; Star rating system (or its successor); Foundation hospital status; Obligations under existing legislation; Draft Mental Capacity Bill; Devolved commissioning.

self, what additional principles do you think are needed to give a comprehensive specification of an ideal DCS? With such a detailed specification you have a template to which you can repeatedly refer, enabling you to check at any stage, whether not the specific solutions you create will deliver *all* the service design principles.

**3. How?**

The third and final stage is to think about how the identified design principles can best be realised as actual processes. There is no hard and fast way of taking this challenging step in which creative solutions must be tempered with feasibility.

The central task in this stage is begin to turn the principles into a ideal map of inter-related processes, a pathway that flows from beginning to end. One way of getting a feel for this, is to create a rough grouping and ordering principles (some steps are dependent on others). For example, looking at Table 2 it can be seen that ‘detection’ comes before ‘pre-assessment advice’, which comes before ‘assessment of need’. In contrast, ‘promote healthy living’ may come before all (as a process for reducing the risk

of developing dementia) but also may reappear throughout the pathway (e.g. ‘healthy living in relation to dementia’ as a process aimed at preventing the development of behaviour problems). When ordering processes it is also helpful to think about the flow as a series of decisions, with explicit criteria about movement from one process to another in the pathway.

When developing an ideal process map that fully captures the service principles it should be remembered that:

- To be feasible any process must be optimally defined on four dimensions – Quality, Quantity, Timeliness and Cost. For example, to achieve the principle ‘facilitate the detection of dementia with timely and accurate diagnosis’ shown in Table 2 it possible to think of different cost options for detecting dementia (e.g. from having clinical psychologist with neuropsychological expertise in every GP practice through to training primary, intermediate and other community care staff in the use of highly sensitive screening measures such as the 6CIT, followed by targeted use of neuropsychological expertise).

Table 2: Examples of Design Principles for an Ideal Dementia Care Service.

**The Dementia Care Service will:**

- Maintain person-hood: physical; emotional, social, financial, spiritual well-being and independence;
- Facilitate the detection of dementia with timely and accurate diagnosis;
- Promote healthy living in relation to dementia;
- Provide easy and equitable access to services;
- Support/value carers at all stages;
- Use the most appropriate evidence-based tools;
- Provide an appropriate assessment based on individual need;
- Give access to pre-assessment advice and guidance for the person with dementia;
- Incorporate increased knowledge, training and education on different levels in the DCS;
- Enable and utilise the influence of users;
- Facilitate and be informed by evaluation and research in order to continually develop services;
- Train, monitor and maintain skill base of assessors;
- Assess and manage risk in all parts of the service;
- Etc.

- There are limitations on the resources available, people, skills, infrastructure, etc., that must be taken into account for the solution to be feasible. Your job is to creatively develop the best options for realising the principles (with effective and efficient processes), given these resource constraints and other limits of the existing system.
- Capacity of the service will be a critical variable. Thus the commissioning process must be supported by accurate information about the needs of your local population. Do not assume the information available is accurate (e.g. the high rate of undetected executive impairment in general medical older patient population diagnosed with anxiety/depression and subsequently screened using a highly sensitive/specific brief cognitive test, Schillerstrom *et al.*, 2003).

As the ideal process map of the service takes shape, what further steps you take will depend on your local circumstances. Most of us are not in the position of designing new services from scratch. In this case, you will need to identify the gaps between your existing and ideal service by comparing the current process map and your ideal process

map. If you are starting with a blank sheet of paper, a clear understanding about the organisation required to run the system will need to be developed. It is beyond the scope of this article to cover this but for example, you will need to consider roles and authorities of those who will be running the processes and managing the service. Finally, implementation of the new service or service changes will require formal project management,

**Conclusion**

The aim of this article is to give you some practical ideas about how you might think about the development of health services, whatever the nature or scale of the service involved. It should have become apparent that my description of principle-based design as 'practical' does not mean it is easy. Indeed one client in the private sector captured his own struggle with the process, when he described the design of his new international business organisation as 'a dark art'. Hopefully, this article will shed of few glimmers of light on what is a tricky and demanding enterprise.

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# Developing a psychology service in old age psychiatry

## An autobiographical account

Anne Crawford-Docherty

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**I**N APRIL 2004 I WAS TASKED TO establish a service model with a view to re-establishing a psychology service within the Trust's Old Age Psychiatry Directorate. The previous Head of Specialty had left the post approximately three years earlier, resulting in the suspension of the psychology service to Old Age Psychiatry and the relocation of the Old Age physical health service to our Physical Health specialty. The staffing level for the Specialty was established as 0.35 wte B grade and 1.0 wte Psychology Assistant. Although key stakeholders within the Directorate, Trust and Commissioning group recognised increasing psychology resources as a priority, no new monies were going to be forthcoming within the next financial year, and beyond.

The Directorate's services comprise three continuing care wards, two acute psychiatric admission wards, six intermediate care beds, two day hospitals, three CPN teams, community OT and physiotherapy service, memory clinic and three psychiatry teams. Integrated multi-disciplinary teams do not exist but multi-disciplinary working is welcomed. At the time of joining the Directorate, the day hospitals had just completed a redesign, the aim of which was to refocus them on treatment rather than an emphasis on social support. The inpatient unit (continuing care and acute admission beds) was also embarking on a redesign. The inpatient unit had been opened in the 1980s and consumed the majority of the Directorate's resources. However, there was dissatisfaction with the efficiency of the service amongst key stakeholders.

The initial challenge for the psychology service was to establish overall aims which

would act as a means for informing decisions about deployment of resources to best effect. The overall aim of the service is to contribute to the improved psychological-mindedness and psychological competency of the Directorate's services, and through these, to contribute to the mental well-being of the older adults of Sandwell. It works from a recognition of the difference between the need for a psychologist and a client's psychological needs, and work to rally multi-disciplinary resources to effectively address the latter, so clarifying the former.

A focus on direct interventions with a psychologist rather than an assessment of an individual's psychological needs is limited in terms of efficient use of resources and in the development of skill mix in key mental health and social care teams. The selection of psychological approaches based on diagnoses rather than on formulation or understanding of the individual's difficulties can lead to targeting symptoms rather than meeting psychological needs. The advantage of focusing on an individual's psychological needs allows for a tiered and targeted intervention package tailored to the individual's holistic needs, thus using multi-disciplinary skills in a more effective, efficient and integrated manner. Obviously, within the above psychology establishment, it would not be feasible to attempt to address face-to-face psychological need through direct clinical work alone. It was within this context that the development of psychology services was initiated.

The first task in development was to assess the readiness for change of the various aspects of the old age psychiatry services.

I have long subscribed to the view that the same processes of assessment, formulation, intervention and evaluation that psychologists apply to individual clients can also be applied to systems. To this end I began looking for **indicators of psychological thinking** within the day and inpatient services in the form of therapeutic work, discourses used to describe clientwork, integration of biopsychosocial model in all aspects of the service delivery and so on. Data to assess such areas was collected through observations of informal client-staff contact, group sessions (where groups existed), client reviews, informal discussion regarding particular clients or presenting problems, observing which clients/presenting problems staff groups found challenging, and how staff related to my handover and treatment plans for those clients I assessed. In addition to assessing levels of psychological thinking I also assessed **openness to change** in the form of new ideas, again as I would with clients seeking individual psychological interventions. Such indicators were willingness to engage in psychological conversations about the work of the service setting, whether people sought me out to discuss client or service issues, reactions to tentative formulations I presented about services or clients, the presence or absence of 'resistant' or avoidant behaviours ('we've always done it that way', 'yes but...'). Such information could inform the process issues relating to making change, like, the timing, targeting and form of offers of ways of delivering psychological thinking, e.g. supervision groups, consultancy sessions, staff training, etc. A third focus of assessment is the services' **past experiences** of systems-focused psychological interventions either from psychologists in the service or from managers trying to make service changes. Also, experiences of psychologists working with clients. Again, informal conversations with different stakeholders yield rich amounts of data in this domain. These three sources of data (indicators of psychological

thinking, openness to change, past experiences), together, provide the bare bones of a formulation of the service's psychological-mindedness and readiness for change, which facilitates a means of selecting and timing interventions.

I will now describe the formulations and interventions that underpinned the development of the psychology service in three of the Directorate's service areas.

### **Day hospital services**

The two Day hospitals in the service have the same function but differ in terms of geographical patch served. Both Day hospitals had recently undergone redesign and were attempting to become more focused on treatment with its associated concerns with client objectives, discharge processes, etc. Both Day hospitals claimed to work within a biopsychosocial model but differed in their approach to the 'psycho' components of their services. The Modern Matron for the Community had experience of cognitive-behavioural interventions and had encouraged her Day hospitals to develop groupwork packages.

My approach to the Day hospitals elicited different reactions from their managers, which I used as part of my assessment data. Day hospital 1's manager seemed to find it very difficult to make an appointment to see me, specifically stating that she would not be able to ever see me on the only two days of the week that I worked in the older adult directorate, due to patient reviews. Day hospital 2's manager accommodated my availability and, at our first meeting sought my advice on the Mind over Mood group they had established. She wanted time from me to support her staff in increasing their effectiveness in running the Mind over Mood group, rather than wanting me to run it for them. Neither Day hospital had had experience of systematic psychology input, but were aware that some of their patients had seen a psychologist before. At that point it was difficult to gain any data on the above areas for Day hospital 1. Day hospital 2

seemed to value psychological thinking and be trying to develop it, welcoming the opportunity to use psychology input to further their biopsychosocial interventions.

Day hospital 2 was offered consultancy sessions focussing on the Mind over Mood group with the two facilitators. This proved helpful for the team to the extent that I was able to offer to facilitate a supervision group to focus on all of the groupwork offered in the Day hospital and open to all staff members. This was well received and, over the last 12 months has broadened its brief to look at individual client issues as well as group, and also service delivery issues. An interesting example of the latter is the issue of clients generalising their coping skills learnt in psychoeducational groups and moving on to discharge. The idea of examining exit strategies for Day hospital patients led to discussing the potential development of a recovery group based on Copeland's (1997) Wellness Recovery Action Planning (WRAP) within the supervision group. Further psychological support was then provided through theoretical resources in the form of literature and trainee clinical psychologist time given. Other outcomes have been joint assessments and interventions for particular clients, together with presenting problem-specific teaching in the supervision group as well as work on formulating clients' difficulties. The psychology service delivered to the Day hospital now takes the form of a monthly supervision group, joint client work and input into the groupwork programme through supporting new developments and governance issues. Such input is sustained by providing one day per week of trainee clinical/counselling psychologist time and one hour per month of consultant psychologist time in the form of supervision group facilitation.

A relationship with Day hospital 1 was maintained through joint clinical work initiated by the consultant psychologist when psychiatric teams wanted to refer clients to psychology who attend the Day hospital. Joint working with three clients enabled

consultancy sessions to informally develop about other clients, which in turn, facilitated access to new psychological ideas. The Day hospital team then approached me for monthly supervision group facilitation, which, at the time of writing has been established for four months. The focus to date has been on formulation of individual clients presenting problems. It is planned to support this work by introducing a day per week of trainee clinical/counselling psychologist time, supported with joint clinical work and supervision delivered by myself.

### **Inpatient service**

Indicators of psychological thinking and openness to change were potentially different in different parts of the inpatient system. At a managerial level, the inpatient unit was embarking on a 'fit for purpose' redesign which involved re-examination of all aspects of the unit's functioning. Thus, it could be concluded that at a management level, the service was open to change. Part of the remit for the change was to overhaul models and processes in keeping with biopsychosocial models and multi-disciplinary working. Thus a theoretical openness to increased psychological thinking could also be assumed. I joined the management team steering the re-design project and took on elements of the overall project; review of all inpatient assessment systems and measures and development of meaningful activity strategy and programmes. These projects also acted as means of collecting data on the psychological-mindedness and readiness for change of particular wards and teams within the unit.

The first stage of psychological engagement within the inpatient unit involved participation in planning events around the redesign and then project planning and facilitating aspects of the redesign project. I co-facilitated the development of meaningful activity models for the inpatient unit, holding multi-stakeholder events mapping current activity provision and prioritising further activity development. At this point

we decided to focus on the acute admission wards and, specifically the one now designed for people with functional mental health problems. Although the nursing team on the ward expressed interest and commitment to development of meaningful activities on the ward, the feedback from other disciplines on trying to implement such activities with the nursing staff seemed to contradict this stance. Assistant and trainee psychologists were tasked with developing three psychoeducational groupwork packages for the functional admission ward, to be delivered by psychology staff and either occupational therapy or nursing staff. The task of implementing the packages would provide myself with some real-time data in psychological-minded behaviour with the ward staff group. It was found that the ward was not equipped to deliver psychological interventions; that is, the ward systems could not accommodate the need to change interaction styles with patients to support their group attendance, to use feedback from the groups in review meetings, to be able to identify patients who were appropriate for the groups due to difficulties in identifying patients' psychological needs, and so on. Further informal data collection on the ward indicated that the psychological-mindedness of much of the nursing team was particularly low; for example, meaningful activity was not clearly conceptualised as an element of someone's treatment but rather a way of passing time whilst the physical interventions take effect, and patients' independence and functioning levels seemed to deteriorate during an admission. Such data was used to formulate the issues on the ward as relating to low levels of psychological-mindedness rather than, for example, an obstructive attitude to talking treatments or resistance to multi-disciplinary working. Once such a formulation was developed and introduced into discourses about and around the ward, interventions became clearer in that they needed to target the psychological-mindedness and culture of the ward. To this end, a supervision group was established on the ward as a

result of the formation of senior managers prioritising such work in the hospital. This group is facilitated by myself on a three-weekly basis, front-loading introductory theoretical input around the biopsychosocial model, patient-centred care and formulating patients' difficulties. In addition, hospital-wide psychological engagement teaching within a cognitive-behavioural framework has been commissioned to start in the new year, with an emphasis on skills development and supervision groups.

### Conclusions

From the above descriptions of service development to date, I hope it is apparent that, within a wholly inadequate psychology establishment, a model has been established within which effective psychology services are being developed and delivered. The effectiveness of the service delivery is heightened by attempts to ensure that the form of service delivered is in keeping with the psychological needs of that particular aspect of the psychiatric system. The above work has provided a foundation on which to build negotiations with commissioners, supported by stakeholders in the old age psychiatry directorate who are receiving valued psychology input into their service areas. The application of fundamental psychology concepts to organisational development has facilitated the development of a multi-faceted specialty service. I am now at the stage in the specialty of applying the concepts to broader community services and in developing research proposals to investigate the theoretical rigour of the concepts and effectiveness of the models.

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# Wellness Recovery Action Planning (WRAP) group with older adults at Hillcrest Day Hospital: A pilot programme

Bernadette Bywater & Christina Hartley

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**T**HE FIRST WRAP GROUP WAS conducted with older adults at Hillcrest Day Hospital, Smethwick, between June and August 2005. Hillcrest is an acute psychiatric Day hospital for people over the age of 65. A recent re-design of the hospital had seen the introduction of groups for functional clients such as Depression Awareness and Anxiety Management. The WRAP group was designed to complement these changes and to promote recovery and self-management of symptoms, without the ongoing involvement of the Day hospital.

## **Recovery in mental health**

Recovery in mental health has been defined as the ability to live a full and satisfying life, within the constraints of mental illness (Anthony, 1993). The emphasis is not on curing the mental health problem, but finding a way to live with it (Davidson, 2005). Deegan (1998) emphasised the recovery of the person 'with or without the disorder'. The goal of recovery programmes in mental health services is to promote these principals so that people can live meaningful lives (Farkas, Gagne, Anthony & Chamberlin, 2005). The National Institute for Mental Health in England (NIMHE, 2005) has emphasised the importance of a focus on recovery in mental health services.

## **Recovery and older adults**

The development of programmes targeting recovery and wellness in older adults suggests that they are capable of becoming competent in managing their own recovery and places value on the future quality of life of older people. In comparison to working

age adults, this aspect of older adult services has been markedly underdeveloped. Where recovery work has taken place with older people, it has mostly focused on those with organic conditions. Addressing this discrepancy is an important strategy for reducing ageism in mental health services. The authors could not find any examples of recovery groups being conducted with older adults with mood disorders.

## **The WRAP programme by Mary Ellen Copeland (1997)**

The group conducted at Hillcrest Day Hospital, was based on the WRAP programme designed by Mary Ellen Copeland (Copeland, 1997). According to Copeland (1997), the aim of WRAP is to develop individually tailored strategies that can be used to promote higher levels of wellness, stability and quality of life.

WRAP is based on five key concepts (Copeland, 1997):

1. Hope.
2. Self-Responsibility.
3. Education.
4. Self-Advocacy.
5. Support.

## **The Wellness Recovery Action Plan (WRAP) consists of the following stages:**

### **Section 1. Daily Maintenance List**

A list of things that each person needs to do on a daily basis to stay well, for example, self-care, exercise, nutrition and opportunities for social contact.

### **Section 2. Triggers**

Identifies individual triggers for symptoms of mental health difficulty, such as conflict with family members or problems with housing.

### **Section 3. Early warning signs**

Identifies individual signs that the person is becoming unwell, such as going out less or difficulties sleeping.

### **Section 4. Signs that things are getting worse**

Individual signs that the person is becoming increasingly unwell, such as crying or physical symptoms of distress.

### **Section 5. Crisis plan**

Each participant develops their own crisis plan, to be implemented if their symptoms become severe enough to interfere with their ability to be in control of their choices. It outlines client preferences for medication, treatment and supporters.

### **The Wellness toolbox**

A central aim of WRAP is the development of an individualised wellness toolbox. The toolbox is a stand-alone resource that details what clients can do to alleviate symptoms and stay well. It is a working document that is developed throughout the WRAP programme and is designed to continue to evolve after the group, as clients themselves continue to develop.

### **Self-esteem**

An important part of the programme targets self-esteem by identifying past achievements and goals for the future. In addition to this exercise, self-esteem is promoted throughout the programme by empowering participants to develop the skills and confidence to manage their own recovery.

### **The WRAP programme at Hillcrest Day Hospital**

The group consisted of six older adults who had a history of mood disorders. It was run as a closed group two facilitators over 10 weekly sessions. In accordance with the principles of

WRAP, the group was user-led with facilitators combining the ideas of participants' with WRAP literature to determine the content of each session.

### **The resource book**

A resource book was collated by participants outside of the WRAP sessions for themselves and as a legacy for subsequent groups. It included a directory of services in the community that could contribute to good mental health and recovery, such as lunch clubs and facilities for older people to exercise. The process of developing the directory was designed to raise group member's self-esteem by making use of their considerable local knowledge and to encourage links with resources in the community.

### **Suggestion box**

Facilitators proposed the use of a suggestion box, so that group members could provide feedback on the WRAP programme. Participants declined to make or use a suggestion box, explaining that they did not have any comments to make that had not already been addressed within the sessions. Moreover, they frequently expressed positive views of the group, some of which are reported below. This decision suggests that the group was genuinely user-led.

### **Evaluation of the group**

#### *Evaluations by group members*

Facilitators periodically asked group members for their views on what had been more or less helpful about the programme. These comments were recorded and taken into account when planning subsequent sessions.

Participants also completed anonymous evaluation sheets at the end of the last session. All participants reported that they understood the concepts of WRAP and found the sessions helpful. The sheets asked for positive and negative aspects of the sessions and all participants elected not to record any comments about negative aspects. Comments on the positive aspects of

the sessions included: 'It helped me to understand my symptoms and why they were happening' and 'giving us confidence to get on with our life and face fears'. None of the participants made any suggestions for future considerations or ways to improve the group, which may reflect the collaborative process that led to the planning of each of the sessions and the genuine involvement of service users. The section asking for any other comments included positive comments such as: 'This group has been very helpful for me and staff give every support possible'.

***Standardised group evaluations used by Hillcrest Day Hospital***

As part of Hillcrest Day Hospital's clinical governance procedures, groups are evaluated at the end of each session by facilitators using standardised forms. Comments are made about the general level of participation and participant's knowledge and understanding of the concepts of the session. Facilitators record their views about the positive and negative aspects of the session, as well as suggested improvements and future considerations. These forms aided the planning of each subsequent session and were particularly useful for a pilot programme. It was noted that for both facilitators and group members, participation in the group led to a shift in attitude and language from a problem focus, to a focus on strengths and the person as a whole.

**Outcomes for individual participants**

When reflecting on the outcomes for each of the participants, it is important to note that the issue of discharge is a challenging area for many mental health services and service-users. Three participants were discharged at the end of the group and one shortly afterwards. One participant is currently accessing significantly reduced support from services and one participant will require ongoing support. Staff also noticed that group participants were markedly more positive about their attitude towards discharge.

Participants decided to swap telephone numbers and have agreed to meet once a month, creating their own wellness self-help group. In addition to being a valuable source of peer support, group members will also benefit from an additional opportunity for social connectedness.

**Suggested improvements to the evaluation of WRAP**

Participant's comments' provided useful information about how the group was experienced by them and is in accordance with the WRAP ethos of being user led and individualised. The standardised forms used by Hillcrest Day Hospital will continue to be used to contribute to meet the requirement of clinical governance procedures as well as to aid the development of future groups.

A useful addition to the methods used to evaluate the group would be the inclusion of a standardised measure of wellness. This is planned for future WRAP groups at Hillcrest.

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# Psychoeducational support groups for clients with early-stage dementia and their carers

Paul Mason, Georgina Slatter & Caroline Sincock

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**T**HIS ARTICLE WILL FOCUS LARGELY on the evaluation of two psychoeducational groups for clients with early-stage dementia and their carers that have been facilitated within the Worcestershire Mental Health Partnership NHS Trust between 2004–2005. We will also reflect on the developments that have been undertaken and on our experiences as facilitators over the three years the groups have been run.

## Background

Since the National Service Framework for Older People (DoH, 2001) indicated a move towards patient-centred care – with an emphasis of providing services when required and treating older people as individuals able to make choices regarding their own care – service providers have had to re-evaluate and address the needs of service users. In turn, this has highlighted a gap in services available for clients, especially in relation to early-stage dementia.

With the development of specialist memory assessment services and advances in medication, people are being recognised as suffering from dementia at an earlier stage (e.g. White, 2004). Although this stage is often characterised by difficulties with short-term memory, concentration and attention, a person's insight into their condition and their understanding of what the future holds can be intact. However, insight can in turn lead to distress with 30 to 40 per cent of clients with Alzheimer's developing depression (e.g. Maynard, 2003); therefore, a need to address the psychological needs of these clients can be identified.

These service requirements have led some older adult research to focus on the usefulness of psychoeducational groups.

## Rationale for Psychoeducational Groups

Generally speaking, psychoeducational groups aim to educate group members in ways of coping as well as providing a source of social support through contact with others facing similar difficulties. In such a setting, group members can develop new skills and knowledge to assist in overcoming or adjusting to environmental challenges and life transitions (Schneider & Cook, 2005).

In relation to clients with early-stage dementia, Yale (1991) and Aggarwal *et al.* (2005) have highlighted that meeting with others provides individuals with a sense of hope, reduces feelings of isolation, facilitates catharsis, altruism and provides a chance to share coping techniques. Kipling, Bailey and Charlesworth (1999) have suggested that being with others in a similar situation helps clients challenge unhelpful thoughts and beliefs.

Ermini-Funfschilling and Meier (1995) reported the effects of a memory-training group for early-stage dementia and found a reduction in depression, whereas the clients not receiving this intervention showed an increase in depression.

Goldsilver and Gruneir's (2001) experience of group-based education for clients with dementia provides further support for the usefulness and supportiveness of this type of group. Eighty-eight per cent found the educational aspect of the group helpful. Seventy-four per cent found the group to have improved their ability to cope with their

problems more effectively. Although their group was primarily designed for clients, the authors also drew attention to the importance of the inclusion of carers.

Snyder and Quayhagen (1995) suggested that involving carers in the group had the potential to enhance communication and sharing between themselves and the client. McAfee, Ruh, Bell and Martichuski (1989) suggested feelings of empowerment at the inclusion of a family member or friend in discussions that affect the whole family.

The literature reviewed here provides support for the use of psychoeducational groups for clients with early-stage dementia and their carers and suggests a range of psychological benefits, from improvements in levels of depression to improving coping ability. Furthermore, within the framework of providing services that are both effective and economic, there seems to be increasing support for the usefulness of psychoeducational groups, not only for the client and carer, but also economic use of therapist time.

### **Service development**

To date there have been five 'Coping with Forgetfulness' groups facilitated across the county of Worcestershire (the focus of our research are groups 3 and 4). All groups have been organised and facilitated by the Psychology team or between Psychology and Occupational Therapy.

### **Aims of the group**

Group aims and content were discussed and agreed between these teams at a countywide meeting – decisions were based on current literature and resources available within the county. The aims were:

1. To improve clients and carers' understanding of Dementia and memory difficulties.
2. To improve clients and carers' understanding of medication and memory.
3. To facilitate client and carer coping ability on both a practical and emotional level.

The content outline is summarised below:

Week 1 – Introduction to the group – Understanding dementia;

Week 2 – Medication and understanding memory;

Week 3 – Development of coping strategies;

Week 4 – Coping strategies – putting them into practice;

Week 5 – Emotional adjustment;

Week 6 – Looking to the future – which services are available, if relevant discuss legal and financial issues, e.g. Power of Attorney;

Week 7 – Group evaluation and review.

Across the course of the first two groups the following factors were identified as being particularly important to facilitating a group successfully and have influenced the running of subsequent groups – these factors were based on the feedback of group members and the decisions and opinions of facilitators:

- The first group was open to clients only – feedback indicated a desire for carers to be present, carers have, therefore, been invited to attend since.
- Some clients have reported that having the space to talk about their feelings away from their family members is invaluable, therefore, this opportunity is still included in the group but is confined to 'Week 5 – Emotional adjustment' – whereby carers and clients are divided into separate groups.
- Early groups highlighted the importance of the selection process – it is felt that matching clients with similar levels of impairment reduces the potential of causing awkwardness or even distress for those with greater insight and encourages group cohesion.
- Early group experiences have highlighted the importance of having a number of group members who are comfortable with talking about their feelings with the aim of facilitating discussion, especially during the 'Emotional Adjustment' session.

## **Recruitment**

The client inclusion criteria for each group is as follows:

- A diagnosis of early-stage dementia by secondary care;
- Insight into their condition;
- A willingness to attend and participate appropriately in a weekly group setting;
- Presence and willingness of a carer to attend (although there is some flexibility on this point if it is felt that worthwhile benefits can be made by the client attending alone).

The referral pathway for all clients was as follows:

1. Referrals received through CMHT (approximately 10 for each group) and through a systematic review of all referrals to the CMHT within the last six to 12 months (generating an approximate number of 15 individuals to assess further for each of the groups).
2. Discussions with keyworker and review of psychiatric notes – the group was deemed unsuitable for a number of clients at this stage.
3. Structured interview with client and carer at their home by two group facilitators – this provided an opportunity for clients and carers to ask any questions and for the facilitators, a chance to assess for group inclusion suitability – the group was deemed unsuitable for some clients at this stage.
4. Invitation into the group for those deemed suitable.
5. Clients and carers required to complete pre-group measures (specifically designed questionnaires comprising open-ended questions and self-rating scales)

Reasons why some individuals were excluded from groups 3 and 4:

- No insight into difficulties;
- Too cognitively impaired;
- Residing in Nursing Home;
- No formal diagnosis of dementia;
- No help wanted;
- Group time clashing with prior commitments.

## **Participants**

Group 3 included five clients (three male, two female) and their carers (one male, three female). One client who did not have a carer was very keen to attend the group so was considered appropriate.

Group 4 included five clients and five carers (coincidentally all clients were men, and all carers women).

The mean average age of clients was 75 years old and the mean average age of carers was 68 years.

## **Measures and design**

Specifically designed questionnaires comprising of open-ended questions and self-rating scales were developed for both clients and carers. The questionnaires were designed to investigate clients' and carers' understanding of memory difficulties, coping ability and the group experience as well as client well-being. Due to the group being relatively new in relation to service developments, specifically designed non-standardised questionnaires were thought to gain more of a detailed evaluation of the group. Furthermore, qualitative methods were considered not only more appropriate due to the small number of group members, but would also provide richer information regarding the individual experiences of group members.

## **Procedure**

After the initial screening meeting, another meeting was arranged to complete the pre group questionnaires. Most meetings were with the assistant psychologist in the group members' own home and all questionnaires were completed one to one.

There were seven group sessions held once a week over a seven-week period. All sessions were one-and-a-half hours long and held in an older adult day hospital setting. Group sessions were led by the clinical psychologist (and occupational therapist during Group 3) with the Trainee and Assistant Psychologist as observers and occasional contributors.

## Findings

### *Pre-group findings*

Although the group members were invited into groups on the premise of having insight into their difficulties, the degree to which the prognosis of a dementia-type illness had been previously explained and explored was fairly limited for most. None of the group members had engaged in any other services other than those offered by their GP and psychiatric outpatient appointment.

During pre-group interviews personal goals from attending the group were discussed with each individual. The themes that arose related to acquiring more information, developing greater acceptance to memory difficulties and to meet other people who understand. This is reflected in some of the following comments – one carer stated that her goal from attending the group was that she *'wanted to learn how to handle and accept things'*, while another client commented that the services he had previously engaged in *'did not explain (his) difficulties very well'*.

### *Post-group findings*

A common theme emerging from the post-group data related to the importance of sharing strategies with other group members e.g. *'listening to others – how they are dealing with things is most valuable'* and *'discussing (coping strategies) with others reinforces own ideas'*.

Reference was made to an improvement in ability to cope with memory difficulties and an increase in acceptance. For example, one carer stated *'I am definitely a bit more patient and, hopefully, a bit more understanding and I can now 'step back' and try and put things into perspective'*.

On a practical level couples spoke of new strategies that they had adopted such as using safe boxes, lists, diaries, making notes and making some changes around the home. One client stated that they were *'looking to downsize the wardrobe'* whilst a carer spoke of their commitment to using different strategies by stating, *'I feel it worth while trying to keep going with some of the coping strategies – I will not give up!'*.

With a number of clients and carers exposed to sensitive information relating to prognosis for the first time, it came as little surprise that quantitatively the data was found to show a slight decline in perceived ability to cope with memory difficulties at the post-group stage – as illustrated in Figure 1.

With regard to client gains, many were identified, for example one client made reference to a *'boosted self-esteem'*, whilst others made reference to enjoying the social aspects, for example *'having a friendly group'*, *'knowing people are listening to what you have to say'*, and *'listening to how others are affected'* were all comments that suggested some fulfillment. None of the clients mentioned the educational format; instead *'meeting others in a similar situation'* as well as gaining assurances that they were *'not the only one'* were factors more commonly identified.

For carers, sharing experiences was mentioned as being a specifically useful aspect of the group. Reference was also made to the educational element of the group as being useful, such as *'discovering support agencies'* and *'understanding medication'*. One carer stated that *'Understanding more about problems with loss of memory has made life easier'*. Carers reported practical information as supportive, however there was an equal emphasis on the emotional support gained from *'being with other carers and partners'*.

Some carers mentioned *'meeting professionals'* and *'being made aware of the help available'* as being the most supportive aspect of the group, while others reported finding out *'Practical methods of coping and gaining information on memory loss'* as particularly useful. The trend for carers to focus on both emotional and practical support was mirrored in the final post group questionnaire. Following completion of the group some carers reflected with regret in relation to their previous service experiences, for example one carer stated that she *'wished things had happened earlier'*.



Figure 1: Bar chart detailing clients and carers perceived ability to cope with memory difficulties.

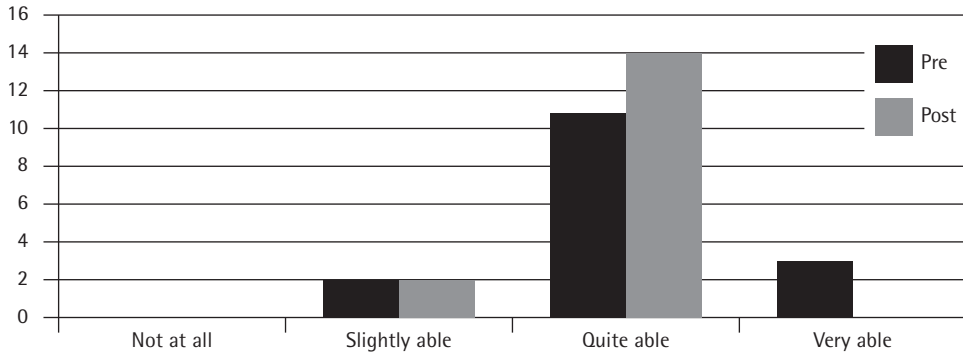
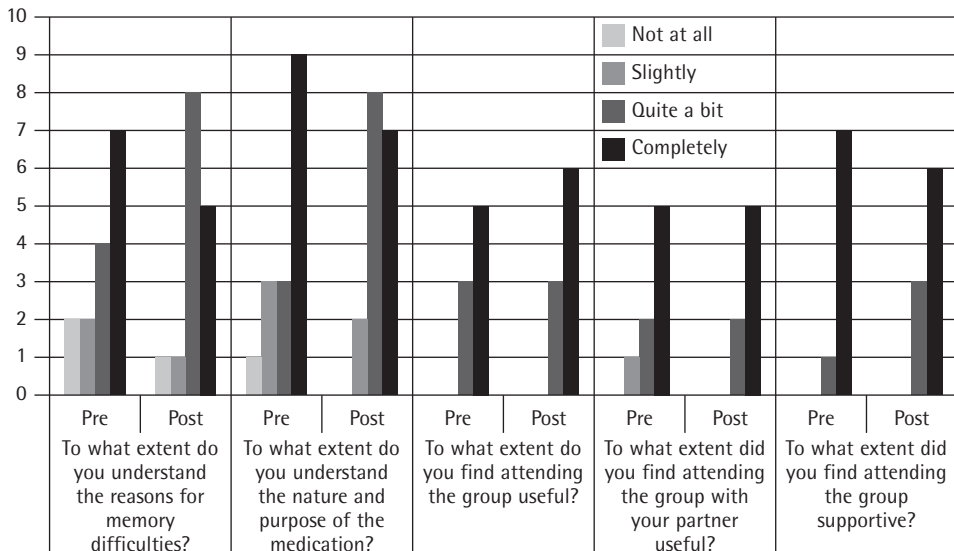


Figure 2: Bar chart detailing clients and carers understanding of memory difficulties and medication and post-group evaluation.



Quantitatively the results indicated that there was a slight increase in understanding of memory difficulties across the two groups as over 85 per cent of individuals, at the post-group stage reported that they understood memory difficulties at least 'quite a bit'. The bar chart also illustrates an increased under-

standing of medication amongst group members with 88 per cent of individuals reporting at the post-group stage that they understood medication at least 'quite a bit'. Quantitatively, group members indicated that they found the group useful, supportive and beneficial to attend with their partner.

## Discussion

Overall the data suggests that all group members found the group useful and supportive.

With regard to coping ability clients made reference to changes in emotional coping with a theme of 'acceptance' applicable to many, providing support for Yale (1991), who suggested that meeting with others had the '*potential for facilitating emotional adjustment*'. Differences in levels of acceptance of a diagnosis of dementia have been described by Woods *et al.* (2003) who stated that receiving a diagnosis marks an '*important transition*' point, from which time the individual gradually '*adjusts and learns to live with the impairment and loss of function*'. Qualitative data obtained suggests that for some the group may have played some part in facilitating this process. However, there were also some clients who found the question of identifying and understanding the cause of their problems difficult to answer. Yale (1995) has suggested that some people in the early stages of a dementing illness cope by denying any problems.

The carers' focus was centred on the practical and emotional implications, and highlights the importance of both the educational and supportive element of the group. Furthermore, some clients and carers mentioned the usefulness and supportiveness of sharing strategies with peers, rather than purely focused on facilitators' advice. Again, this demonstrates not only the importance of education and support, but also draws attention to an interrelationship between the two.

Clare (2004) provides a definition of '*awareness*' within dementia as '*the recognition of the fact, degree and implications of one's own illness*' and goes on to state with some concern that '*there is an underlying assumption that an individual's awareness of their dementia is something that can be straightforwardly rated and classified and reliably elicited in a brief clinical interview*'. Future research may want to focus more on broader questions rather than specific ones, and specifically on qualitative

and thematic analysis, which is longitudinal in nature.

One of the main indicators that members valued the supportive aspect of the group came not from the answers given during interviews, but from the fact that all members were eager and now all attend a 'post-coping with forgetfulness group'. This group provides an opportunity for members to meet up once every two months to participate in more socially orientated meetings with group members developing a more active role in determining the activities for each meeting. These meetings appear to be a positive continuation from the group as attendance to date has been high. In addition to the social element, adequate opportunity is given to ponder current dementia care issues relevant to the group, either in the form of group debate or informal one-to-one discussion. This group provides further research opportunities in determining the long-term value of psychoeducational groups as well as post-group support.

The importance of a continuation group is supported by the findings of Bender *et al.* (2004) who commented on the '*ability of the group to change and develop*'. This can be in relation to the course of each group member's illness, as well as through the development of social relationships between group members, but also with regard to levels of acceptance. A support group can allow this process to happen within a supportive environment.

In conclusion, the results of this study have provided support for the use of psychoeducational groups for this client group and their carers and is in line with the research conducted by Goldsilver and Gruneir (2001). Anecdotal comments relating to improvements in confidence and acceptance as well as changes in perspective through recognising that others are in similar positions have provided support for the group. In turn this has also provided support for Yale (1991) and Aggarwal *et al.* (2005) who suggested that meeting with others provides clients with a sense of hope,

reduces feelings of isolation, facilitates catharsis, altruism and provides a chance to share coping strategies.

### Service implications

All localities within the Trust are gaining an increased number of clients who are being referred in the earlier stage in their illness for confirmation of diagnosis and for information, advice and support regarding prognosis. The Memory Clinic, currently being implemented, serves to facilitate diagnosis and the prescribing and monitoring of anti-

cholinesterase medications. All professionals within the Community Mental Health Teams have an increased rate of referrals for clients and families who require further support to facilitate their adjustment to the diagnosis. Psychoeducational support groups as described above are an opportunity to provide appropriate support and advice, making use of evidence-based practice, psychoeducational strategies and peer support, in a cost effective manner to complement the provision of medication.

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# The Phoenix Group – living again after a diagnosis of dementia

Linda Randeria & Judith Bond

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## Concept and philosophy

**H**OWEVER SENSITIVELY THE NEWS is delivered, receiving a diagnosis of dementia is a profoundly life-changing experience, not only for the individual themselves, but also for the wider social context of family and friends. With the trend towards earlier and earlier diagnosis, although individuals vary in their degree of insight and concern, the impact of receiving such a diagnosis in these early stages can have a profound effect upon the person and their families.

The ability to adapt to these changed life circumstances can be enhanced by a supportive social environment (Kitwood, 1990) and research has demonstrated that factors such as acceptance by a peer group and universality are important elements in making these early adjustments (Peach & Duff, 1991).

These principles were the primary motivating factors in the conception of the Phoenix Group, which is a group that offers ongoing psychoeducational and social support to people with dementia and their families. The philosophy of the group is to encourage independence and socialisation, thus reducing the sense of isolation that can follow a diagnosis of dementia.

## What makes the Phoenix Group different?

In this way, the Phoenix Group is not unique. There are now many short-term support groups for people with a diagnosis of early stage dementia, varying in length from a few weeks to several months. Some of these groups cater for only the person with the diagnosis, some include carers, but the common theme within those groups appears to be that

they are set up and facilitated by professionals, with structured dementia related topics for discussion. Generally, this leads on to more relaxed, less formal interactions, with group participants taking a more active lead. However, what makes the Phoenix Group different to many others is the degree to which the group members are actively involved in their service, and that it is an ongoing, open-ended service that offers input whilst it is needed, however long that may be.

## Origins

Within North Warwickshire, there was a Post-Diagnosis Support Group, which was essentially a time-limited intervention to provide immediate post-diagnosis information and support for the person with dementia and their family. As frequently happens, at the end of the group, the participants expressed sadness that it was coming to an end, as they had begun to develop bonds that could potentially develop into friendships. The need for longer-term intervention was painfully clear.

Some attendees of this group were younger individuals who had recently been diagnosed with early-stage dementia. In early 2003, these attendees, their significant others, staff from the Day Hospital, along with colleagues from Psychological Services for Older People gathered together to discuss the lack of appropriate services for younger people with dementia within North Warwickshire.

What emerged from these initial consultations was the need for a proactive and positive approach to meeting the very real need for meaningful occupation and the maintenance of independent living. Although statutory services were available, they were clearly

insufficient to meet the specialist needs of this group of people. There was also a strong realisation that the diagnosis had profoundly affected not only the person who received it, but also the whole family unit and beyond. This highlighted the carers' need for ongoing inclusion, and for staff to face these issues within a social context.

From the beginning, there was a shared vision about the direction the group needed to take, and a strong sense of ownership and commitment amongst the group members. The Day Hospital staff responded positively and proactively to the challenges presented by this new development, including managing the risks involved, as this was a radical departure from the usual kind of service offered to this client group.

*'The beginning was very difficult because I felt out on a limb – I wasn't sure whether I was allowed to be doing what I was doing. Government documents talk about carers and users having more influence and power so I knew from this perspective we were on the right track, however, it was still very scary. I wasn't sure whether I was allowed to do what I was doing as I was breaking away from the traditional way that the Day Hospital was run and doing things differently. You get scared empowering people and the risks that could ensue from this – however, this was covered by disclaimer forms.'*

The name of the group directly reflects this philosophy and concept of 'rising again from the ashes' – restructuring life after a devastating event, to face the challenges of developing a new way of living with the illness, with the emphasis on living rather than on illness.

### **Group structure**

The Phoenix Group first met on a weekly basis, on Trust premises at a local clinic. Although this venue was suitable in terms of cost and accessibility, it was not ideal due to having to share the rooms with the baby clinic. There were other limitations, such as a lack of rooms to discuss any confidential issues or 'escape' to if the emotions became

too overwhelming to deal with in the wider environment. Time restrictions were also a difficulty, as the room was not available until after 11.30 a.m., which meant there were time pressures that distracted from the enjoyment of the day.

Given these problems, an alternative venue was secured in a local village hall. As there was an obvious funding implication in the hiring of premises, the group formed a steering committee with a nominated chairperson, secretary and treasurer, and began to hold a weekly raffle to raise funds. A weekly subscription of £1 per person was agreed, to help meet these costs.

### **Activities**

The group is strongly focussed upon providing a wide range of activities that promote and maintain independence and challenge the traditional 'day hospital' concept.

*'Derek tries to arrange a trip out every five or six weeks. Canal trips and lunch out are always very popular, and we have visited Aston Hall and Shugborough Hall. This is nice for carers, but perhaps not so beneficial for their partners if they are not very mobile or no longer interested in that kind of thing. We have done craft work, but more trips would be nice, but it's finding things to suit all. When the craft activities are on the programme, there are a few reservations, especially from the men, but when we get started with the bit of paper and stuff, we all really enjoy it. It's also nice when we have speakers coming in to talk to us, for example, Helen (CPN) came to talk to us, and we have had a talk about finance. We have bought a digital camera to take pictures of our activities, and help us remember what we have done. We have an Xmas lunch arranged again for this year, and we have games like skittles and giant Jenga to play. We all enjoy that.'*

### **Emerging themes**

As the group became more established, a new factor emerged that had not been anticipated by anyone involved – the issue of age discrimination. It soon became apparent

that the need for proactive psychosocial activities and support for people in the early stages of the illness was not limited to younger people – older people could also benefit from this opportunity. Thus the parameters of the group were widened to include anyone who had been recently diagnosed with early stage dementia and their carer.

In late 2004, a small-scale research project was carried out to evaluate the group. Focus groups were held with clients and carers and thematic analysis was carried out. The following themes were identified:

**Clients:**

- Universality;
- Keeping involved in the process of living;
- Acceptance of each other;
- Enjoyment within the group;
- Unconditional positive regard;
- Improving confidence and self esteem.

**Carers:**

- Universality;
- Enjoyment;
- Escape;
- Staff support;
- Sharing of feelings and experiences.

**Support and universality**

These themes were expanded upon by a recent series of interviews with staff and group members. The issue of support and universality is one that arises repeatedly when discussing the group with participants.

*‘Support has to be top of the list, but I think it’s much more about support for carers than those with the diagnosis. The carer does not get as much support from the professionals – at the Phoenix Group, there are like-minded people who understand the emotional turmoil, and their support is invaluable. In fact, it became my lifeline to sanity, as I used to look forward to Tuesdays, I would say to myself ‘I can get through until Tuesday’ ... Wednesday and Thursday were better, and then the cycle would begin again. I think it’s about not having to explain ...’*

*‘We aim to bring together carers and those who have been diagnosed with dementia in a relaxed setting, where we can enjoy each other’s company and support.’*

*‘It definitely empowers people and encourages socialisation. They become more relaxed about their illness and can talk openly in the group and you can see that this is good for them. Partners similarly gain a lot in terms of support from other carers.’*

*‘It’s very difficult for a partner to see the one they love disintegrate, you have to learn to love and accept them all over again. In order to do that you need the support of others: families are marvellous, but you can’t always talk to your children. It’s too upsetting and too much emotion goes into it. Children grieve too, and you all have feelings of guilt, as if you are not doing enough. Having the group enabled me to make friends for a start – it’s not easy to relocate to the Midlands – but it’s also the feeling that there are people to whom you can chat in an informal way. We sometimes ring each other up, and it’s good to know that we can have a good ‘moan’ to each other.’*

Another common theme was one of staff support and information sharing, including the transition into more established services when this becomes necessary.

The informality of the group makes it more accessible and means that we can move easily to adapt to the needs of those that attend. The group also assists with the transition to other services and facilities. For instance, new members are encouraged by existing members to go along to the local Alzheimer Café. Therefore, accessibility to other services is made via client/carer links and not through other services.’

*‘M went to the Day Hospital, but he didn’t settle – he would stay for about an hour-and-a-half, but then someone would have to bring him home. I was not there, so maybe he saw it in a different way? For people who are reluctant to stay, day centres are not suitable – attending together makes such a difference.’*

*‘When we got there, we were surprised as we didn’t expect it to be as much fun. We do get an awful lot of information from people in the*

*same situation, rather than from the professionals.'*

### **The staff perspective**

It is not just the clients and carers that benefit from this group – the staff also feel valued and rewarded by being able to be more involved with the group attendees, not just as a role but on a personal level as well. The continuity afforded by the regular weekly contact enables staff to identify subtle changes in the home situation and offer possible solutions before it develops to into a crisis.

*'The main thing for me is from a nurses point of view, seeing the patient and carer together makes it so much easier to give more care. A lot of people don't like to ask for help or feel that they are letting the person they look after down but because you are getting to know them so well you can see things getting worse and can jump in. For example, when they are at a certain point in the dementia journey and you know what they need. This can take the responsibility and decision-making off the carer – for them to ask for respite and other services is very hard.'*

*'It also highlights the issue of anti-dementia medication. This is seen as a crutch for by carers and many are under the impression that there's hope while they have the drug. We can support them at the time when drug use is stopped – we can support them in making the decision when the time is right. It's all about the unobtrusive ongoing assessment – knowing them both, so you know when to jump in.'*

Staff also report a very real sense of job satisfaction that comes with such close working relationships. This in turn increases motivation amongst staff members and may help in the longer term to reduce staff sickness.

*'They love the group and like watching it grow. Initially they found it very scary but can now see the benefits and derive a great sense of job satisfaction, particularly watching the interactions and banter between members of the group.'*

*'Because the group is novel there's a real sense of ownership. They've learnt a lot from the*

*group and how important it is for those that attend.'*

*'It is very tiring, physically and mentally but they get an awful lot back.'*

### **Next steps**

Given the success of the Phoenix Group, staff and members are keen to see the concept expand to other areas, so that people in similar circumstances can enjoy the benefits that a group like this has to offer. Group participants were asked what advice they would give to others looking to set up a similar group.

*'You cannot set up a group like this without the support of the PCT – funding is a major issue, and support from the PCT is vital. You also need enthusiasm and organisational skills, as well as insight into the condition and the carers' needs. It would be beneficial to visit the Phoenix Group and see how we gel – we really, really laugh, pull each other's legs, or call each other names. It makes you realise that you are not alone, in a very isolating condition.'*

From the staff perspective, there is a strong acknowledgement of the role played by senior managers within the PCT in having the faith and vision to allow them to take a risk, to try something radically different.

*'Management supported me by allowing me to go with ideas and develop the group.'*

### **Conclusions**

The Phoenix Group appears to reach people at many different levels. There is ample evidence that the psychological health of everyone involved with the group is enhanced by the experience, and that the group is empowering to all who attend. For the clients, their sense of personhood is maintained, which in turn, increases their self worth and self-esteem. The activities promote meaningful occupation and independence by maintaining skills and interests. For the carers, it seems to be the sense of being supported and understood by others in the same position, and of having someone to turn to when problems seem to be overwhelming that is the main benefit of

attending the group. For the staff, they have the reward of really making a difference to the lives of the people whom they care for, and the challenge of seeing the service expand and evolve as it continues. The dementia journey can be a lonely one – this group celebrates the positive qualities of sharing, caring and laughing – together.

### **Acknowledgements**

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For comments on the article, please contact the authors. All members of the Phoenix Group would welcome approaches from interested parties who would like more information about the group, or who are interested in setting up a similar group in their local area.

If interested, please contact Derek Harrod on 01827 872593 or visit [www.phoenixforyou.org.uk](http://www.phoenixforyou.org.uk)

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# Understanding 'challenging behaviour' in dementia: Reflections on a series of two-day workshops for formal carers

Anna Fairhurst & Helen Toone

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**T**HE OLDER ADULT MENTAL Health Service in Wolverhampton has a long tradition of commitment to assist with staff training needs in residential and nursing homes across the city. A two-day training event has been offered over the last 10 years, covering a range of topics including understanding dementia, person-centred care and life story work. In recent years it was agreed that helping staff understand behavioural changes in dementia was a training priority. Due to significant demand, the training was also made available to NHS staff and repeated on four separate occasions between February and July 2005. A total of 92 staff attended. A summary of the training programme, participant feedback and general reflections is provided below.

## Background

Person-centred approaches to dementia care and 'challenging behaviour' are familiar terms in the psychological literature relating to the care of older people (e.g. Kitwood, 1997; Stokes, 2000, 2002). However, the awareness, understanding and regular implementation of such approaches across care environments are often variable, and the 'old culture' (Kitwood & Benson, 1997) may prevail. Many staff may receive little formal training about the symptoms or causes of dementia and have limited support with understanding the complex and varied needs of individuals experiencing such illness.

Similarly many unusual or 'challenging' behaviours remain conceptualised within a predominantly medical paradigm as mere symptoms of a disease, rather than important communications of feelings, needs,

pleasures, interests or distress (Stokes, 2002). Formal carers often have no real framework for understanding these complex communications and may rely on negative or one-dimensional explanations in an attempt to make sense of complicated interactions and behaviour.

In response to such issues and observations during clinical work, the older adult mental health service has offered an annual training event for staff across formal care settings. This was originally organised by a consultant psychiatrist with primary responsibility for patients in residential or nursing care. In later years this was shared with the Consultant Clinical Psychologist for older people and her team, who continue to co-ordinate the event.

## Practical arrangements

The 2005 training was designed and facilitated by a multi-disciplinary team of professionals with support from the Alzheimer's Society. It was open to all care staff working with older people. A flyer advertising the event was distributed to all known residential and nursing homes within the city. Places were also offered to PCT employees. There was a nominal fee of £10 per person for non-NHS staff. The psychology secretary, Alzheimer's Society and Dementia Plus provided practical assistance with arrangements. Trainee Clinical Psychologists and colleagues from within the service helped to facilitate group discussions.

## Training philosophy, aims and content

The training was couched within a person-centred care philosophy. It aimed to raise

awareness of the need to understand the person with *dementia* and acknowledge the individuality and potential complexity of their needs. It also aimed to acknowledge and consider the difficulties faced by staff in working with older adults experiencing behavioural change. It was advertised at an introductory/refresher level.

### Content of training

The training days were divided into assessment and intervention strategies. A variety of teaching methods were employed. These included provision of information in lecture format, video presentations, experiential exercises, involvement in occupational therapy activities, alternative therapies, role-play and case discussions in groups.

### Day 1: Assessment and understanding

The training was introduced as an opportunity to think together about working with people with complex needs. Participants were encouraged to contribute throughout the days, offering their own experiences and ideas.

### Person-centred care:

Person-centred ideas were introduced as a way of beginning to understand the *person with dementia*. This was described as akin to *'being a detective'*, getting to know the person and looking for clues in their life history and evidence or patterns in their current behaviour that might help to understand their needs.

### Understanding dementia

Participants were then shown an extract from the television documentary 'Malcolm and Barbara: A love story'. The video portrays a moving account of a couple struggling to come to terms with the development of an early onset dementia. The chosen clip shows Malcolm (the sufferer) and his wife describing their journey through the initial stages of Alzheimer's disease. Participants were asked to get into groups to discuss the impact of the video and their thoughts about how the illness affected both parties.

This set the scene for providing further information on understanding dementia including details about different types of

Figure 1: Aims and objectives of the training days.

<p><b>Aims</b></p> <ul style="list-style-type: none"><li>● To introduce staff to thinking about person centred approaches to understanding and managing difficult or unusual behaviour in older adults with dementia.</li></ul> <p><b>Objectives</b></p> <ul style="list-style-type: none"><li>● To recognise the range of possible factors that can contribute to 'challenging behaviour'.</li><li>● To recognise that 'challenging behaviour' is usually purposeful, and tends to communicate something.</li><li>● To understand the important role of the environment, availability of meaningful activities and staff response to 'challenging behaviour'.</li><li>● To understand the basic concepts of person centred approaches to 'challenging behaviour', e.g. knowing the needs of the person, their history, likes/dislikes, individual personality, self-concept, etc.</li><li>● To have an understanding of strategies to prevent and respond appropriately to different types of 'challenging behaviour'.</li><li>● To have some 'take away' assessment ideas and management strategies to think about implementing with a particular client.</li></ul>
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illness, symptoms, progression, the emotional impact and coping styles. Participants were then asked to link this to their understanding of behavioural changes in dementia and why the two might be related.

**Understanding challenging behaviour**

Other ways of understanding 'challenging behaviour' were introduced by asking participants to list their own behavioural challenges (things that friends or family would note as difficult or challenging) and the reasons why they behave this way. Their responses were then linked to various possible influences under the headings of physical or social environment, physical or medical reasons and personal or psychological factors. A multi-dimensional model listing these influences (see Figure 2 below) was then described and illustrated with case

examples. Through this participants were introduced to the idea of setting conditions, triggers and functional analysis.

This was followed by introducing a framework to guide staff through a systematic process from identifying the behaviours of concern to evaluating interventions (see Figure 3 overleaf).

Participants then completed an experiential exercise, imagining themselves as someone they work with that has dementia and behavioural problems. They were asked to complete a series of questions about that person's life, feelings and motivations 'as if' they were that person. After the exercise, all participants were invited to reflect in pairs on what it was like to imagine themselves as that person and any new ideas they had about why the person might behave in that way.

Figure 2: A multi-dimensional model for understanding behavioural problems.

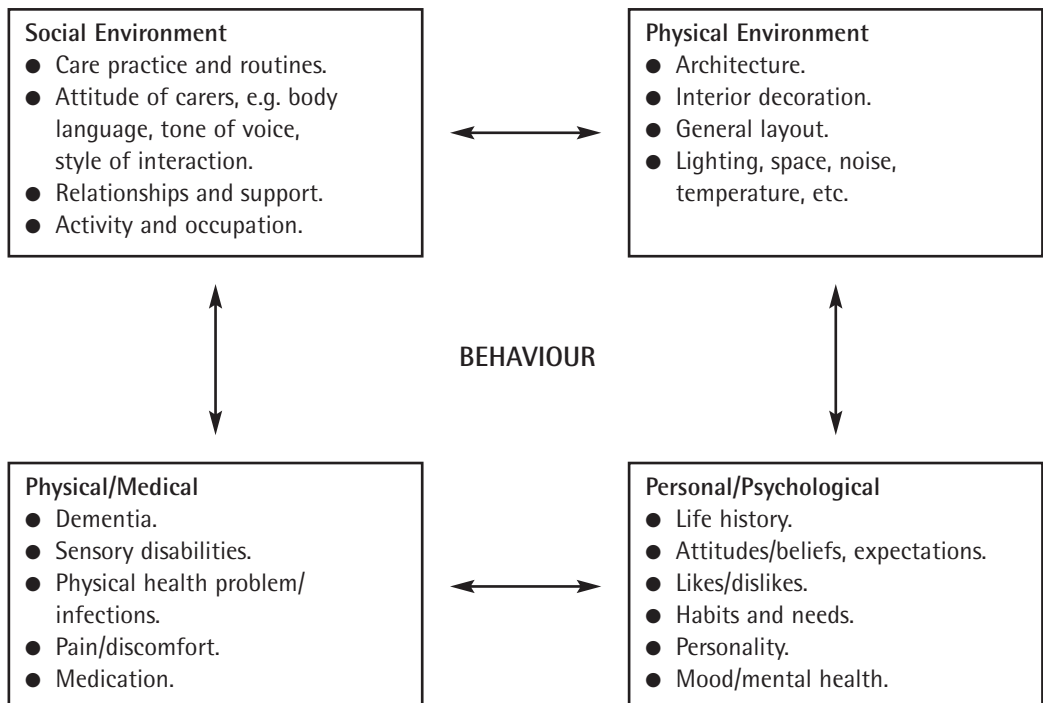
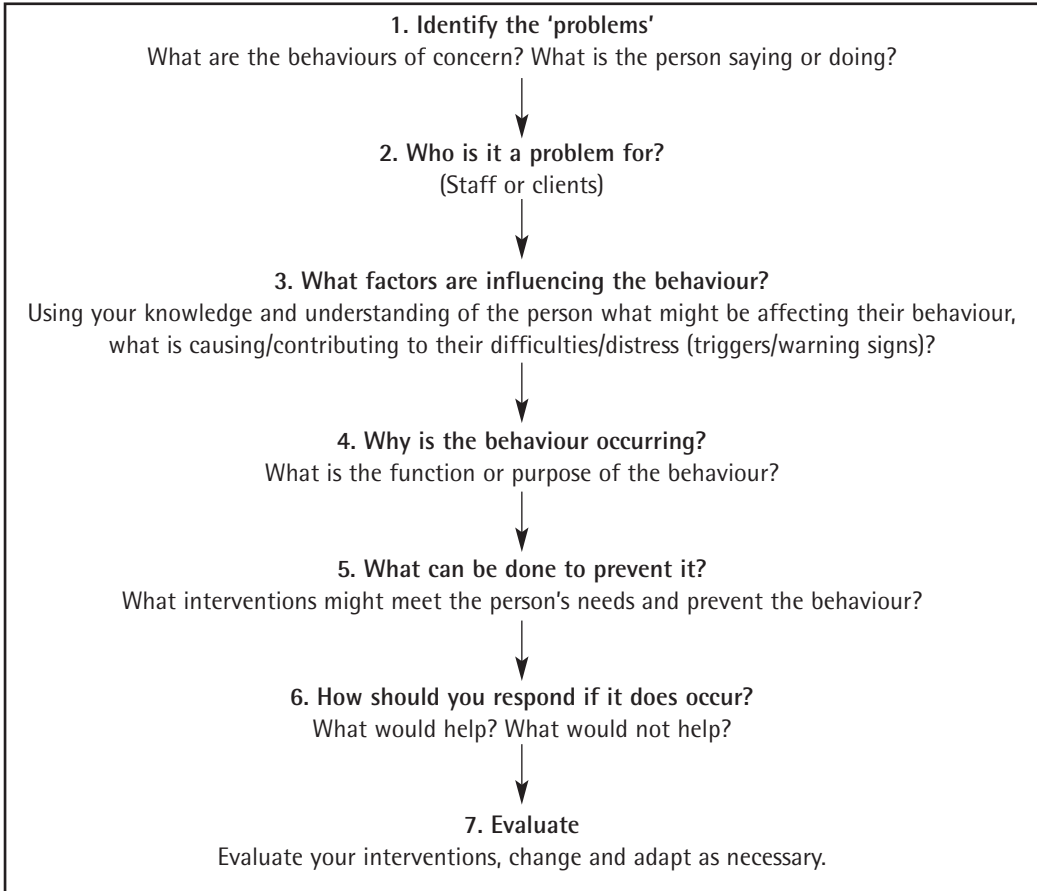


Figure 3: A framework for understanding and responding to behaviours that challenge.



**Assessment techniques**

The afternoon session covered assessment techniques and ideas including the use of ABC charts, communication diaries (Chawner, 2003), reflective accounts, observation and life story work (Hazell & Punshon, 2003).

**Case discussions**

Participants then moved into small groups to discuss one client per group from an actual work setting. One person was asked to provide details in confidence of someone they work with and all group members were given the framework to work from (Figure 2) in order to identify the behaviours, triggers, setting conditions and possible function.

**Day 2: Interventions**

The emphasis of the intervention day was *'prevention is better than cure'*. It focused on ideas around removing or addressing triggers and setting conditions, increasing occupation and activity, developing alternative communication styles and therapeutic contact rather than acting in a purely reactive way.

**Alternative therapies**

A senior physiotherapist presented the rationale and benefits of alternative therapies, including practical demonstrations of aromatherapy oils, massage techniques, snoozelum equipment, SAD lamps, acupuncture and relaxation.

### ***Occupation and Activity***

Colleagues from the Occupation Therapy Department highlighted the benefits of appropriate and meaningful engagement in activity for people at different stages of a dementia process (Perrin & May, 1999). This included a video presentation about the use of arts with people with dementia and a group exercise. For the latter participants were asked to complete a practical task wearing a range of 'aids' such as gardening gloves, scratched goggles, and earplugs. Participants were also asked as a large group to list their interests, hobbies and likes and compare this to what they have available for clients in the establishments where they work.

### ***Communication and therapeutic relationships***

There was additional emphasis on communication and building therapeutic relationships with people with dementia (Morton, 2002) including the use of reminiscence (Bender *et al.*, 1999) and resolution therapy (Goudie & Stokes, 1990; Goudie, 2002). Ways of adapting communication (Perrin & May, 1999) and the use of memory aids (Hazell & Punshon, 2003) were also discussed.

### ***The role of medication***

A Consultant Psychiatrist discussed the use of medication for clients with dementia and behavioural disturbance. The emphasis on psychosocial, rather than purely pharmacological interventions was reiterated.

### ***Reactive strategies***

A summary of reactive strategies if behaviours do occur was then provided by the psychology team, including a general list of 'do's and don'ts' (e.g. Stokes, 2002).

### ***Case discussions***

Participants were then invited to use the intervention ideas to complete their case discussions, looking at preventative measures and reactive strategies for the clients they had discussed on the previous day.

### ***Staff support and supervision***

The final session looked at staff support and supervision. Stress, burnout and abusive practice were acknowledged as complicated realities in working with people with complex needs. Staff were invited to discuss their support structures at work and outside and consider additional ways of gaining appropriate support. Stress busting techniques and self-care were outlined.

All participants were given a folder containing the main handouts from the day, a reading and reference list and leaflets from the Alzheimer's Society.

### ***Participant feedback***

Ninety-two people attended the four sets of workshops. Over half (60 per cent) were from residential or nursing homes in Wolverhampton, 12 per cent were from an integrated health and social care resource centre, 11 per cent were nursing staff from the inpatient facilities and five per cent were from community nursing. The remaining delegates (12 per cent) were Memory Clinic staff, Social workers, Physiotherapists, and Intermediate Care Staff. Three were from the learning disability service.

Evaluation forms were given to each attendee at the end of each of the two sessions. A total of 103 forms out of a potential 184 were completed (55 per cent). A summary is outlined in Figure 5.

### ***Qualitative feedback***

Participants were also asked what they found most and least useful and for any suggestions of changes to the days.

### ***What worked well?***

Different participants identified different areas of satisfaction and dissatisfaction with the workshops. However, common themes included appreciation of experiential exercises, the Malcolm and Barbara video, case discussions and group work. These apparently succeeded in facilitating reflection and generation of new ideas about people who had previously been perceived as 'challenging'.

Figure 4: Attendance by staff group.

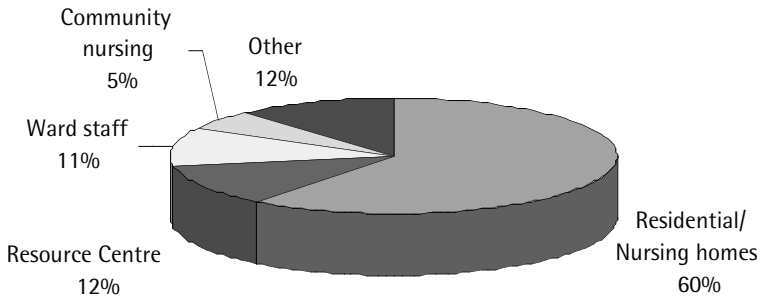


Figure 5: Summary of quantitative data from feedback questionnaires.

Feedback questions	Not at all	A little	Moderately	Very	Extremely
1. How relevant was the content of training to your work? (103 responses)	0 (0%)	0 (0%)	4 (4%)	59 (57%)	40 (39%)
2. How useful was the training in thinking about your work with older people? (103 responses)	0 (0%)	0 (0%)	3 (3%)	60 (58%)	40 (39%)
3. How satisfactory were the teaching methods and presentation of the training material? (89 responses)	0 (0%)	0 (0%)	8 (9%)	59 (66%)	22 (25%)

Comments included:

*‘It has given me a different insight into understanding challenging behaviour’; ‘It helped me understand why patients behave the way they do’; ‘It enabled me to think about what I do and alternative ways of doing things, it is so easy to do things without thinking and stick to a routine’; ‘I got a really good insight into what it’s like for the client group I work with.’*

The multi-disciplinary approach and input to the teaching was also highlighted as a positive aspect of the workshops. The talk

from the Consultant Psychiatrist about the limited use of medication seemed to have reinforced a powerful message about alternative approaches to dementia care. Some participants also found the theoretical aspects and assessment procedure session particularly helpful.

**What did not work so well?**

Most participants did not put any comment when asked about what they liked least about the training. Those who did respond mentioned not liking the group work aspect,

and feeling that they had no control over medication issues so were unsure of the usefulness of this talk. One person did not like the occupational therapy activity task. There were some comments about repetition of information.

### ***Recommended changes***

No major changes to the workshops were recommended although some practical changes, such as smaller groups were suggested. Some more experienced staff found it a useful 'refresher' but had wanted more 'in-depth' ideas and reflection. The possibility of a more advanced course to support qualified staff was raised. Other ideas included more variety in teaching methods, more group work and role-play, more information about different types of dementia and self-harm. Some participants suggested that a greater variety of outside speakers would be good.

### **Our reflections**

As a psychology team and wider training group we met to reflect on the workshops and discuss future developments. We felt they had generally been a success and our ideas about what did and didn't 'work well' largely corresponded to those suggested by participants. We were particularly pleased with the interactive nature of the work and involvement from attendees. We noticed that acknowledgment of the difficulties and benefits of working in care environments and the session on staff stress and supervision was important in validating the work of formal carers and allowing them to speak more openly about their roles.

The case discussion exercises did not work as well as we had hoped. This may be related to participants' limited experience and confidence in reflection and behavioural analysis. Some staff also seemed to feel under scrutiny by other participants, despite the emphasis on problems solving and being non-judgmental. Stress and mixed feelings in supporting people with complex needs also created some blocks to creative thinking.

### **Difficulties and dilemmas**

The interest and enthusiasm of participants created some dilemmas for us in our awareness of the need for training and appropriate support for staff in order to influence organisational practice and culture to any significant extent. We have ongoing questions about how to sustain and support interest across the city, whether different training should be provided for qualified and unqualified staff and the resource implications of trying to deliver effective training ideas.

### **Future developments**

#### ***Further training events***

A further set of two-day workshops is planned for 2006. We hope to encourage staff from more disciplines to help facilitate this training, including community nurses and ward staff, taking on board the feedback received. An in-depth training course for qualified staff over a longer period has been requested, which if agreed may assist in cascading the ideas and approach across settings. Alternative teaching methods such as 'solution circles' and follow up supervision may also be considered.

#### ***Development of a resource pack for residential and nursing homes***

With support from Alzheimer's Society, an information pack is being prepared on understanding dementia and behavioural changes, which we hope to distribute to care homes throughout Wolverhampton. This will include information on the philosophy of person-centred care, basic information about dementia, responding to common communication problems, ideas for activities, alternative therapies, reference materials and contact details of relevant local and national organisations.

#### ***Evaluating the implementation of ideas***

We may also return to the use of personal pledges (Hazell *et al.*, 2002), asking participants to give a written statement of their goals about ideas and/or changes that they

plan to pursue as a result of the workshops. With permission these would be followed up to evaluate the longer-term efficacy of the training and research factors that assist or hinder the implementation of change.

### Conclusion

The training events largely appear to have been successful in their aim of introducing person centred ideas and providing some practical 'take home' strategies and advice. There were some difficulties and limitations and no specific follow up support was arranged to assist the implementation of new skills or ideas.

However, it is hoped that raising awareness through training and the use of experiential techniques may go some way to supporting care staff in developing more person centred approaches in their work with older people. The process of consultation and involvement of staff will hopefully

encourage the idea of a reflective space, which allows creative thinking about the needs of both clients and themselves as formal carers.

### Acknowledgements

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# The Single Assessment Process (SAP): A personal perspective

Nicky Bradbury

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## NSF Standard 2

*'NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrating commissioning arrangements and integrated provision of services, including community equipment and continence services.'*

**T**HE SINGLE ASSESSMENT PROCESS (SAP) recognises that many older people have health and social care needs and that agencies need to work together so that assessment and subsequent care planning are effective and co-ordinated. The process is triggered when an older person presents with (or is suspected of having) significant health and/or social care needs or it is thought they would benefit from, or they request, wider exploration of their needs.

The SAP is intended to ensure that:

- The scale and depth of assessment is kept in proportion to the older person's needs;
- Agencies do not duplicate each other's assessments; and
- Professionals contribute to assessments in the most effective way.

The Single Assessment Process explicitly acknowledges that the greatest experts in the care of older people are older people themselves. They will know when they are having difficulties, the nature of those difficulties, and what might be done to resolve them. In the past, assessments may have been done to, not with, older people and services planned without considering their views and wishes. The principles of obtaining consent to share information between agencies and of person held records are central to the process

(although this can be challenging when applied to people with some mental health problems).

The process begins with a pre-assessment contact where a judgement is made about the need for further action. This is followed, if required, by four levels of assessment:

- Contact – basic personal information is collected and the presenting and wider health and social care problems established and explored.
- Overview – carried out by competent, trained practitioners if they judge a more wide ranging assessment is needed.
- Specialist – undertaken by respective agencies by professional staff with relevant expertise.
- Comprehensive – a range of specialist, in-depth assessments by different professionals or specialist teams, co-ordinated by a single agency.

SAP, however, is not necessarily a linear process. For instance, when an older person with depression is seen in primary care it may be clear at the point of Contact Assessment that a Specialist Assessment is needed straight away. It is anticipated that a comprehensive assessment will be required where permanent admission to a care home is a possibility.

Although the DoH was not prescriptive about the methods of information collection, the areas or 'domains' to be covered as part of the assessment process were clearly indicated: user perspective; clinical background; disease prevention; personal care and physical well-being; senses; mental health; relationships; safety; environment and resources. In view of the poor identification of mental health problems in older people across the health and social care

economy, SAP, in theory at least, presents a valuable opportunity to improve access to appropriate services.

Health Service and Local Authority circulars issued in 2002 set out 12 steps for national implementation with the 'how' to be agreed locally. The DoH requested regular reports on progress, signed off by all local partners. The target set for full implementation of SAP was 1 April 2004. All health and social care services across in England should have been working with SAP for the past 18 months.

What impact has the introduction of SAP had on the working lives of individual Clinical Psychologists? I would predict that this is largely dependent on the services which employ them. Within specialist mental health services the Care Programme Approach (CPA) is likely to continue to dominate the clinical practice of MDTs. CPA can be regarded as the mental health specialist assessment within SAP and therefore becomes subsumed within the wider process. In Birmingham this has allowed the Mental Health Trust to avoid the overhaul of assessment documentation undertaken by other services. As a secondary care service the contact assessment (and sometimes the overview) should have been completed prior to the referral to mental health services. In practice, however, Birmingham GPs are, in general, reluctant to work with SAP so mental health practitioners have to complete at least the contact assessment in order to access other services. With no electronic solution in sight, front line staff in all areas are bogged down by the additional paperwork.

And what of the intended benefits to older people and their families? Just occasionally I come across a yellow SAP folder in a client's house containing copies of assessment documentation – a useful receptacle for the copies of the letters I write about them and their CPA care plans and reviews – and momentarily the policies feel 'joined up'. Overall, however, the outcomes have, so far, fallen well short of expectation. There is evidence that many staff are not completing the mental health screening questions within the SAP overview assessment (the four item GDS and 6CIT) due, perhaps, to their own discomfort in asking questions which do not fit comfortably with their usual assessment practice. And even if they do, there is little evidence that the care pathways for depression and dementia (see Standard 7) are being applied consistently within primary care.

Eighteen months on, Birmingham is still working on completing the implementation of SAP. Keeping it as a developing and evolving process involving 10 Trusts and the largest Local Authority in the country when nobody 'owns' it presents a continuing challenge.

And now we're on to 'Choose and Book'...!

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

## Notes



## Notes

## Notes

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## 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.

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

[sinclair@ltshelford.freemove.co.uk](mailto: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.

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