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

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Letter from the Editor
Louisa Shirley

As Jo covers the introductions to this edition in her Letter from the Guest Editor, it just rests on me to thank the South Thames group for their informative and high quality submissions. The standard was excellent, and the submissions from Assistant Psychologists clearly demonstrated the level we expect people to work at before even entering training! I have shared, in advance, some of the service and process developments I have read about, including Jouko Koecher’s development of a suitable battery of assessments for carers of people suffering from dementia, and Ariane Zegarra and Meg Rolleston’s work in developing day services along with Occupational Therapy colleagues. This edition effectively demonstrates the possibility of continuing to develop services even in the context of economic stress.

With regards to future editions, many thanks for all the ideas for themed editions, and the promises of papers. You will see below, that the first themed edition will be on formulation and supervision. This decision was made on the basis of how many people showed an interest in submitting papers which I took as a reasonable indication of the general interest in the topic. The next most popular suggestion has been an edition looking at personality disorder in later life. This would be the theme of the October 2011 edition as we have another geographical group edition in December, and a ‘general’ edition in April. Other suggestions have been – working with care homes and services for people with dementia. One idea was to hold a vote on what theme would be preferred.

E-mail me (louisa_shirley@hotmail.com) and let me know your thoughts. In the meantime, enjoy and share the work of South Thames group.

CALL FOR SUBMISSIONS

The next Newsletter in October will be the first themed edition and the subject will be ‘Supervision and formulation – specialist skills for psychologists working with older people’. I would like to invite submissions for this edition to get to me by the end of July. I am looking for case material, literature reviews, service development papers and research papers.

Please note – my e-mail address has changed. All submissions and queries should now be sent to: louisa_shirley@hotmail.com
WELCOME to the South Thames edition of the PSIGE Newsletter.

The General Election has stirred up the passions of the nation and generated a sense of excitement and promise! In the NHS there is also a sense that change is afoot. But with change comes uncertainty – despite pledges by politicians we know that economic pressures will impinge on services but we’re not sure in what way! Nonetheless, the work that we, as psychologists working with older people, are doing still goes on, although the way we work may be set to change in future. In this issue, there is an article by Alison Kirkpatrick which investigates envisaged changes to older people’s services. There is an article by Zegara and Rolleston about developing a new structure for delivering therapy services and one by Gracey and Averbeck about a family inclusive service. There is also an article by Ian Kneebone and others about the training that will be considered relevant in future for psychologists working with older people. Most of the rest of the articles present new projects and on-going work that is currently being done or has been completed across the region – work with inpatients, with carers, with personality disorders, with patients in the severe stage of dementia, and more.

South Thames PSIGE consists of Kent, Surrey, Sussex and South London. Services range from inner city settings such as London and Brighton to more rural areas in Kent and Sussex. There are five large NHS Trusts in the region who provide mental health services for older people. South Thames PSIGE currently is the biggest of the various PSIGE branches. There are three Clinical Psychology Training courses in our region: Salomons, Surrey, and the Institute of Psychiatry. The committee is responsible for organising the six-day Older People’s Clinical Neuropsychology course with Salomon’s Clinical Psychology Training Scheme.

The South Thames PSIGE committee meet bi-monthly and plan four training events a year, in February, which includes the AGM; in June, which takes place in Brighton; in September at Salomons, traditionally a research day; and in November which can be in Dartford or at the British Psychological Society’s London offices. Our enthusiastic committee has been trying to recruit members from across the region, hence the reason for having the training event venues widely spread. In the past year we have been lucky to have three new people join the committee: Jacqui Bryant, Margaret O’Shaughnessy and Natasha Newberry, although we lost Tracey Lintern, who went off on maternity leave. Other committee members are Reinhard Guss (our long-standing Treasurer) and Tina Lee, whom we were pleased to welcome back after her maternity leave. Tamsin Fryer (Co-convenor), also currently off on maternity leave, is due to rejoin the committee in July.

There was a tremendous response to our call for articles and the membership went to a lot trouble to submit their contributions on time. We thank all the contributors to this South Thames edition of the PSIGE Newsletter for the time, thought and effort that went into their submissions. We are pleased to be able to present such a rich diversity of papers, offering an impressive reflection of the exciting work that is being undertaken in our region. We hope our readership enjoys them as much as the committee did in reading and editing them!
HELLO and welcome to the July Newsletter!

You may well notice how large this edition is, and also how early it is coming through your letterbox. Thanks to Louisa for all her hard work on this and thanks to all the contributors who have made this such a bumper issue.

This Newsletter falls at a time in the calendar when we are preparing for the annual conference and AGM on 1 July, and yet this ‘July’ edition shouldn’t reach you until after that date. However, due to the efficiency of the publication process, it may yet arrive before the AGM. This leaves me with a dilemma as to what best to update you on!

Firstly, I think it is important to note that the national conference is going ahead this year, and to thank the Training & Development Subcommittee for their work on this. Special thanks go to Cath Burley for chairing this committee and her personal efforts in making sure that we have a conference this year – it feels important to have this back in the calendar and I hope to see many of you on 1 July. The committee have also decided to commit to a two-day conference in Scotland in 2011, and Scottish PSIGE is well ahead with their plans for this. We hope that you will continue to support the annual conference and make use of this great opportunity to network with other members as well as update your CPD.

In relation to this year, you will have received the notification of the AGM and subsequently the AGM reports by post from the British Psychological Society’s office, so you will be able to see the review of the year’s activities. Our key priorities have been to focus on: (i) providing sustainable, affordable and accessible CPD for members; and (ii) collating and disseminating information regarding policy developments to the membership, and influencing policy and practice developments where appropriate. The focus for 2010/11 will be on how to take these forward and the national committee has been working on proposals for how to do this. These proposals will form the basis of our discussions at the AGM and we will be able to provide an update on any decisions following this. However, I am optimistic that we will be in good shape (with your help) to take these plans forward and I am looking forward to the next year.

In the meantime, I hope that you are all enjoying a fine British summer and I look forward to seeing as many people as possible at the conference.

Best wishes.

Don
SPECIALIST SERVICES for older people with mental health problems are increasingly being challenged by commissioners and Government policy as to whether services should continue to be provided across the spectrum of mental health problems. Several key documents have already identified this as being of concern (Consensus Statement, 2008; RCP, 2009). Nevertheless, the push towards older people’s specialist services providing for people with dementia seems a real one. In one part of our Trust in Kent we have already developed wards that are for all-age groups, including people with dementia. This paper will explore the history behind the initial development of a specialist service, consider how the current challenges to a specialist service have developed, explain the case for and against an all-age service, and propose some recommendations for future service developments that commissioners might usefully take into account.

When did specialist services for older people first develop?

It is said that the one of the reasons for studying history is to learn from our mistakes (see WAIS comprehension since its inception). Therefore, what can we learn from the history of the development of older people’s specialist mental health services? It could be argued that the beginnings of the development of specialist services for older people happened within general medicine. After World War II, a Government enquiry found there were 140,000 patients whose long-term care needs were blocking beds, and this committee decided that people with chronic physical health care needs should be the responsibility of the local hospital services. Dr Marjorie Warren is seen as the first advocate for the creation of the specialty of geriatrics. In 1943 and 1946, she argued that there was a lack of good diagnoses, medical leadership, rehabilitation, and an absence of a multi-disciplinary approach. The first Consultant Geriatrician was subsequently appointed in 1948. He started collaboration between physicians, social services, GPs, and psychiatrists (Lynham, 1995).

Within psychiatry, the first consultant psychiatrist posts were created in 1969 to specialise in the problems of old age. These posts developed from a background of large psychiatric hospitals in which the vast majority of wards contained older people who had lived in these institutions for years. Six consultant posts were followed by a specialist training course for psychiatrists being established at the Maudsley Hospital in 1970 by Felix Post. By 1973, the Royal College of Psychiatry had its first meeting of psycho-geriatricians. In the wake of this, PSIGE (Psychology Specialists working with Older People) was then founded in 1980 within the British Psychological Society.

We can see from this that the older people’s mental health specialty has a very young history that began because of the neglect of older people’s needs, and the recognition that a multitude of services needed to collaborate together to ensure older people received good prospects of recovery. The question needs to be asked whether this collaboration will be put at risk by creating an all-age approach.
How the issues of age discrimination arose
In 2001, with the publishing of the National Service Framework for Older People (DoH, 2001), age discrimination was for the first time highlighted as an issue that needed to be tackled. Standard 1 was entitled ‘Rooting out Age Discrimination’ and it stated that ‘NHS services will be provided regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.’

When you looked further at the issues raised within Standard 1 they were;
● For fair access to services.
● For decisions to be based on need not age; however, it acknowledged the need for specialist services and gave the example of cataract services.
● To root out age discrimination in staff attitudes.
● To ensure older people did not have to prove a higher need for social care services than younger people.
● To recognise that older people from BME groups were particularly disadvantaged.
● To ensure older people had access to resuscitation.

Interestingly, these issues stemmed mainly from concerns about the treatment of older people within physical health care settings and social care. When it came to mental health services Standard 7 stated that specialist mental health services should be available to consult and treat most common mental health problems in old age. They should provide a range of services, from community to inpatient care, to support for carers.

What has happened since the National Service Framework for Older People?
Since 2001 the age discrimination agenda has promoted the notion of all-age services for people with functional mental health problems covering working and older adults. Locally in Medway, we now have three wards for all-age groups (including dementia patients, although it is recognised that this group do have special needs and a specialised ward will be established in future). In addition our CRHT (Crisis Resolution Home Treatment) teams cover all age groups for people with functional problems, and our intake team within adult mental health secondary services takes all referrals regardless of age, although at the moment there is a specialist Community Nurse in older people’s services who does all the initial assessments. It looks certain that in future our functional team for older people will be amalgamated with the adult intake service. How psychology and psychiatry will fit into this is unclear at present. My impression is that what is happening in Kent is similar to other areas around the country (Consensus Statement, 2008).

The benefits of an all-age service
The arguments in favour of this development are the following:
1. Older people will be less stigmatised and may prefer to be treated the same as, and even together with, younger people, as, for example, in group therapies.
2. Both adult mental health and older people’s mental health services can learn from each other and provide specialised services that are equitable to all.
3. This could increase the awareness by mental health practitioners of older people’s problems (possibly including dementia) in the community and increase the numbers having access to psychological therapies.
4. Special interests, such as in personality disorders in old age, could still be encouraged to develop.

The case against an all-age service
The arguments against this development are quite numerous:
1. Older people with mental health problems are already under-diagnosed by GPs and receive inadequate treatment, therefore, an all-age service will not
ensure that older people’s needs are a priority. They are a group that has always been discriminated against. Sube Banerjee (2009, personal communication) argues that denying that different age groups have different needs is being ‘age blind’ which will ultimately only enhance the discrimination.

2. Older people have different types of mental health problems compared to younger people;
   a. The issues are often about coping with multiple losses, loneliness, coping alone, a fear of dependency, institutionalisation, and of dying.
   b. They have more complex problems often involving multiple physical health problems and physical frailty.
   c. Cognitive problems are more common than realised and often are quite subtle in their presentation. The National Dementia Strategy found that only a third of people with dementia are diagnosed and in contact with specialist services (2009). People presenting with depression in old age frequently have an underlying cognitive problem (Vinkers at al., 2004).
   d. Suicide is more of an issue, with less older people being likely to carry out para-suicide attempts than would be the case in younger populations.
   e. Alcohol problems are more prevalent than often recognised.
   f. Levels of mental health problems can change with increasing age. For example, depression rates increase with age, so that people older than 85 are twice as likely to suffer from depression as people aged 65 to 85 (DoH, 2009).

3. Older people’s longer life history means that the process of assessment takes longer, necessitating the need to often involve carers, which is different from younger people’s services. Assessment procedures are also different in terms of always needing a cognitive screening test and different scales for depression and anxiety, including information on physical health and home care packages.

4. Treatments may also be longer due to sensory, physical, and cognitive impairments, and because people with longer histories of mental health problems become more chronic and take longer to recover. Families and couples are far more likely to be involved in treatment. The usual CBT packages need modification as older people may have more difficulties with reading materials, and completing homework. It has been found that the use of audio-tape is more beneficial for older people (Laidlaw et al., 2004).

5. Staff working with older people need to be trained in understanding cohort differences in terms of people’s values, beliefs, and experiences. For example, in understanding the trauma of world war experiences, evacuation, and the possible differences in the beliefs of older people about the level of support their families should provide, compared to the beliefs of younger generations and these issues (Knight & McCallum, 1998).

6. Staff working with this age group also need to have more knowledge of physical health problems and their impact on mental health, as well as knowledge of specialised services for them. This includes: benefits, social care policies, community care services, voluntary care services, and legal services, to ensure older people get the best help. Joint agency working is essential and there is still a need to develop joined up working (Consensus Statement, 2008).

7. Inpatient services for older people need to be designed differently compared to those for younger people. The facilities need to allow for physical frailty and dementia. For example, older people need easier access to toilets, higher chairs to sit on, orientation cues in the building, designs that cater for those with arthritis who cannot easily open doors and cupboards.
8. Age-specific training for staff is important for other reasons too. There can be a tendency for staff not trained in working with older people to be overprotective of them, and therefore to be unhelpful to them. We have experienced our CRHT team setting up care packages for people who were perfectly capable of cooking their own meals, or suggesting residential care far too early.

9. There is an assumption with the concept of all-age services that a 65-year-old person will have the same service needs as an 85 year-old. This could be the case for some, but for many they may also be very different.

10. Older people are discriminated against in society generally. Amongst professionals also they are the least popular specialty, for which it is hard to recruit to. By forcing staff whose interest is not with this group, to engage with them one may be creating the risk that they will be neglected again.

11. The experience of IAPT (Increasing Access to Psychological Therapies) pilot programmes where staff were particularly asked to focus on older people has not been encouraging. In fact, the evidence so far is that they did not succeed in improving the numbers of older people being treated in the community (Glynn-Williams, 2008; Hilton, 2009). The DoH document, New Horizons (DoH, 2009), has emphasised particularly the low rates of depression being identified in Primary Care. The DoH is doing a cost benefit analysis of increasing GP consultation time with older people to try to ameliorate this.

12. Some older people may not choose to be with younger people in services – what research has been conducted to assess their views? Older people are frequently choosing age-segregated housing, and this may be representative of their preferences. In other words, they may equally find young people difficult to identify with and feel intimidated in group situations.

Towards solutions

The debate that is emerging is on a needs-led service, but the issue is how do we define this? The Royal College of Psychiatry, in its position statement on age discrimination in mental health services (2009), calls for comprehensive specialist services for older people to be resourced and has stated they will develop a toolkit that allows self-assessment of services based on need, rather than age. The DoH document, New Horizons (DoH, 2009), also supports this and says there is a dearth of evidence to identify ways of measuring a non-discriminatory service.

One issue seems to be reasonably clear: that most people recognise that people with dementia need a specialist service that caters for all age groups. Nevertheless, carers of younger people with dementia are, in my experience, quite vocal that they want certain particular services for their relatives, such as support groups, day care and residential care specific for their age. This suggests that we need to offer separate pathways within the same service. Due to the greater complexity in diagnosing dementia in younger adults, an ideal service would involve neurology as well as psychiatry and psychology. Treatment packages for those diagnosed would also have differences. Perhaps less clear is who provides a service to the carers of people with dementia. In our service we have had discussions around IAPT providing initial screening of carers and treatment where the problems identified are not about caring for their relative with dementia. Where the problems do concern caring for a relative with dementia, these would be referred on to secondary care specialist services.

For older people with functional mental health problems, we perhaps need to consider the person’s developmental stage and the life task they are facing. People facing adjustment to physical frailty, dependency, and coping with multiple co-morbidities, may be better provided for by a specialist service for older people. Whilst those people still active and possibly still in
employment may be more adequately treated by an all-age service. In addition perhaps, services need to allow for personal choice, so that those feeling disadvantaged (e.g. being in group therapy where issues of later life are not able to be addressed) or physically intimidated (e.g. by being on a ward with younger psychotic and/or agitated age groups) can be offered as an alternative.

There are other specialist services that also need to examine how they are targeting their resources. It is well known, for instance, that alcohol abuse is under-recognised in older people. Specialised personality disorder services rarely address the needs of older people either. Within primary care psychological therapy services and secondary intake services, training should be undertaken to ensure the needs of older people are understood and targeted. They should have staff who specialise in this area, to ensure equality of service provision. Lastly there are rapid response services and intermediate care services that primarily have developed for older people with physical health needs. When these types of services are further enhanced to cover people with mental health needs they should not only employ staff trained in the mental health of older people but should link in with the local older people’s specialist service to ensure they get adequate training and support. Otherwise we will not learn from the lessons of history that have shown us that neglect and poorer health is the result where there is no specialist training in the challenges of later life.

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References

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All-age mental health services versus an Older Adult Specialism: A response to Alison Kirkpatrick

Jo King

TAKing an historical perspective, Alison Kirpatrick presents a well-argued case for and against the Older Adult Specialism in Mental Health Services in the NHS (see her article in this issue). She concludes that, with the current guidance focussing on ‘needs-led’ services, the likely end-result will be that patients in the Older Adult Specialism who develop dementia, irrespective of age, will be taken care of in a specialist dementia service. Most of these will be over 65, but not all. The criterion for entering this service will be the diagnosis and accompanying care issues, not age. The majority of patients in current Older Adult Services would probably find themselves in such a specialist dementia service. The question is what happens to the rest of the over 65s who have what we generally refer to as ‘functional’ or non-organic problems? Do they remain in a separate service for those over 65 or do they become integrated with the other grown-ups in society? My contention is that the trend toward ‘needs-led’ services and away from the Older Adult Specialism may not only be inevitable but also appropriate.

Let me say at the outset, that I am mindful of possibly being regarded as a heretic or traitor for putting forward a viewpoint that in any way undermines the notion of an Older Adult Specialism! In this respect I would like to draw attention to the ‘PSIGE mentality’ referred to by Woods (2005) and quoted by Straughan et al. (2010) (see article in this issue). The ‘PSIGE mentality’ according to Woods (2005) is about a ‘passion for work with older people, a commitment to training and to helping raise the profile of the speciality,’ When I came to this country in 2001, the year the National Service Framework for Older People (DoH, 2001) was published, and started working with older people I was struck by the fact that the Older Adult Specialism carried with it an aura of the sacrosanct and that my colleagues seemed to be on a mission campaigning for older people. I found this intriguing, having worked across the age range all my working life and never entertaining the notion that any particular age was more deserving than another.

Ten years later I’m aware that the sense of mission is undiminished, despite the National Service Framework for Older People and its attempts to create a climate for more equitable services for older people. I have over the years learned about some of the reasons for the zeal that accompanies work with over 65s, with the most influential being the neglect that has been shown to older people over a period of many years. From my understanding this has two sources: the under-investment in the NHS before 1997 and age-discrimination.

Regarding the question of resources for older people, it certainly seems that they have benefited from improved allocation of resources. I wasn’t here before 1997 but in the time I have been in the UK my perception has been that over 65s actually seem to have access to services more easily than under 65s. In my locality a 64-year-old is either unlikely to be able to access any form of therapy except a small number of sessions from the Primary Care Counsellor (or nowadays more likely a Low Intensity IAPT worker), or gets put on a two-year waiting list.
for psychotherapy. But if the patient was over 65 and their GP referred them to the Older Adult Specialism, they could see a psychologist within one to three months. The point I am wondering about is: if older people are now getting a better deal, is it necessarily the case that they will again be neglected if they are integrated into adult services? Was the problem of neglect of older people not the effect of poor funding in general, and now that services in the NHS have generally improved is there any reason to believe that older people will again be neglected? Is it perhaps the under 65s who are actually being neglected? There seems to be a host of specialist services targeting the under 65s, like Eating Disorders Services, Drug and Alcohol Abuse Services, etcetera, but they seem to cater for so few patients that one wonders whether the ‘average’ adult patient really has better access to services than the ‘average’ older person, who may not get a specialist service but will still be ‘held’ in the Community Mental Health Team. I believe that one of the reasons why most psychologists are wedded to the notion of an Older Adult Specialism is that they realise that older people get a better deal than working age adults and they are reluctant to let go of this. This seems like territorialism to me and does not take into account the question of fairness for all categories of patients in the NHS.

At this point I would like to refer to the work of Rachel Freeth, a Consultant Psychiatrist and Psychotherapist. A perennial problem facing the NHS is that of funding. According to her it is this reality that gives rise to the need for dividing the population into categories. She refers to the ‘era of categorisation’ (Freeth in Russello, 2007, p.85) and says that a health system which aims at being cost-effective and efficient with limited resources will ask itself two questions: the first is at which category of people should it target its limited resources, since it cannot meet the total demand? The second is which part of the service treats what? By defining types of patients and their needs according to objective criteria, services become standardised, which in turn makes the outcome more easily measurable and more costable. Funding and categorisation are inextricably linked – creating categories is an attempt at making an unmanageable problem manageable. However, in the case of the Old Age Specialism what is striking is the ‘crudeness’ of the age criterion for creating the category. Age is actually a poor definer of the nature of the population within that category – how different is a 65-year-old from an 85-year-old or a 95-year-old?

This brings me to my second point – age discrimination. My sense is that the attitude of society and of policymakers toward the notion of age is and has been changing in quite fundamental ways during the last decade or two. Because people live longer and because they remain healthy and youthful later into life the connotations attached to the second half of life have changed. The idea of a set retirement age no longer pertains and even aspects of life that have always been strongly determined by age, such as a woman’s fertility, are no longer set in stone. Age no longer determines aspects of our lives in quite the same way as before. So is it appropriate then for us to hold on to age as a useful criterion for defining or categorising a group of people?

For us as psychologists/psychotherapists there is another reason not to get too bound up in defining the nature of a person by their age. Age is but one of the many influences in a person’s life that determines how they experience their world and themselves at any particular point in life. The kind of relationships they have had or currently have, the kind of work they do or used to do, their experience of parenthood, or of loss and trauma, and so on, are all factors that we take into account when working with a patient regardless of their age. In terms of a person-centred approach it is more important to find out from the patient what meaning they attach to their age than to assume that because they have reached the age of 65 they will define themselves as old! Doing therapy with a patient is about making
meaning – the therapist uses what the patient brings to help the patient make sense of their life. Age may be a defining issue for a patient or it may not.

Perhaps the most important reason for not dividing adulthood into two stages – older and younger, or as some prefer, working age adults, although this label is also beginning to lose its usefulness – is that it creates a dissonance in patients themselves. It has often been expressed to me by patients that they do not identify with the label ‘older adult’ – this perception has nothing to do with their actual chronological age but more with a state of mind. They often feel that they are not ready to be regarded as ‘old’. However, it is true that once they settle down in the service they disregard their label because they feel they are being well looked after! This, I believe is evidence that the service is quite well resourced.

From a practical point of view, it is easy to support the notion of an Older Adult Specialism because, on the whole, categorisation has resulted in a more effective service for those over the age of 65. But to achieve this I suspect something has had to give somewhere else – could it be Adult Mental Health Services? On philosophical grounds, however, the notion of defining a patient as ‘old’ because they have reached an objectively measured point in their life, namely the age of 65, suggests that we are missing the essence of that person. Age is a poor criterion for defining an individual as much as it is a service.

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The Psychology of Later Life Module at the University of Surrey: To what extent does it adhere to PSIGE recommended syllabus content?

Amy Straughan, Ian Kneebone, Arlene Vetere & Tushna Vandrevala

Trainees of the Surrey PsychD (Clinical Psychology) programme were surveyed to identify if the courses module on older people – The Psychology of Later Life met the guidelines on training recommended by PSIGE. It was confirmed the course met the recommendations.

PSIGE – Psychology Specialists Working with Older People – initially formed over 30 years ago, following the Government-commissioned Trethowan Report (Woods, 2005). This report identified work with older people as a distinct speciality in the organisation of psychological services. In 1983 the British Psychological Society recognised this speciality status with the establishment of PSIGE as a special interest group within the Division of Clinical Psychology (Woods, 2005). In 2003 PSIGE was reclassified as a Faculty of the Society’s Division of Clinical Psychology (DCP) reinforcing the continuing relevance of the speciality.

Since it commenced, PSIGE has attempted to dispel the myths surrounding psychological work with older people (such as; few trainees are interested in the speciality, older people are dementing, or are too rigid to change) and created the ‘PSIGE mentality’ something considered to include a passion for work with older people, a commitment to training and to helping raise the profile of the speciality (Woods, 2005). The work conducted by PSIGE led to the establishment of teaching modules in older people in clinical psychology training programmes and mandatory older people placements.

PSIGE’s ideals remain relevant in the new millennium. The historical imbalances in resource allocation and under diagnosis and under treatment for older people continue. While almost 20 per cent of people in the UK are aged 65 and older and show equivalent rates of psychological distress to younger people (Division of Clinical Psychology & PSIGE, 2006), only about five per cent of the clinical psychology workforce specialises in work with older people (Department of Health & British Psychological Society, 2003). Despite PSIGE’s best efforts there has been no proportionate growth in services to older people over the last decade. The failure to progress highlights the need for training programmes to continue to provide specific training and relevant experience in order to prepare and encourage trainees to specialise in older people’s services post-qualification (Boddington, 2000; Department of Health & British Psychological Society, 2003; Division of Clinical Psychology & PSIGE, 2006).

In previous years clinical psychology training programmes typically included six, six-month clinical placements (average three days per week). This allowed the trainee to gain direct experience and develop skills working in a range of specialities including working with older people. In the late 1990s, however, as training places expanded, it became difficult for courses to maintain...
the number of older people placements, whilst retaining the quality of the placement experience.

In response to this dilemma and also taking an approach that recognised the potential value of core competencies-based training rather than individual specialist teaching/placements, (where the opportunity for overlap and repeated skills teaching is more likely,) in 2002, the Society revised the criteria for accreditation of programmes. These new criteria state the importance for qualifying level clinical psychologists to have acquired a set of core competencies or skills that allow them to work with individuals with a range of difficulties across the lifespan. The primary focus of the training programme is, therefore, not solely to provide an opportunity to obtain specific teaching and placement experience with different populations but rather to ensure the development of core skills outlined by these criteria (Committee on Training Programmes in Clinical Psychology, 2002; Division of Clinical Psychology & PSIGE, 2006).

A dedicated Psychology of Later Life teaching module (Vetere & Kneebone, 2005) continues at the University of Surrey with the general content as outlined in Table 1. This report details a survey conducted in order to establish the extent to which this module adheres to the suggested syllabus outlined within the PSIGE Good Practice Guidelines (Division of Clinical Psychology & PSIGE, 2006).

It was hoped that the survey would establish a baseline on what is being taught so that as the programme moves to a competency based approach required elements identified by PSIGE to be retained and any gaps in the course filled.

**Method**

**Participants:** 16 trainee clinical psychologists (16/26), one male and 15 females from the doctoral course (Cohort 33/3) at the University of Surrey completed and returned a survey via e-mail.

**Survey design:** An Older People Teaching Survey Form was devised based on the PSIGE suggested syllabus content (Division of Clinical Psychology & PSIGE, 2006). The survey form required the respondents (trainee clinical psychologists) to examine the syllabus content in detail under five main categories.

1. General issues in ageing.
2. Normal ageing and the impact of life events.
3. Physical and psychological disorders in older people.
4. Service provision.
5. Intervention approaches and clinical skills development.
The survey required trainees to look at each syllabus item, consider the Older People module and indicate in the appropriate box, the extent to which the items were covered using the following response categories 0, 1, 2 and 3, whereby:

0. This item is not covered as part of the Older People module.
1. This item is referred to during the Older People module.
2. Attention is given to this item during the Older People module.
3. Individual lectures are primarily focused around this topic during the Older People module.

Procedure: The survey was administered via e-mail in February 2007, approximately six months after the Older People module was completed for cohort 33/3. Several reminder e-mails were sent to the trainees between February and April 2007 to increase the response rate.

Process of analysis: The information from all respondents was collated and descriptive statistics calculated. For each syllabus item, the final score for each response category was determined by calculating the mean (average) from the responses provided by the trainees. The results were then clustered and tabulated so that all syllabus items with an overall rating of 0, 1, 2, and 3 could be clearly identified.

Results
According to trainee responses, all suggested PSIGE syllabus items were covered by the course. Table 2 lists those items that were least considered, i.e. those that, on average, were just ‘referred to’ rather than ‘given attention’ or were the ‘primary focus’ of a specific lecture within the Older People module, University of Surrey Doctoral Clinical Psychology Training Programme.

Discussion
Findings: The Psychology of Later Life offered within University of Surrey Doctoral Clinical Psychology Training Programme the module covers all areas suggested by PSIGE.

Limitations: The survey relied on trainee’s memory of their Older Adult teaching. On repeating the survey it may be more accurate to ask trainees to complete the survey following each of their older people lectures.

<table>
<thead>
<tr>
<th>Lecture</th>
<th>Title</th>
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<tbody>
<tr>
<td>1</td>
<td>The Psychology and Sociology of Ageing.</td>
</tr>
<tr>
<td>2</td>
<td>Psychometric assessment, communication and interviewing skills with older people.</td>
</tr>
<tr>
<td>3</td>
<td>Behavioural and cognitive therapies with older people.</td>
</tr>
<tr>
<td>4</td>
<td>MOT: Application of structural and brief solution focused models to working with older people at individual and client levels.</td>
</tr>
<tr>
<td>5</td>
<td>Psychodynamic psychotherapy with older people.</td>
</tr>
<tr>
<td>6</td>
<td>Psychological (functional) problems presenting in older people.</td>
</tr>
<tr>
<td>7</td>
<td>Formulation of psychological (functional) problems presenting in older people.</td>
</tr>
<tr>
<td>8</td>
<td>Ethical, legal and service issues when working with older people.</td>
</tr>
<tr>
<td>9</td>
<td>Neuro: Stroke.</td>
</tr>
<tr>
<td>10</td>
<td>Administration and Interpretation of Psychometric Tests with older people.</td>
</tr>
<tr>
<td>11</td>
<td>Dementia care and psychological interventions for dementia.</td>
</tr>
</tbody>
</table>

Table 1. Lectures in the course ‘Psychology of Older People’ offered within the University of Surrey, Doctoral Clinical Psychology Programme, 2006.
Table 2: Syllabus items that are referred to during lectures (score 1).

<table>
<thead>
<tr>
<th>Syllabus Item</th>
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<tbody>
<tr>
<td>Limitations of the knowledge about ageism</td>
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<tr>
<td>Knowledge of pharmacological treatments</td>
</tr>
<tr>
<td>Psychosis with onset in later life</td>
</tr>
<tr>
<td>Impact of earlier traumatic event in later life</td>
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<tr>
<td>Substance abuse and alcohol</td>
</tr>
<tr>
<td>Complex reactions to bereavement</td>
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<tr>
<td>Suicide and attempted suicide</td>
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<tr>
<td>Life expectancy</td>
</tr>
<tr>
<td>Essential psychological components of medical care</td>
</tr>
<tr>
<td>Falls prevention and fear of falling</td>
</tr>
<tr>
<td>Continence</td>
</tr>
<tr>
<td>Pain</td>
</tr>
<tr>
<td>End of life issues and palliative care</td>
</tr>
<tr>
<td>Pharmacology and us, addiction to and abuse of prescribed and illicit drugs</td>
</tr>
<tr>
<td>Co-morbidity</td>
</tr>
<tr>
<td>Community psychological approaches and older people</td>
</tr>
<tr>
<td>Models and techniques for older adult involvement in service planning</td>
</tr>
<tr>
<td>Knowledge of current pharmacological treatments</td>
</tr>
<tr>
<td>Working in continuing care environments</td>
</tr>
<tr>
<td>Psychological contributions to physical rehabilitation</td>
</tr>
<tr>
<td>Intervention for fear of falling</td>
</tr>
<tr>
<td>Interventions for older people and psychosis</td>
</tr>
<tr>
<td>Interpersonal therapy</td>
</tr>
<tr>
<td>Narrative approaches</td>
</tr>
<tr>
<td>Solution-focused approaches</td>
</tr>
<tr>
<td>Working with traumatic experience</td>
</tr>
<tr>
<td>Family therapy</td>
</tr>
<tr>
<td>Community Psychology</td>
</tr>
<tr>
<td>Subtleties of multidisciplinary and team work</td>
</tr>
</tbody>
</table>
**Further work:** It would be useful to complete the same survey using trainees from other clinical psychology courses. A comparison would encourage courses to learn from one another about how they weave together the core competency model and syllabus guidelines from PSIGE. PSIGE guidance aside it might also be useful to ask placement supervisors whether they have noticed any gaps in trainee’s knowledge that might inform not only course development but future PSIGE guidelines.

As the University of Surrey course implements core competencies and faces competing demands on curriculum time from other study areas, changing government policy and DCP initiatives, teaching on older people should continue to regularly be reviewed. The opportunity for using supplemental online resources for course development (such as Ken Laidlaw’s initiative in Edinburgh) should also be considered. Further the flow of trainees to jobs in which they work with older people should be monitored to consider the influence of both the course and placements on speciality choice.

We are prepared to make the Surrey survey available to other programmes so they might be encouraged to conduct their own surveys. It may then be possible to share and co-ordinate programme responses through the *PSIGE Newsletter*, or through the meetings of the Group of Trainers in Clinical Psychology.

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References


IAPT supervision: A new experience

Miranda Weller

THIS ITEM is to share with you the experience of supervising the first intake of High Intensity Cognitive Behavioural Therapists (CBT) from Salomon’s Department of Applied Psychology.

I currently practice as a BABCP (British Association of Behavioural and Cognitive Psychotherapies) Accredited Cognitive Behavioural Therapist and BABCP Accredited Supervisor. My background is as a Registered General Nurse (RGN), and Registered Mental Nurse (RMN). I currently work in Mental Health Services for Older People and with working age adults. It is my BABCP accreditation that qualifies me to supervise IAPT trainees.

IAPT supervisors training started in September 2009 at the Salomon’s Campus at Tunbridge Wells, a satellite of Canterbury Christ Church University, with the first intake of IAPT trainees starting in October. The first training day was quite generic and included the Competence framework for Supervision and application of specific models, Kolb’s learning styles, our own strengths and preferences, a look at the Stepped Care Model for Mental Health, NICE guidelines, supervision methods and supervision metacompetencies. We met the staff who had the daunting task of setting up and running the course – the stress was palpable! I left the first day with a head full of scrambled thoughts and an armful of paperwork, but keen to be involved in this new experience.

This first day of supervisors’ training in September was swiftly followed up by the allocation of our supervisees. By 13 October, we had started supervising our first High Intensity trainees!

The second day of training, 18 November, we evaluated our own supervision practice using the Cognitive Therapy Scale-Revised (CTS-R). The CTS-R was to become fundamental to our supervisory practice as a working tool to assess therapeutic skills.

I learnt that a Psychological Well-Being Practitioner (PWP) delivers low intensity work, assessing and supporting people with, principally, anxiety and depression (criterion: Step Care mental health level 2 for mild mental health problems), using mainly guided self-help based on the CBT approach, including behaviour activation, cognitive restructuring, thought diaries, medication support, exposure therapy and problem-solving. This would be delivered largely through telephone contact averaging three to five hours per client. After a year, trainees would gain a Postgraduate Certificate and a Band 5 post but as an outcome objective of the course, would not be expected to have accreditation with BABCP.

The third day at Salomon’s, 25 November, looked at high intensity work with step 3 and 4 (moderate or severe mental health problems, recurrent, atypical and those at significant risk) of the Stepped Care mental health model, through face-to-face contacts for an average of 12 hours. This is a much more in-depth training and follows the traditional CBT structured session which gives importance to collaborative conceptualisation and formulation of problems from which interventions are built, and Socratic dialogue, guided discovery, self-practice, the interpersonal effectiveness of the therapeutic alliance, schema work, and so on, are developed.

These trainee’s will become accredited therapists with the BABCP once they have met the criteria, including eight training cases and a literature review, and may expect to be appointed at Band 7 if they successfully complete the Postgraduate Diploma course.
My responsibility as a supervisor was to provide a minimum of 30 hours supervision for each trainee, top up any of the 40 hours supervision they may have missed from course supervision (total of 70 hours required) and provide reviews and a final report. To meet with BABCP criteria, in conjunction with course work, trainees need to complete and write up a minimum of eight training cases, with five hours minimum supervision per case and have a minimum of 200 hours CBT assessment and treatment.

Day 4, 22 February – this day allowed for a review of supervision in practice, meeting with trainees and tutors to discuss any issues relating to the course and supervision role. It gave us the opportunity to highlight areas that needed further attention and those that were going well. There are still plenty of things that need to be ‘ironed out’ and we had this opportunity to say what we felt they were. By this time we had also set up a High Intensity supervisors support group where supervisors could meet on a regular basis.

Our final day, 28 April, we received feedback on trainees’ performance and looked at our own supervision metacompetencies in peer supervision groups, utilising Christine Padesky’s ‘Road Map for Supervision’. We also considered our responsibility with regard to our trainees asking us for references for the BABCP, which includes the standards of conduct, performance and ethics in the practice of Behavioural and Cognitive Psychotherapies.

Overall, I feel this course is very hard work for the trainees but it will take them to a different place quickly and effectively. Both trainees and supervisors need to keep up with the plentiful but necessary paperwork with various criteria to be met in a short space of time. For the majority of trainees this has proved difficult as they are not able to complete on time.

I feel the course is of very high quality with excellent speakers such as Prof. Paul Salkovskis (OCD), Prof. David Clark (social phobia), Prof. Anke Ehlers (PTSD), to name but a few. I can see change happening in the trainees as I work with them and feel that they will be competent practitioners providing a much needed service.

Helpful links
For ‘Improving Access to Psychological Therapies’:
www.iapt.nhs.uk/
For ‘Stepped Care’:
For Salomon’s ‘IAPT’ course:
www.canterbury.ac.uk/Salomons/
For Christine Padesky:
www.padesky.com/

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RGN, RMN, MSc. Cognitive Psychotherapy, BABCP Accredited BABCP Accredited supervisor.
Developing a family-inclusive mental health service for older adults

David Gracey & Marcus Averbeck

There is a substantial and growing body of evidence which demonstrates how direct clinical outcome is enhanced through the involvement of families, alongside alleviating the wider burden of carer stress (Stratton, 2005). This can be considered especially relevant to work with older people as there tends to be much more in the way of intergenerational issues (Curtis & Dixon, 2005). Despite the evidence for efficacy, and a plethora of national policies to which family-inclusive practice has become attached to, this has not lead to the establishment of family intervention services in routine clinical settings (Brooker, 2001).

The origins of prioritising family-inclusive practice as part of service development within Oxleas NHS Foundation Trust dates back to 2006. At the time, ideas about what could be gained from enhancing the levels of confidence and competency of staff in working with the wider family network were very well received at a higher management level with the trust. The training package that was subsequently commissioned drew primarily from the work of Stanbridge and Burbach (2007) who had established a programme tailored to a whole-team approach, drawing from primarily systemic ideas. The purpose of training was threefold:

1. To raise awareness about working inclusively with families.
2. To change the culture from thinking about the individual towards a consideration of a person’s wider network.
3. To learn new skills.

We also wanted to avoid the trap of training up people for a few days and then not being able to offer continued support, as it has been our experience that these skills would not be used otherwise.

Family inclusive practice training programme

When it came to delivering the programme to those working within older adult settings, it quickly became apparent that certain aspects of training underestimated the kind of clinical practice that was already going on. Health care professionals within older adult services in the trust already were involved in a lot of direct work with family members and carers. Having conducted a training needs analysis, it was identified that older adults services required more of a skills-enhancing based approach and this directly informed the structure of the emergent training programme. At the same time, we were mindful of the fact that, when it comes to staff training in which there is a variable skill-mix, there needs to be a component on improving education and awareness of working with families. Various modifications have continued to take place although, broadly speaking, the training programme as delivered consists of a number of distinct characteristics.

The three-day training package

The aim of this package is to provide an introduction to thinking about families and social systems, and considering individuals who present to our services in their relational and social context. It also provides training in basic family interviewing skills and problem-solving.

The focus on Day 1 is on education and awareness. The relevance and benefits of a family/social network perspective, including its evidence base and links with national policy, are considered. Through ‘a carer’s story’, as told by a carer who has experienced a similar service within the trust, attendees...
are encouraged early on to begin considering what this wider perspective might mean for their own practice. Ideas around systemic thinking are then introduced, and the beliefs and behaviours involved in interactional cycles within families which can maintain problems are examined. These ideas are explored by means of exercises and pairs/small group discussions using staff’s own clinical experience and are supported by didactic teaching. Issues around information-sharing and confidentiality are explored.

Day 2 concentrates on teaching the basic interviewing skills required for convening, engaging and conducting a session, including problem solving. This is done by means of role play techniques using prepared vignettes and situations based on staff’s own clinical experiences. At the end of Day 2 a detailed, manageable, action plan for the team is developed.

Day 3 is scheduled for a minimum interval of one month after the initial two training days in order for staff to have time to put their learning into practice. The focus on this day is on hearing how the team got on in their meetings with families, what went well or not so well, and providing supervision on cases. Additional skills are taught as required and follow-up training and consultation sessions are planned.

Training is overseen by experienced staff who themselves, at a minimum, have a recognised qualification in systemic therapy. This three-day awareness/education and basic skills training is provided for all trained staff in all care groups, the stated aim of which would be to increase the involvement of families in the assessment/admission process and the inclusion of family/carer needs and systemic issues in the written care plan. In order to maximise the impact on clinical practice the training to each service is provided using a team training approach. It is planned to supplement this with additional awareness-raising training for non-professionally trained staff.

All of the training needs to take into account that many clinical teams consist of experienced therapists who practice individual cognitive behavioural therapy and cognitive analytic therapies, as well as Community Mental Health Team (CMHT) workers with a special interest in specific disorders. Training may also include a presentation by a carers assessment worker on their role and the resources available for carers, as well as a demonstration of the recording of family/carer information on the electronic patient record system (RiO).

Outcomes of the training have included amending operational policies, increasing the involvement of families in the assessment phase and increasing assessment/support for families and carers.

Feedback from participants
‘This has been a really useful “consciousness raising” for me, making me very aware of being constrained within a very individual model – not so much in terms of the relevance of the family where I’ve always worked on the family inside someone’s head but more the potential for actually seeing more of other family members.’

When asked to give examples of how this training had influenced practice, another person commented: ‘More confident in meeting with families. More aware/conscious systemic thinking when working with individuals. Some more tools to offer practical/signposting support and information to carers. Genograms will be very useful to use more.’

Further evaluation
An evaluation process has accompanied this initiative, identifying the usefulness of the training package for clinicians and the impact on service users. Indeed, service users are directly involved by participation in a Carers and Families Steering Group which has been set up trust-wide as part of the training strategy.

It is clear that family-inclusive practice training and continued support can only happen if there is a sufficient level of clinicians working within the trust that have
received some formal training in family work. To date, we have trained some 24 clinicians from all care groups and professional backgrounds, including a sizeable proportion of those working within older adult settings. 2010 will see a further 12 health care professionals, alongside an increase in the level of designated family therapy posts with the trust. We believe that a successful training programme delivered to a wide staff base is highly dependant upon a robust supervision/consultation structure which allows continued support for those wishing to work more inclusively with families, alongside a management awareness of the importance of this sort of partnership working.

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**References**


GREENWICH is a demographically diverse borough in South East London and Oxleas NHS Foundation Trust is the local mental health provider. Five years ago we had a small Day Hospital that ran three days a week, in which people with predominantly functional difficulties attended for the whole day and attended whatever groups were running on those days. There was one main group room, which also doubled as the dining area and kitchen. Many people had been attending the service for years and moving them on was often very difficult. The service was highly valued by the people who attended, but inevitably focused on those with longer term mental health needs. It lacked the capacity or the structure to provide input to people with more acute needs and there was no evidence of its clinical effectiveness. The service was attended by 25 to 30 people in a typical month.

Because of a staffing crisis and the struggle to retain our services in the context of annual Cost Releasing Efficiencies – perhaps also informed by a national move away from the provision of Mental Health Day Hospitals – we faced three choices:

● To close the Day Hospital;
● To merge it with the Working Age Adult (WAA) Day Hospital;
● To find a ‘third way’.

Having explored the viability of merger with the WAA Day Hospital, we made a proposal based on the last option. We wanted to keep the aspects of the old Day Hospital which were of most value, but to develop the model. We visited other services, did literature searches, looked at the resources we had at our disposal and the future priorities of the wider service. That led us to set up the Day Therapy Service (DTS) in 2004. This article focuses on the development of that service and its utility as an alternative service model for the provision of therapeutic interventions for older people. At this time one author (MR) was the Head of Specialty for Psychology and Lead Clinician in the local Mental Health Service for Older People.

The Day Therapy Service

The DTS consisted of all the Occupational Therapy and Psychological Therapy posts in the wider service, together with those posts funded by the old DH. We proposed that this group of staff would provide:

● A therapeutic group programme for people on the wards and in the community.
● In reach to the wards for one-to-one assessment and interventions, consultancy and staff training.
● Input to the Community Mental Health Team via 1 to1, couple and family work.
● Training and consultation to other relevant agencies in the area when resources allowed (e.g. Residential and Nursing Homes, Day Centres).
● Evidence-based care, incorporating the principles of person-centred care, recovery and social inclusion.
● Service relevant research, evaluation and audit projects.

We also wanted to put service user involvement at the heart of our structure, and established a User Consultation Board.

We aimed to help prevent unnecessary admissions, speed up discharges from the ward, increase throughput, provide therapeutic interventions on the basis of individual need, and support people...
intensively when necessary to help reduce caseloads in the CMHT and to enable people to resume their optimal level of emotional and practical functioning as soon as possible.

We increased the group programme from three to five days per week and established selection criteria, aims and objectives for all groups. We introduced a wider, evidence-based group programme, including more interventions for people with dementia and their carers. We also set up regular peer supervision and reflective practice meetings for staff running the group programme.

We met regularly with service users to consult about the changes, and there was a formal consultation process for staff. Most people – service users and staff – were supportive of the changes and were enthusiastic about the benefits. People already attending the programme were particularly welcoming of groups focusing on specific problems and approaches, for example, a Depression Management Group based on a Cognitive Behavioural model, Out and About groups to help address social isolation and enhance confidence and social integration, a Coping with Memory Difficulties group for people with dementia and their carers. We faced on-going challenges with staffing levels, and also with our premises, which were cramped, run-down and generally unsuitable for group or individual therapy sessions. Over a period of years we successfully argued for alternative, updated premises and these have just opened.

The model we adopted for the DTS was devised and implemented by senior clinicians within Psychology and Occupational Therapy, who established a clinical management team to oversee the change process and the development, delivery and evaluation of the clinical service. This has been a key factor in terms of gaining support from staff and being seen to delivery a cost effective service. As resources have increased we have been able to extend the clinical developments in to our inpatient units – especially the acute admission ward – offering a varied group programme, facilitating person centred care and reflective practice meetings, running formal teaching sessions, and conducting audits and surveys evaluating patient experience of the units. These have informed the local quality improvement plans of the units.

The ward and community group programmes have been developed in order to meet the needs of people who move from crisis to stability and recovery, as well as those of people with longer-term mental health needs, who may require on-going low level support.

We have continued to increase the range of groups on offer, for example, we have started running regular Mindfulness Based Cognitive Therapy groups for depression, and are planning a work stream of therapeutic groups for carers. We have just started an activity-based group for people with young onset dementia and plan to further increase our groups for people with dementia of all ages. In February 2010, 123 individuals attended the community group programme.

**Developing the management structure**

In 2008 we proposed changes to the title, remit and management structure of the DTS. It is now known as the Therapy Service, and its remit includes the need to increase the availability of Psychological Therapies – one of the Trust’s main priorities. The management changes included a Consultant Clinical Psychologist and the Head Occupational Therapist becoming the Joint Operational Managers, and the role of Clinical and Strategic Lead for the Therapy Service becoming part of the job description for the Head of the Psychology Specialty. These changes also enabled us to create a new Psychological Therapies post and to strengthen administrative support to the service.

**Evaluation**

In 2009 we conducted an extensive audit of the service – both the group programme and the one-to-one work offered by Psychology
and OT – including a postal survey (N=34) and in-depth interviews with a smaller sample of Therapy Service users (N=6). The main domains were based around key sections of the National Patients’ Survey and some of the results are summarised below:

- 83 per cent of respondents knew who had referred them and why.
- 91 per cent found the group they attended useful.
- 83 per cent thought that the service had helped them achieve what they hoped for.
- 50 per cent thought the group had changed how they spend their time, with 32 per cent pursuing other groups in the community once discharged from the TS.
- 100 per cent felt welcomed.
- 100 per cent felt treated with dignity and respect.
- 42 per cent thought that their carers needed additional information.

People reported that the most useful aspect of the groups was having a space to voice their difficulties and discuss them with people in similar situations. Professional advice, for example around caring for someone with dementia, was also highly valued. These aspects of the groups were considered to be more useful than learning new coping strategies, or receiving advice from other group members.

For people attending the Therapy Service groups, their hopes included improving their mood, relaxing, socialising, and learning about difficulties such as dementia. Feedback about the individual and group therapies included the following comments:

‘She helped me to see that life can be a lot better than I had been perceiving it to be.’
‘I understand why I have the problems and the ‘hang ups’ that I have’.
‘Listening to others helps me realise you are not too bad and not on your own as some people are.’
‘Being there changed my perspective and made me push myself.’
‘They always welcomed me and treated me as a person, not an old person.’

**Personal reflections**

The Therapy Service has strengthened the identity of the therapy professions within our service. It has enabled staff to consolidate and expand their skill base and to work flexibly across the service when this has been helpful to their own professional development or to the needs of the service. We have worked hard to ensure it has had the support of senior clinical and managerial colleagues, who explicitly espoused the move towards a more holistic biopsychosocial model of care. The fact that increasing the availability of psychological therapy to all care groups has been a Trust priority in recent years, and that it was agreed this should be part of the remit of the Therapy Service, has strengthened our hand in making the case for more resources – posts, clinical space, training and specialist supervision.

Following the initial agreement to try the ‘third way’ option, it has taken much longer than we had envisaged to reach our present position, in which we are close to achieving our original aims. In many ways it has been helpful to be able to start with pretty much a blank slate, rather than trying to make gradual changes to an existing structure. Being able to stand back from what we had – which was no longer viable – enabled us to plan a therapy service that would fit well with the future direction of local MH services for OP. It has also been hugely positive to see the benefits for both professions from the close work this has necessitated between Psychology and Occupational Therapy.

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HOPE for the future: Gaining an insight into the experiences of people with dementia

Sally Stapleton, David Moore, Gill Constable & Kirsty Jones

In the following article we attempt to describe our experiences of trying to gain an insight into the experiences of people with dementia, in order that care services, provided by a number of different agencies in Sussex, can improve the quality of care that they provide. There are two main ways in which we have attempted to do this. The first is the creation of the ‘HOPE of People with Experience (HOPE) Group’. This is a group of people who are living with dementia. The HOPE group have been working with West Sussex County Council to help deliver training to professional staff and students. The second is through training of Sussex health and social care staff in the use of Dementia Care Mapping (Brooker & Surr, 2005), a multi-agency initiative that has been led by Sussex Partnership NHS Foundation Trust. We hope to demonstrate that by multi-agency projects such as these, our services can work towards having an informed and effective workforce for people with dementia and their families as specified in the National Dementia Strategy (Department of Health, 2009).

Workforce development:
The recommendations of the National Dementia Strategy.
Objective 13 of the National Dementia Strategy recommends ‘An informed and effective workforce for people with dementia.’ (Department of Health, 2009, p.56.) The National Dementia Strategy also specifies that the most effective way of meeting this objective will be for health and social care systems to work together in the developing their workforce.

Sussex Partnership NHS Foundation Trust have been working in partnership with West Sussex County Council and Skills for Care via the provision of training in Dementia Care Mapping (DCM) by trainers from the University of Bradford. A specific local project using DCM, led by Skills for Care, has also led to partnership working with Brighton and Hove City Council, East Sussex County Council and the Care Training Consortium (West Sussex). The HOPE group (a group of individuals who are living with dementia) have been working with West Sussex County Council, Brighton and Sussex Universities and Skills for Care. This article will specifically describe each of these projects, grouped according to two themes: 1. Gaining an insight into the lived experience of people with dementia; 2. Attempting to gain an insight into the experiences of people with dementia via the use of DCM.

1. Gaining an insight into the lived experiences of people with dementia (the HOPE of People with Experience (HOPE) group)
A particularly exciting and innovative project which is based in Sussex is the HOPE (HOPE of People of Experience) group. The HOPE group is formed of people who are living with dementia. The HOPE group provide awareness training sessions for professionals. The following has been written by members of the HOPE group:

REAL PEOPLE, REAL LIVES, TELLING HOW IT IS FOR THEM
HOPE is a group of people who have direct experience of a variety of dementias. Some of the group members attend with their carers and would attend sessions together. This allows staff and students to hear directly of the impact of the disease on both person and their carer and how this impact might lead to conflicting needs being experienced.

We believe that by sharing our experiences of dementia, staff and students can gain important insights that would be difficult to acquire any other way. We have already been involved in Service Users Carers Network with the Universities of Brighton and Sussex and a presentation for a conference on dementia held by Skills for Care. Members are also involved in an advisory panel for a research programme, run by DENDRON, on the efficacy of physical exercise in slowing down cognitive impairment in people. We are also going to be working with Adults’ Services in West Sussex training Social Workers, Occupational Therapists and other professionals.

2. Gaining an insight into the experiences of people with dementia via DCM

Psychologists Tom Kitwood and Kathleen Bredin, at the University of Bradford, developed DCM in the early 1990s. DCM is an observational method that looks at the experience of being in a care setting such as a hospital ward, day centre or care home, from the viewpoint of the person with dementia. The results of a Dementia Care Map can be used to help staff plan ways of enhancing the well being of people with dementia.

In 2008, Sussex Partnership NHS Foundation Trust made a decision to train members of staff in the use of DCM. Following consultation with the University of Bradford, Sussex Partnership NHS Foundation Trust commissioned two Dementia Care Mapping courses (Basic user) from the University of Bradford. Some of the places were purchased by West Sussex County Council (WSCC) and the Skills for Care project team. There have been approximately 60 staff trained in Dementia Care Mapping across Sussex Partnership NHS Foundation Trust, WSCC and Skills for Care (with staff from University of Chichester and the Independent Care Sector). There have been three main projects that have used DCM. The following will provide a description of how DCM is being used across different health and social care agencies.

a. Enhancing person-centred care within inpatient services (Sussex Partnership NHS Foundation Trust)

Sussex Partnership NHS Foundation Trust have been using DCM within inpatient services for people with dementia in West Sussex. All units have made a commitment to ensuring that all staff attend training in person-centred care. This has been provided by two training days. The first is an introduction to working with people with dementia, which is run jointly across all of the trust, led by a consultant clinical psychologist. The second training day is a specific introduction to the concepts of DCM. The introduction to DCM forms part of the ‘briefing’ part of the DCM process, whereby members of the staff team are given information about DCM and the opportunity to ask questions and express any concerns.

Briefing sessions have also been completed on each of the inpatient units, including one to one sessions with people with dementia and group sessions with relatives and friends who visit the inpatient units. Information leaflets and posters have also been produced for people with dementia, relatives and staff to assist with providing information about DCM. These have been made accessible to all Dementia Care Mappers via the Trust’s computer network. Templates of these documents and presentations have also been shared with all Dementia Care Mappers who have completed their training alongside Trust staff. Sussex Partnership NHS Foundation Trust provides a monthly Dementia Care Mapper’s Forum, chaired by an advanced
Dementia Care Mapper  This provides continued professional development and support for Dementia Care Mappers.

So far, three full six-hour Dementia Care Maps have been completed within inpatient services. The results have been fed back to the staff teams for action planning. The use of DCM has led to teams making a number of changes. Many of these have involved changes to the inpatient environment, such as changing the ward layout and the provision of additional materials to support activities. There are plans to continue to map within the inpatient services in West Sussex on an annual basis to continually review and further enhance care practice.

The DCM project team won the ‘Innovations’ award at the Sussex Partnership NHS Trust Staff awards ceremony in 2009 and have been nominated for a further award this year for ‘Great Steps in People Development’. The Trust’s management team are keen to ensure that examples of good practice are implemented across all areas of the trust.

b. Enhancing person-centred care for people with dementia in care homes (Multi-agency Skills for Care project)

A developmental project was commissioned by the Skills for Care Involvement Team (Sussex) whose members include service users and carers, as well as health and social care agencies. The focus of the project was to support the well-being of people with dementia in care homes within the private and third sector in Sussex. The project was extended through additional funding provided by Skills for Care, Brighton and Hove City Council, East Sussex County Council and the Care Training Consortium (West Sussex).

The project has linked very closely with the Sussex Partnership NHS Foundation Trust’s Dementia Care Mapping Project. Skills for Care provided funding for seven care home managers to attend a Dementia Care Mapping course in May 2009 which was commissioned by Sussex Partnership NHS Foundation Trust and delivered by the University of Bradford.

The care homes were supported in the implementation of person-centred practice and mapping through the following activities, which were delivered by the University of Chichester:

- Person-Centred Leadership in Dementia Care – three-day training course for care home managers, which included coaching skill and the use of the VIPS framework for quality assuring practice (Brooker, 2007).
- Learning Set for care home managers to support them in developing mapping skills, which included linking managers in pairs to practice map.
- Person-Centred Practice – half-day workshops for care staff.
- Creative Therapies in Supporting People with Dementia – two-day courses for care staff.
- Life Story Work and Enhancing Observation Skills with People with Dementia – two-day course for care staff that focused on the Pool Activity Level (PAL: Pool, 2007).

Instrument, life story work, memory albums and memory boxes.

The work of the project was presented at the Skills for Care South East Region Showcase Event on 5 March 2009, and at the conference Dignity in Dementia on 15 July 2009. A Sussex Think Tank session was facilitated by Skills for Care Surrey and Sussex on 9 December 2009 on identifying workforce development priorities. The event involved local stakeholders and the Department of Health.

The key outcomes of the project have included effective multi-agency partnership and collaboration between Skills for Care, Sussex Partnership NHS Foundation Trust, Brighton and Hove City Council, East Sussex County Council, Care Training Consortium (West Sussex) and the University of Chichester. All the activities in the project have been well evaluated and enabled managers and care staff to implement a range of
approaches to support person-centred practice.

c. Enhancing person-centred care for people with dementia in day services (West Sussex County Council)

In October 2008 two members of West Sussex County Council (WSCC) Adults Services, Kirsty Jones, Training and Development Officer, and Simon Kral, Assistant Day Centre Manager, completed training provided by Bradford University in conjunction with Sussex Partnership NHS Foundation Trust, in Dementia Care Mapping (DCM).

Following this training, a pilot project of DCM at one of WSCC Multipurpose Day Centres was agreed with the County Day Services Manager (Multipurpose Day Centres). The purpose of the pilot was to provide the opportunity for a clear and systematic review and evaluation of the effectiveness of DCM within a day centre service and to see how DCM could provide WSCC Adults Services with the opportunity to review the experience of attending a day centre from the perspective of the person with dementia.

The expectation of the results of the DCM included the opportunity to provide constructive training and feedback to staff, to implement action plans to achieve a truly person-centred dementia care service within WSCC day centres and to implement a quality improvement programme across all day care services.

The pilot project has proved to be very successful and has identified that DCM can provide a defined system for planning and achieving person centred care for individuals and also for identifying how the day service can be provided.

In conversation with the County Day Services Manager (Multipurpose) there is a commitment within the service to roll out DCM across its sites where dementia services are being provided. This is part of an ongoing quality development programme looking at existing service delivery. Continued conversations about DCM and other developments within dementia services provided within day services will also need to be had within the strategic joint commissioning discussion around the implementation of the National Dementia Strategy.

Four further WSCC Adult Services staff members have now received training in DCM and will be meeting to review the work of the pilot project and to plan the implementation of the DCM at other day centres.

Concluding thoughts: HOPE for the future

In order to become more person centred in our training of the health and social care workforce, we need to be able gain an insight into the experiences of people with dementia. The HOPE group demonstrate a way that people who are living with dementia can have a direct impact on the training of health and social care professionals. DCM offers a further way of gaining an insight into the perspectives of people with dementia who access services, so that these services can continue to strive to make continuous improvements. We hope that by working together on multi-agency projects such as these, our services can work towards having an informed and effective workforce for people with dementia and their families as specified in the National Dementia Strategy (Department of Health, 2009).
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Developing and delivering a psychotherapeutic group on an acute psychiatric ward

Jacqueline Bryant, Vikki Kelly & Ariane Zegarra

We describe the development and delivery of a psychotherapeutic group on two acute inpatient wards for older people. Ward A is for people with ‘functional difficulties’ and Ward B is for people with functional and ‘organic difficulties’. The groups provide support and feedback from group members dealing with similar age-related issues. Some of the most salient themes are summarised and feedback from group members and staff is discussed.

Rationale

According to Holmes (2002), while it is not ‘robust’, research evidence provides some grounds for thinking that psychological interventions might have an important role to play in improving quality of care for patients on acute wards. The Mental Health Policy Implementation Guide for adult acute inpatient care provision (Department of Health, 2002) reported that a lack of structured activity and individual attention correlated with a higher incidence of untoward accidents and risk. They stated that boredom and disturbance could be minimised with more structure and stimulation, including the implementation of therapeutic intervention and interaction.

The authors provide sessional input on two acute admission wards in adjacent boroughs in the same Trust. Both are mixed gender acute admission wards for people aged 65 and over. Ward A mostly sees patients with primary diagnoses of depression, anxiety and/or psychosis, Ward B also includes people with organic difficulties. Sessional input from clinical psychology was a new development in both wards. Our aims were to increase access to psychological therapies, and to increase the therapeutic impact of the wards generally.

Informal interviews with some of the inpatients suggested that they wanted a psychotherapeutic group to be available on the ward; somewhere they could talk about their thoughts and difficult feelings, a space to reflect on their experiences of being an inpatient. It was agreed with the nursing staff that a nurse would co-facilitate the group, in the hope of developing a more psychologically minded culture across the ward. According to Holmes (2002), observation of group skills can help to equip ward staff with basic psychological skills, which can strengthen therapeutic alliance between staff and patients and provide the first step in a psychotherapeutic approach.

Group therapy can be a rich experience for older people where they can express themselves, feel acknowledged and develop connections with people who understand their difficulties firsthand (Agronin, 2009). The earliest written records describing group therapy with older people focused on providing education, motivation and support (Silver, 1950). In the 1970s, Goldfarb (1972) notes that there was ‘great interest in the field of group therapy for old persons’ and a strong evidence base to back it. Currently, we have limited outcome literature on the efficacy of various group psychotherapies, but ‘it is clear from the data that do exist that they provide unique opportunities and benefits in late life that are not available from individual therapy alone’ (Agronin, 2009, p.29).
Yalom (2005) explained how inpatient psychotherapy groups can aid interpersonal learning, understanding, insight and correc-
tional emotional experience. Whilst Yalom (1983) did not specifically discuss his group psychotherapy principles in relation to older adults, he worked extensively with older people and maintained that the core tech-
niques were applicable to all age groups. Yalom describes 11 primary agents for
change in groups. Some of these, including, existential factors and the acceptance of
difficult realities, the instillation of hope, interpersonal learning, group cohesiveness
and catharsis, will be discussed later.

Development of the groups
The group on Ward B started nearly two
years ago and is ongoing. When a weekly
session of clinical psychology input was also
allocated to Ward A, it was decided that the
group would be piloted here, initially for six
sessions. This process was to allow more time
to review the group in the light of patient
and staff feedback, and so to create a
stronger sense of it being a shared multi-
disciplinary development on the ward, to
enhance a sense of ownership.

Aims and objectives
The aims of the groups were aligned to
recommendations made by Acute Problems
(The Sainsbury Centre for Mental Health
[SCMH], 1998) and the Mental Health
National Service Framework [NSF] (Depart-
ment of Health, 1999) which advocate a
collaborative approach to working with
service-users. These included:
- To provide opportunities for inter-
personal learning.
- To offer multiple relationships to assist
the individual in personal growth and
problem solving.
- To facilitate the process of communica-
tion among patients.
- To provide containment.

The groups were designed to be unstruc-
tured. However, group work with older
people is reported to need a more direct
approach than working age adults (Corey &
Corey, 1992), therefore we decided to
provide information and direction where
appropriate, for example, reinforcing posi-
tive behaviours such as empathy and
supportive listening; and emphasising
commonalities to help instil a sense of group
identity. The objectives were:
- To enable patients to express their own
thoughts and feelings about their
hospital admission and experiences of
being on the ward.
- To enable patients to acknowledge and
share their thoughts and feelings about
discharge.

It is interesting to note, while Smiley and
Kalechurn (2008) acknowledge the value of
the evidence base for inpatient therapy
groups, they suggest that with limited
resources and a high patient turnover, facili-
tators need to be realistic about achieving
aims and objectives. Similarly, Simpson
(2010) argues it is important to accept that
objectives must necessarily be limited, as
patient groups can have difficulties with
basic socialisation processes. Given this, our
overall goal of the group was simply to estab-
lish a ‘shared conversation’, which according
to Smiley and Kalechurn (2008) would be a
satisfactory outcome.

Initial assessments
Information was obtained from case notes
and discussions with the nursing staff.
Patients who appeared suitable for the
group, met individually with the group facil-
itors. Assessment involved the informal
evaluation of patients’ psychological,
physical and social needs. Patients were
excluded if they did not appear to have the
capacity to listen or respond to others in a
group setting. However, we tried not to apply
the inclusion criteria too strictly as it has
been suggested that some individuals who
might at first seem too unwell to work with
the group process could end up getting a lot
out of the group (Agronin, 2009).

PSIGE Newsletter, No. 111, July 2010
Some of the patients approached were initially wary of psychologists. In part, this was attributable to generational attitudes and the perceived stigma attached to mental illness. To some of the patients, seeing a psychologist meant that they were ‘really mad’. We attempted to allay some of these fears by exploring their assumptions of psychology and dispelling some of the myths attached to mental illness. In addition, the word ‘group’ discouraged some patients. The idea of ‘sharing’ their problems with others was sometimes not something they felt comfortable with. According to Agronin (2009), older people might be ambivalent about attending groups because they think that other depressed or debilitated individuals may depress them further.

Due to the transient nature of contact with acute services our groups are open, meaning that new members were able to join at any time.

**Group format**

Each week we arrived on the ward an hour before each group started. We set up the room, liaised with nursing staff about new admissions and received updates on patient status or critical events. We assessed new admissions, reminded patients about the group and addressed any concerns about attending.

On both Ward A and Ward B, the groups were run in the only suitable rooms on the ward. They were facilitated by a clinical psychologist, a trainee clinical psychologist and a member of the nursing team. On Ward A the piloted group ran for six consecutive weeks. Each session was 60 minutes. On Ward B, the group runs once a week for one hour and is ongoing. Due to the transient membership, the group rules were reviewed each week. Potential issues to discuss were identified by the facilitators the week before; however, interestingly these were rarely used as discussion points, as there was no shortage of material from group members.

At the end of each session, time was set aside for peer supervision to give the facilitators an opportunity to reflect on the content, group dynamics, and plan for the following group.

**Group intervention and process**

We focus here on the group piloted on Ward A, as this provides a snapshot of the themes and processes that are also seen recurrently in the group in Ward B. Some of the issues raised by working also with people with organic difficulties on Ward B are discussed later.

**Presenting issues**

Diagnoses included depression; anxiety disorder; bipolar affective disorder; schizophrenia and obsessive compulsive disorder. Ages ranged from 67- to 86-years-old. Attendance varied from week to week but ranged from three to eight patients and averaged at five. Over the total six-week period, 10 different patients attended. The difficulties presented were diagnosis-specific but also included coping with loss, loneliness, physical pain and difficulties with adjustment and complex family issues.

As this was a six-week pilot, sessions focussed on the ‘here-and-now’ (Yalom, 2005) namely, and current life experiences. Particular attention was given to Yalom’s (1983) 11 therapeutic factors, as discussed later.

The first session consisted of introductions, an ice breaker, aims, structure and goals of the group, group rules and group discussion. Subsequent sessions included introductions for any new members, a recap on group goals and rules, before moving into group discussion. Six one-hour, sessions were planned over a six-week period. The four most salient themes are outlined.

- **Similarity and difference**

People came onto the ward feeling that they were different but sharing experiences made them realise that many of their thoughts and feelings were similar. Patients learned that they shared feelings of anger, frustration, sadness and fear. Realising that there were
others like them provided reassurance and helped with feelings of isolation.

This theme seems to link well with Yalom’s ‘Universality’ factor – Life can sometimes feel lonely and isolating in old age (Sprenkle, 1999). Because some of the group members were isolated they thought that their experiences were unique to them. Listening to how others coped with problems similar to theirs gave them reassurance and helped inspire them towards better adjustment.

● **Recovery**
Much of the focus was on how much recovery was being made, how patients would know they were recovering, and what steps needed to be taken in order for patients to recover enough to be discharged. There was a fear of whether people would be able to cope following discharge. Having people in the group at different stages of recovery engendered hope that others would ‘get better’.

● **Achieving sense of purpose**
Feelings of uselessness increased as the patients’ ability to give to and feel needed by others diminished. Feeling empowered in the sessions seemed to help patients realise that autonomy could still exist for them outside of the group. This links with Yalom’s ‘Altruism’ factor – contributing to a ‘support’ group enabled them to feel useful again.

● **Existential factors and the acceptance of difficult realities**
Life-related issues felt particularly poignant to this client group, adjusting to fundamental issues of life and death, recognising that at times life is painful and unfair. The trust that had developed between members enabled them to start exploring existential factors and the acceptance of difficult realities, that is, what it felt like to lose some aspects of their identity, independence and freedom and also the existence of their loved ones as ‘visitors’ in their lives (Terry, 1994).

Returning to Yalom’s (1983) curative factors, in addition to those outlined above, others seemed to have greater application and ramifications for this client group. These were:

**Instillation of hope** – feeling empowered in the sessions helped patients realise that autonomy could still exist for them outside of the group.

**Interpersonal learning** – As a rule, older people receive little feedback (Haight & Gibson, 2005). The lack of interaction in the lives of these group members seemed to have led them to become more self-absorbed and isolated. In this group although patients did not appear to engage in much ‘input’, that is, members saying what they thought of others, there did appear to be some ‘output’, that is, becoming more trustful of groups, learning about the way they relate to other members.

**Group cohesiveness** – The sense of togetherness which developed in this group felt particularly meaningful as the individuals had experienced a number of significant losses. Cohesiveness is widely considered an essential element of group effectiveness (Anderson, 1997; Evans & Dion, 1991) but this phase is generally not reached until the middle stage of group work (Reid, 1997). It is possible that the group achieved group cohesiveness within a relatively short space of time due to the ‘sub-grouping’ which occurred as a result of being closely together in an inpatient setting. The short duration also possibly helped protect against two potential negative aspects of group cohesiveness; dependency and conformity.

**Catharsis** – it is deemed extremely important for people in institutional settings, who often feel powerless, to have a space to vent their feelings and gain universal acceptance (Sarton, 1973).
Existential factors – Life-related issues felt particularly poignant to this client group facing up to basic issues of life and death, recognising that at times life is painful and unfair.

Finally, it is suggested that in group settings the therapist can become the primary unifying force, and if the members do not know each other then the therapist serves as a ‘transitional object’. This is reported to have a greater occurrence in older adults (Burnside, 1994). We observed how in the first couple of sessions the patients chose to direct much of their conversation at the facilitators, even when directly responding to another group member’s comments. This behaviour could be explained by Bion (1961) and his ‘Basic Assumptions’ whereby the group looks to its leader for nourishment. These behaviours fit with the notion that new groups need a lot of containment (Bion, 1962) and primary maternal preoccupation (Winnicott, 1960). As the group matured, and anxiety subsided, there was less reliance on the group facilitators.

Evaluation/Feedback
This was an unstructured therapy group and given the lack of specific therapeutic focus that could be compared (e.g. depression or anxiety) we decided to base our evaluation on the aims and objectives of the group. Given the transient nature of this group we questioned how meaningful quantitative measures would be. Therefore, our goal was to evaluate the experience of the group via qualitative feedback. We devised a brief semi-structured interview which a nurse from the Community Mental Health Team used as a guide to facilitate a group conversation after the last group. Discharged patients were also invited to provide feedback over the telephone.

The feedback was generally very positive. It was reported that the group provided an important function (e.g. therapeutic engagement). Patients appreciated being listened to and treated in a non-judgemental way.

Members reported that the peer-to-peer interactions improved self-understanding and interpersonal skills. These interactions appeared to encourage discussion about psychosocial problems which suggested that the aims and goals of the group were met. This was probably aided by the high level of cohesiveness. Groups that have strong cohesiveness are reported as having better overall outcomes than groups that do not (Yalom, 2005).

Feedback was also sought from the nursing staff at a review meeting. They valued the opportunity for joint working and described how differently they had come to see certain patients. This process helped them to feel more empathic towards patients who evoked strong emotions in staff. Staff also suggested that their involvement in the group had helped to foster an attitude of more open communication on the ward; some practical issues were also discussed, including encouraging relatives to delay their visit until after the group, and making a commitment to include a consistent member of the nursing team.

Reflections
In acute settings opportunities to engage in therapeutic work may be limited if the biomedical model becomes the dominant discourse. It was helpful to consider the problems on an acute ward from a systemic perspective with patients seen as part of an organised social structure. Kibel, (1993, p.89) recommends integrating ‘the psychotherapy group into this social structure and the treatment programme of the hospital rather than to insert it as a foreign body’. We observed how the therapy group operated as a microcosm of the wider ward environment, and how intra-group dynamics reflected dynamics present on the ward (see Simpson, 2010, and Terry, 1994, for further discussion). Therefore, this experience has helped us to recognise the importance of exploring all the systems that impinge on the patients, the tensions between them and the ways they reinforce each other. Furthermore, it has
highlighted the capacity of service users to articulate their experiences when given the opportunity.

Since it stated two years ago, the group on Ward B has seen numerous changes. Perhaps most significantly, there has been a shift in the inpatient population, such that we see many more people with severe dementia, and less with functional difficulties. This has presented challenges in terms of populating the group, to the extent that we questioned if it was viable to continue running it. Increasingly, we see splitting and projective processes among our patients, between those with functional difficulties (who see themselves as ‘normal’), and those with organic difficulties (who are seen by the ‘normals’ as ‘mad’, and whom they avoid). We have to be very mindful not to mirror this process. For the group on Ward B, our assessments for suitability for the group are longer and more multi-disciplinary. The group is shorter, with more containing and supportive interventions, and less interpretive or directive facilitation, depending on its members. At times we wonder whether we have included individuals who are perhaps too unwell to engage. But at other times these same people surprise us with their level of social awareness, and their reports of how much they value their group membership. Despite the challenges this group faces, we believe it is important that patients continue to be offered this opportunity to share and be together.

The group on Ward A is in the process of running for the third time. We hope that it will become a regular feature of the ‘therapeutic day’ timetable, a ‘Star Wards’ initiative (Star Wards, 2008), to enhance therapeutic opportunities for patients (Janner & Page, 2008), which we are working towards achieving on the ward.

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THE National Dementia Strategy – Living Well with Dementia (2009) has established objectives around enabling easy access to care, support and advice following diagnosis and the development of structured peer support and learning networks. In addition it wishes to address the need for good quality information to people with dementia and their relatives in order to reduce social isolation and promote self-care. It also notes the need to develop access to expert patient and carer programmes.

The cost of caring for people with dementia was estimated to be £17 billion in 2008.

The problems that are known to develop when relatives of people with dementia are not supported are extensive and include; anxiety and depression, physical ill-health, financial burden, exhaustion, sleeplessness, grief, anger, difficulties in accessing resources and practical help, social isolation and even premature death. These problems are not to be underestimated as they affect a substantial proportion of relatives. Gallagher-Thompson et al. (2009) found the rates of clinical depression in carers to be as high as 50 per cent, and Schulz and Beach (1999) found that carers were four times more likely to die in a four-year follow-up period if they experienced high levels of stress. The effects can also be serious for the person with dementia as the challenges of caring for them can lead to frustration and the risk of harm to them. Ostwald et al. (1999) state that ‘persistent behavioural problems, coupled with caregivers’ perceived or actual inability to handle them, emerge as important sources of caregivers’ stress and burden’. Without family support many more people would require residential care, 34 per cent according to the Canadian Commission (Hebert et al., 2003). Carer burden is the primary reason for resorting to a residential home.

Many approaches have been developed to provide families with more education and coping strategies for looking after their relative with dementia. Acton and Kang (2001) describe five categories of interventions: peer support, psycho-educational groups, counselling, educational and multi-component interventions. Peer support without professional intervention has been found to have no effect on depression or self-esteem but to have some effect on coping with disruptive behaviours (Pillemer & Suitor 2006).

Gallagher-Thompson (2007) has reviewed evidence based treatments for caregivers and found there were three types of treatments: psycho-educational programmes, psychotherapy treatments and multi-component interventions. The psycho-educational programmes were derived from CBT theories and tended to focus on behaviour management, depression management, anger management and introducing a low stimulus environment for PWD. Psychotherapy interventions were also based on CBT but were particularly focused on carers with severe depression and anxiety. The multi-component interventions would consist of at least two of the following: telephone counselling, family meetings, behavioural management and a support group.

A meta-analysis of caregiver interventions by Sorensen et al( 2002), covered six types of interventions and six outcome measures and
found that psychoeducational and psychotherapeutic interventions proved the most effective on all short term outcome measures. The outcome measures used were caregiver burden, depression, subjective well-being, perceived carer satisfaction, ability/knowledge, and care receiver symptoms. The effect of interventions was reduced however in the studies that only dealt with dementia carers as opposed to those that had a heterogeneous group of carers, including people with physical health problems. The study also found that the longer the intervention lasted the greater the effect on improving carer depression. They suggest that interventions may need to be longer than seven sessions to have an impact on levels of depression. Additionally they found that spousal carers’ benefited less than adult carers from current interventions and they suggested that spousal carers may need more focus on taking care of their own health needs and ways of building their social networks.

Whilst the evidence base is now clear that psychological interventions can help carers, many of these cover a diverse range of topics and types of carers. Some people are beginning to develop groups for specific types of dementia. For example, Dielh et al. (2003) describe a group for people with fronto-temporal dementia. Others have run separate groups for spouses and adult carers. Nevertheless the fact that stress and burden must increase as the person with dementia declines has not been addressed. Behavioural problems are well known to change over time; some problems may disappear, whilst at the same time new ones arise.

Perren et al. (2006) found that the severity of behavioural problems increased with the level of cognitive decline and that this was strongly correlated with a decrease in carer well-being. An eight-week psychoeducational course which aimed at giving knowledge of the illness, and improving carers’ self care, managed to stabilise well-being levels relative to a control group over one year. Unfortunately these effects were not maintained at two-year follow-up.

In our service we have for many years run a psychoeducational course as a 10-week, two-hourly programme. During the courses the difficulties of addressing a wide range of behavioural difficulties that carers were coping with at different stages of the illness were becoming increasingly problematic and so the service began to think about developing different courses for specific stages of dementia. The need became more evident when a highly developed memory clinic service led to more people being referred and diagnosed and the stage of dementia more easily identified. This paper will describe one of the two psychoeducational courses that were developed. This course is for carers of people in the later stages of dementia which we believe, based on the published literature, to be an innovation. It will also describe our evaluation of the affects this course had on carers’ levels of stress, burden and quality of life, and carers’ satisfaction with the course.

**Study design**

**Course outline**

Initially an eight-week two-hourly course was designed. However, due to feedback received from carers in the satisfaction questionnaire, citing problems getting the necessary respite cover to attend, we trialled a more intensive four-day course which was eventually compressed into three days. The final programme consisted of:

- **Day 1** – Introductions, definition and types of dementia, common signs and behaviours in the severe stages.
- **Day 2** – Occupations and activities suitable for a person with severe dementia.
- **Day 3** – Understanding the brain and behaviour.
- **Day 4** – DEALING WITH INCONTINENCE.
- **Day 5** – Drug interventions.
- Psychological strategies for coping with behaviours in late stage dementia (including managing aggression, wandering, carrying out care-giving activities such as toileting, washing, bathing and dressing, and sexually disinhibited behaviour).
Day 3 – Communicating with people with dementia and dealing with swallowing and feeding difficulties.
Decisions for long-term care.
Coping with loss and end-of-life issues.
Experiences of a long-term carer.

Most sessions were run by a Consultant Clinical Psychologist, with some guest speakers taking specific sessions. An Assistant Psychologist was present throughout to facilitate and note any questions arising. Guest speakers included a Speech and Language Therapist, an Activities Nurse, a Continence Advisor and an Admiral Nurse.

The sessions took the form of information giving, group discussion and focussed on individual’s specific difficulties and issues.

**Participants**

We will report about courses two and three because no data about stress, burden or quality of life was obtained before this time. In total, 12 carers have attended these courses.

In terms of their caring situation, the participants’ circumstances were as follows:
- Three spouses were living with their partners at home.
- One spouse was recently widowed, having cared for husband until very late on when he was taken into residential care just a few weeks before he died.
- One spouse was caring for their partner in residential care.
- One adult child was living with both parents, one of whom had dementia.
- Four adult children were caring for their mothers who lived at home alone.
- One adult child was caring for a mother who lived at home with her husband.
- One adult child cared for a mother living in a residential home.

Altogether there were five male and seven female participants.

**Outcome measures used**

Outcome measures used were:
- A Satisfaction with the Course Questionnaire which examined issues such as; carer’s views of particular sessions, perceptions of impact on relationship with the person with dementia, and accessing other services.
- The Behaviour Problem Checklist (Hodgson, Higginson & Jefferys, 1998) which is a measure of carer stress linked to the occurrence of specific problem behaviours.
- The Satisfaction with Life Scale (SWLS) (Diener et al., 1985), a five-item questionnaire rated from ‘strongly agrees’ to ‘strongly disagrees’ for each item.

The Satisfaction with the Course Questionnaire was administered immediately following the course. The other outcome measures were given at the beginning of the first day of the course and then administered at a reunion approximately six months later.

Unfortunately we only had four people who completed the pre- and post-outcome measures due to relatively low attendance at the reunion sessions. Therefore, statistical analysis could only be performed on these five cases. However, we had a total of 11 pre-intervention completed measures and eight post-intervention completed measures. We have, therefore, presented the averages for the more complete data.

**Results**

The results of the Satisfaction with the Course Questionnaire are shown in Tables 1 and 2.

**Qualitative data:**

Further questions that were asked were:

*Since attending the course have you accessed other services?*
Three replied yes.
Five said not yet but will do.
One said no.
Can you give examples where the course has helped?
Two said: ‘Knowing we’re not alone.’
‘Learning from the experiences of others.’
‘Being more patient and aware.’
‘Understanding why a person’s moods change and their eating habits.’
‘To contact the community mental health team instead of going through the GP.’
‘Relating better to my mother’s dementia.’

Were there any aspects you still find difficult that the course did not help with?
Seven said no.
‘Still have difficulties coping with my mother’s personal hygiene.’
‘Incontinence issues as this seemed rushed.’
‘Having a parent that refuses to accept that his wife has dementia.’

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Rating of usefulness (1=not at all, 5=very)</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction: What is dementia</td>
<td>0 0 0 1 9</td>
<td>4.9</td>
</tr>
<tr>
<td>Understanding the brain and behaviour, communication</td>
<td>0 0 2 3 6</td>
<td>4.36</td>
</tr>
<tr>
<td>Occupations and activities suitable for people with severe dementia</td>
<td>0 0 3 5 3</td>
<td>4</td>
</tr>
<tr>
<td>Dealing with incontinence</td>
<td>3 1 1 5 1</td>
<td>3</td>
</tr>
<tr>
<td>Drug intervention</td>
<td>0 1 2 6 2</td>
<td>3.73</td>
</tr>
<tr>
<td>Psychological approaches to coping with behaviour</td>
<td>0 0 0 4 8</td>
<td>4.67</td>
</tr>
<tr>
<td>Communication and feeding difficulties</td>
<td>0 0 0 6 5</td>
<td>4.54</td>
</tr>
<tr>
<td>Coming to terms with loss and terminal care</td>
<td>0 0 0 4 7</td>
<td>4.54</td>
</tr>
<tr>
<td>Decisions for long-term care</td>
<td>0 0 0 5 6</td>
<td>4.55</td>
</tr>
<tr>
<td>Experiences of a long-term carer</td>
<td>0 0 1 2 3</td>
<td>4.33</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Rating of Improvement (1=No increase, 5=Greatly increased understanding)</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding later stages of dementia</td>
<td>1 1 4 4 4</td>
<td>3.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Rating of Improvement (1=Greatly worse, 5=Greatly improved)</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive impact on relationship</td>
<td>2 5 4</td>
<td>3.82</td>
</tr>
<tr>
<td>Positive impact on communication</td>
<td>1 1 6</td>
<td>3.82</td>
</tr>
<tr>
<td>Manage problems more effectively</td>
<td>1 1 4</td>
<td>3.91</td>
</tr>
<tr>
<td>Reduce levels of stress</td>
<td>1 3 6</td>
<td>3.55</td>
</tr>
</tbody>
</table>
Living even better with dementia

Can you identify what aspects of the course were most useful?
‘Knowing what to expect in the later stages.’
‘Coming to terms with dementia.’
‘Understanding dementia and its effects.’
‘Coping with eating problems.’
‘Coping with behaviour problems.’
‘Coping with loss.’
‘Legal and financial issues.’
‘Understanding brain and behaviour, it made sense of the behaviour.’

Can you identify what aspects of the course you found least useful?
Two said the session on incontinence because of the way it was put across.
Two said understanding the brain.
Five said nothing was not useful.

Views on the format of it being held over full days rather than several two-hour sessions
All respondents said they found the three-day format easier to attend; one commented that after attending both the early stage and late stages course, the early stage course being held over 10 two-hour sessions, found the late stage course easier to attend. Adult children still at work found the time easier to take off work when taking full days.

The results of the Behaviour Problem Checklist and Satisfaction with Life scale are shown in Tables 3 and 4.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>Problem behaviours Pre-post (N=5)</th>
<th>Contact with services Pre-post (N=5)</th>
<th>Carer stress/ coping with behaviour Pre-post (N=5)</th>
<th>Carer stress/ coping with contact with services Pre-post (N=5)</th>
<th>SWLF Pre-post (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>( z )</td>
<td>-1.069</td>
<td>-0.406</td>
<td>-0.405</td>
<td>-0.137</td>
<td>0.000</td>
</tr>
<tr>
<td>Asymp.Sig (2-tailed)</td>
<td>.285</td>
<td>.684</td>
<td>.686</td>
<td>.891</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Wilcoxon signed ranks test (N=5)

Table 4

<table>
<thead>
<tr>
<th></th>
<th>Problem behaviours</th>
<th>Contact with services</th>
<th>Carer stress/ coping with behaviour</th>
<th>Carer stress/ coping with contact with services</th>
<th>SWLF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre (N=11)</td>
<td>.90</td>
<td>1.07</td>
<td>.71</td>
<td>.75</td>
<td>19.5</td>
</tr>
<tr>
<td>Post (N=8)</td>
<td>1.29</td>
<td>1.125</td>
<td>.74</td>
<td>.74</td>
<td>20.25</td>
</tr>
</tbody>
</table>

Average scores on BPC and SWLF
Discussion of results
The results from the satisfaction with the course revealed that two sessions scored below 4 on average. These were: drug intervention and dealing with incontinence. Feedback from these sessions indicated the information was presented in too complex a manner and was not sufficiently related to the individual dementia patients being cared for. The information was frequently far too general and failed to deal with people’s immediate concerns, for example, their worries about how to get hold of the correct continence pads.

All other sessions scored higher than 4 on average. Most sessions were scored above 4.5, but three fell between 4 and 4.5. These sessions were: Occupations and Activities, Experiences of a Carer and Understanding the Brain and Behaviour. It seems that Occupations and Experiences of a Carer were rated lower because they gave little new information, whereas Understanding the Brain and Behaviour could have given too much new information for some. It was suggested in the qualitative data that the Experiences of a Carer session was superfluous because the group had already learnt a lot from each other.

The highest ‘tier’ of the rated sessions seems to deal with the very immediate problems that carers were facing and may have generated more questions which were answered at the time by the facilitator and other carers.

Whilst levels of stress immediately following the course did not improve it did seem to have a greater ability to improve the relationship with the person being cared for, communication with them, understanding the later stages of dementia, and the ability to manage behavioural problems.

The results from the Behaviour Problem Checklist showed no significant differences pre and post the intervention; however the number of subjects that we had completed data on was very small. Looking at the averages across the data there is a slight trend towards the number of problem behaviours increasing, and yet stress in coping with these behaviours remains the same and did not increase. There was a very small increase also post-intervention in carers making more use of services. Finally the measure of satisfaction with life shows a slightly better score.

Ostwald et al. (1999) cite behavioural problems as a main cause of stress in caregivers. Our data shows an increase in problem behaviours as would be expected over a long time period when dealing with a degenerative illness such as dementia. The stress levels remain fairly constant, however, suggesting that although the problem behaviours increase, the stress levels do not increase in correlation with them.

Conclusions and recommendations for the future
The results of the evaluation of a new course for relatives caring for people in the later stages of dementia found that in general relatives found it helpful. They were satisfied with most of the course content. They rated themselves as having greater understanding and this having had a positive impact on their relationship with the person with dementia and on their ability to manage some behaviours. These effects were not revealed on the Behaviour Problem Checklist but it did show that even though behaviour problems would naturally be expected to increase with the illness, that there was no change in people’s perceived level in stress in coping with those behaviours. Additionally there was a slight trend suggesting that satisfaction with life improved as a result.

Interestingly, we found that this course was of benefit to a relative whose partner had already died prior to the course, as this relative stated that it had helped her to come to terms with her partner being placed in residential care shortly before his death. She reported to us that the course had helped her to accept and understand what had happened. A further carer had raised issues around the difficulties of her father being in denial of his wife’s dementia. We were able
to suggest some ways of addressing this through education, but also by offering family work outside the course.

It is also of interest to note that the group format appeared to be helpful in both of these participants’ cases. The understanding of other carers who were in ‘the same boat’ seemed to make the participants feel listened to in a way that may not have been possible had they been talking solely to health professionals.

In terms of issues that we felt we needed to consider for the future, we recognised that currently the course does not address carers’ emotional states, in particular anxiety and depression. These issues are probably of particular relevance for spousal carers. There is a need to identify relatives with emotional needs and to consider whether a further course can be developed specifically for this, using the approaches described by Gallagher-Thompson (2007). Furthermore, in future courses, we are keen to provide more information about direct payments and budgets as these are now becoming a government priority. Helping families to get the best possible care packages is seen as a goal for the course, and there has been anecdotal evidence that we have succeeded in this on occasion. Another item of importance is that outside speakers need to be asked to address more specifically the concerns of the carers rather than following a pre-determined lecture type style.

Even though most participants found having a whole day course the most practical for them, they were the ones who could manage this. There is a need to find ways of providing respite care for those who cannot manage this, but achieving this will be difficult. Some local schemes such as Crossroads offer a full-day respite service where possible when a course such as this is running, but this is dependent on staffing levels and as a voluntary organisation this cannot be relied upon. In the past staff on-site have also helped by supervising people with dementia while their caregivers attended the carers course. This was a good but expensive solution to the problems which is unlikely to be adopted by the NHS in the current financial climate.

In researching other approaches to carer education, we came across an interesting paper by Kanas (2006). He describes a 15-week multi-component course, with four weeks spent on identifying stressors and distinguishing which were modifiable, followed by four weeks on using problem-solving to deal with modifiable ones, three weeks on reframing the meaning as a way of dealing with non-modifiable ones, and four weeks on seeking social support. Our course can be argued to provide all of these things but in a less formal style although unfortunately the informal style and low response rates of NHS users make this difficult to statistically demonstrate. Although it is empirically difficult to assess, the positive feedback we obtained suggests that it contained some of the same elements as this researcher found. In addition it appears that the informal format was of benefit because it enabled us to concentrate on the specific problems of the group members instead of having a rigid structure to keep to. For this reason it is difficult to justify a much more structured course as Kanas (2006) describes because it would risk losing an important element of what makes this format useful to caregivers of people with late stage dementia.

We hope with future courses to build on these foundations and further develop packages that will lead to more carers finding success in living better with their relatives with dementia.
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References


In search of carers’ assessment best practice examples, I found myself sifting through Governmental prose and was struck by the common adjunct ‘... and carers’, which seemed more and more like an after-thought to me. The National Carers Strategy (HM Government, 2008) places Carers at the heart of 21st-century families and communities, the National Dementia Strategy (Department of Health, 2009) consistently refers to ‘people with dementia and their carers’ (e.g. p.3), and there is a multitude of carers’ assessments to choose from. Yet when clients first visit a memory clinic because of memory problems, the people accompanying them do not consider themselves as carers; they are husband or wife, daughter or son, relative or friend. They might not appreciate the question Do you ever feel you can no longer cope with the situation of caring? (Carers Stress Scale; Pearlin et al., 1990). A ‘diagnosis’ has not (yet) been made. Hopefulness may still allay concerns, uncertainty and fear.

Once at a Memory Clinic, most of the time available is spent on finding out information about the referred client – often considerably relying on the people accompanying them. Where does this leave the family member or friend accompanying the client throughout the Memory Clinic assessment process? What about the potential caregiver’s needs? How do we best cater for this heterogeneous population psychologically? It comes as no surprise that my attempt at an answer has raised yet more questions, but I very much hope that touching upon these questions in the following may serve to contribute to a discussion amongst us about the most useful way forward.

What are carers’ assessments?
Carers’ assessments as defined by the Department of Health (2010) due to statutory requirements (HM Government, 2000, 2004) and provided by Social Services will be differentiated from carer’s assessments that would be provided as part of Memory Clinic assessments.

A carer’s assessment from the point of view of Department of Health guidelines and legislation:
‘... is the route for carers and the people they look after to get help and support from their local authority social services department. (...) The social services department of your local authority may be able to carry out a community care assessment of the needs of the person you’re looking after, as well as a separate assessment of your own needs as a carer.’ (NHS Choices, 2009)

In this context, needs of carers arise on the basis of providing ‘substantial and regular’ care for their relative or friend, regardless of the condition which the person cared for may have been diagnosed with. Support of carers includes respite, emotional support, support with caring and household activities as well as financial support (Kent Adults Social Services, 2009).

Memory Clinics are in most cases the first point of contact for all primary care referrals in order to reach (or rule out) a diagnosis of a dementia, and provide treatment by: informing patients and carers about memory problems and the diagnostic process in general, offer assessments of people with memory difficulties as well as their carers, and provide treatment or referral–dependent on informed consent at all stages.

Care for carers:
Memory Clinic caregiver assessments
Jouko Koecher
From the point of view of Memory Clinic services, caregiver assessments would thus be provided at an earlier stage and with a view to the provision of information and psychological support, in addition to the support potentially provided by Social Services or other agencies. This distinction merely serves to delineate the scope of carer’s assessments in Memory Clinics and does not exclude a collaboration with Social Services, which is in fact integral to the ‘whole systems approach’ (National Collaborating Centre for Mental Health et al., 2006).

Caregiver assessments at Memory Clinics would thus:
- serve to support carers throughout the assessment of the referred client, and could be the first stage en route to the provision of individualised information that is appropriate at each stage (e.g. about the assessment process, coping strategies) as well as (referral to) psychological support and Social Services;
- require carers to receive information about assessment options in order to make an informed decision about whether or not to go ahead with an assessment;
- potentially include psychological assessment of personality (e.g. coping styles), mood and general well-being;
- need to be distinguished from, but may be interlinked with, the important role that carers can play in the assessment of their relative with memory problems;
- be constrained by available resources (staff time and available in-house treatment or referral options).

What is the role of ‘caregivers’ during the assessment process?
Caregivers accompanying the Memory Clinic service user can potentially contribute information to the assessment process (in a so-called collateral assessment) and may require or wish to be offered support for themselves, the kind of which could be delineated by a caregiver assessment. It may be useful to separate the former informant role from the latter caregiver needs role.

Striking a balance between these informant and needs roles seems particularly important, as most Memory Clinic (assessment) time is after all spent on the referred client. A caregiver’s needs may thus be more easily overlooked, and many (potential, future) caregivers tend to reject the notion that they may have needs too. Indeed, the majority of actual caregivers do not consider themselves ‘carers’ during the first year post-diagnosis, and this only changes after five years for about a third of caregivers (Carers UK, 2006).

It might, therefore, be important to involve caregivers for their own sake, as this could help to initiate a process of coming to terms with a potential future diagnosis of their relative. Early contact with other support services (e.g. the Admiral Nurse or Social Services) might also prove supportive throughout the assessment process.

How do Memory Clinics do carers’ assessments?
‘Over 90 per cent (52/58) of [memory] clinics assess carer stress/burden and carers’ needs’ (Lindesay et al., 2002) and ‘only seven (two per cent) of respondents reported using caregiver assessment scales. These were the Carer Strain Scale (Zarit et al., 1980), the Relatives Stress Scale (Green et al., 1982), the Problem Checklist and Strain Scale (Gilleard, 1984) and the Ways of Coping Checklist (Vitaliano et al., 1985; Reilly et al., 1984).’ These two studies are based on at most partially intersecting subsets of memory clinics, had collected data at separate times, and were tapping into different professions. Nevertheless, if these findings are considered in combination, they would suggest that whilst most Memory Clinics assess carers in some way, few seem to be employing standardised measures. This appears to be corroborated by anecdotal evidence from memory services across Kent, where some localities administer the Relatives Stress Scale, for example, whilst others make a
clinical judgement based on the information obtained during a collaborative interview (e.g. via the Caregiver Distress Scale of the Neuropsychiatric Inventory; Kaufer et al., 1998), or indeed do a bit of both.

Caregiver assessment scales can be found in abundance. Roach and Welch (2000) list more than 50 different tools and Burns, Lawlor and Craig (2000) is a useful resource too. What most of these scales have in common is that they focus on burden (or the ability to cope with it) and thus employ terms that are suggestive of a diagnosis (e.g. ‘I have little control over my spouse’s illness’; Vitaliano et al., 1991) or imply an established caring role (e.g. ‘Has your standard of living been affected in any way due to the necessity of caring for your elderly relative?’; Gilleard, 1982), neither of which would commonly be the case upon first contact with the memory clinic. In addition to this, many caregiver assessment tools contain more than 20 items which may make the assessment a lengthy and potentially burdensome experience in itself. Finally, most ‘carer burden’ scales indeed focus on burden, which leaves little room for an exploration of positive experiences in caregivers (Bacon et al., 2008), if only as a starting point for the development of coping skills.

Modular and multi-stage caregiver assessments

Informed by the above considerations, I set out to delineate process and content of future caregiver assessments at our Memory Service locality. The assessment process should, therefore, ideally be:

- non-suggestive regarding a possible diagnosis;
- sufficiently brief so as not to overburden the person being assessed, but also because there are constraints on available staff resources;
- focussing on potential (future) caregiver needs rather than primarily assessing the service user and obtaining information about caregiver needs in the process (as a side-effect or afterthought);
- employing standardised and validated measures (as opposed to something ‘home-grown’).

In addition to these characteristics, I had an assessment process in mind that might be suitably adapted to an individual’s needs, again, so as not to overburden client’s relatives or friends with a whole barrage of questionnaires or interview questions in addition to their involvement in collateral (or informant) interviews. Finally, there was the practical implication of when and how to assess relatives, commonly in the presence of or nearby the client (making it potentially more difficult for them to raise their concerns or voice their feelings in an ‘uncensored’ way).

As part of my research of available caregiver assessment tools I came across a scale devised by Montgomery and Borgatta (Montgomery, Gonyea & Hooyman, 1985; Montgomery, Borgatta & Borgatta, 2000; Montgomery, 2002). The Montgomery-Borgatta Caregiver Burden Scale (MBS) comprises of 14 items that are intended to measure three dimensions (or sources) of burden: subjective demand burden (‘the extent to which the caregiver perceives care responsibilities to be overly demanding’), subjective stress burden (‘the emotional impact of caregiving responsibilities on the caregiver’), and objective burden (‘perceived infringement or disruption of tangible aspects of a caregiver’s life’) (see Figure 1).

Depending on empirically derived cut-off values on each respective dimension (see values in Figure 1), Montgomery (2002) suggests that carers may benefit from different kinds of support (see Figure 2). A caregiver scoring highly on objective burden, for example, may thus benefit from receiving help with ‘caregiving responsibilities’ (e.g. financial support or help with household tasks). Analogously, a high score on subjective stress burden would suggest that caregivers may be in need of emotional support. Montgomery and Borgatta’s suggestions are supplemented by proposed actions...
(small arrows in Figure 2) that would allow for a ‘staged’ approach whereby additional assessment tools are only employed when indicated by an individual’s score on the MBS.

This staged approach goes beyond Montgomery and Borgatta’s (2002) proposals and ensures that the administration of formalised assessment tools is kept to a minimum (reducing the burden) whilst making possible an individualised and yet standardised assessment which seems especially important when considering risk (e.g. depression). A modular and thus individualised assessment also makes it possible to provide specific information for services referred to (e.g. Social Services or the Admiral Nurse), avoids the commonly observed duplication of assessments, and thus potentially eliminates an additional source of burden.

Additional assessment tools include the Coping Self-Efficacy Scale (Chesney et al., 2006), the Zung (1965) Self-Rating Depression Scale, and the General Health Questionnaire (Goldberg & Hillier, 1979). They were chosen based on their established validity and suitability to facilitate a process of coping or adjustment in conjunction with the Memory Service assessment procedures and a possible diagnosis of a dementia of a person close to the caregiver.

**Are we there yet?**

MBS has been implemented at our Memory Service in a slightly modified form: the title has been changed to ‘Questionnaire for patient’s relative’ and the introduction has been made more generic ‘Since you began noticing changes in your relative …’. The team have been using the questionnaire for about three months now, and it appears to be well accepted by clients’ relatives – hardly any queries tend to arise, especially when compared with the previously employed Relatives Stress Scale. Initial analyses of questionnaires suggest that the majority of scores are relatively low and evenly distributed. In some cases, however, scores on the respective dimensions seem to dissociate such that a person may score highly on objective burden but low on subjective demand burden or vice versa. This would suggest that the differential administration of additional assessment tools may have some merit.

Some of the additional assessment tools proposed above are not administered on a routine basis at present. This may be mainly due to time constraints (most of the assessment time is still taken up by the client referred to the memory clinic) and, similarly, staff availability. Furthermore, whilst we have liaised with Social Services, Carer Support Groups and the Admiral Nurse (all of which...
are happy to take on referrals of relatives at the early stages of the assessment), referrals are still being made in the traditional way, that is, without synergistically utilising the information available from our assessment in order to avoid duplication.

As to be expected from local projects such as this, there is still considerable scope for further work to be done. The status quo ensures that differential caregiver assessments are conducted on a routine basis and documented accordingly. These arrangements are intended to supplement sound clinical judgement and do not serve to replace it. One could even argue that any kind of questionnaire-based approach is unsuitable and burdensome, but this is outweighed, I believe, by the benefit of offering a systematic assessment framework for caregiver assessments whilst taking into account the assessment environment and constraints on resources.

Acknowledgements
I would like to thank my supervisor Margaret O’Shaughnessy for her excellent mentorship, and the team at the Ashford Memory Service for allowing me to be part of the family.

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The Home Treatment Service (HTS)

The Home Treatment Service (HTS) in Kent was established in April 2007 as an intensive, short-term, intermediate care service for people with dementia, their relatives, carers and residential or hospital staff. The development and recent evaluation of the service has been described by Culverwell et al. (in press) and its multi-disciplinary way of working on a shared caseload has also been briefly outlined by Slaughter and Steeden (2009). The service sits within the Community Mental Health Teams for Older People, run by the Kent and Medway NHS and Social Care Partnership Trust (KMPT).

The HTS typically receives referrals for individuals with complex and challenging needs, where there are signs that the care arrangements in place are beginning to break down. The HTS is often seen as a last attempt to prevent an individual with dementia being moved out of their current home and into a new, more enhanced care environment, such as hospital or care home setting. Data collated from the recent evaluation outline clients which the service has typically worked to support (Culverwell et al., in press).

As the service is still in its infancy, it continues to evolve and expand, with the recent addition of three new services in August 2009. With six HTS services in Kent now operational, the assessment tools, procedures and general operational policy is reviewed on a regular basis. Since very early on, the services have employed the Camberwell Assessment of Needs for the Elderly (CANE; Orrell & Hancock, 2004) as the key assessment tool. This tool involves rating an individual’s met and unmet needs from the perspective of key people, including the individual themselves. The CANE emphasises the psychosocial aspects of a person, and was felt to be one of the few assessment tools available which could be used effectively within the person centred model of the HTS.

Whilst the CANE asks for ratings from the perspective of the individual, for the clients who are typically referred to the HTS it is often difficult to gain information from their perspective. As a result this information has tended to be gathered from a member of staff deemed to know the person well. There are obvious difficulties and limitations of working in this way. Consequently the HTS have tried to gain insight into an individual’s perspective through conducting observations. The HTS have used observations to understand the behaviour of the person with dementia, the systemic effects on a person’s well-being and the environment around them.

Dementia Care Mapping

Dementia Care Mapping (DCM) (Bradford Dementia Group, 1997, 2005) was originally developed by Tom Kitwood. It is an observational tool which Kitwood described as ‘a serious attempt to take the standpoint of the person with dementia, using a combination of empathy and observational skill’, (Kitwood, 1997, p.4). The process of DCM involves coding the person’s behaviour using a behaviour category code (BCC) together with rating the person’s mood and engage-
ment using a mood and engagement value (ME value). The ways in which staff members in a care environment enhance or undermine the personhood of the person with dementia are also recorded, and are known as ‘personal enhancers’ and ‘personal detractors’. The tool has undergone several revisions over the years, now being on version 8. In order to use the tool, it is a requirement that you attend a training course run by the University of Bradford and pass a short test, giving you Basic User Status.

KMPT have invested in training from the University of Bradford resulting in approximately 50 staff (including staff in the HTS) gaining Basic User Status, as well as 20 staff progressing to Advanced User Status. Many of the trained mappers are located within the HTS teams, enabling some of the services to work towards employing DCM as their primary observational tool. In accordance with this, the HTS operational policy now contains information about using DCM for assessment and intervention.

Using Dementia Care Mapping in the Home Treatment Service

The HTS have found that the model of DCM and its person-centred care philosophy fits well with their own ethos and ways of working, as both DCM and the HTS consider the client’s experience as paramount. DCM has been used to compliment the services’ key assessment tool, the CANE, by providing much more detailed understanding and information from a client’s perspective. This is used to assist staff in identifying where an individual’s needs are currently met or unmet, and in developing an intervention plan which the service will implement, or ask other professionals to assist with. Due to the nature of work undertaken by the HTS, the tool of DCM has been successfully used in several settings to support both assessment and intervention. These settings include residential care homes and inpatient wards where observations are undertaken only in communal areas, as specified by the DCM tool. DCM observations also provide valuable insight into the difficulties encountered by care staff and family members in their interactions with the client.

The advantages of using Dementia Care Mapping

Aiding a detailed assessment

As DCM provides such detailed information about the needs of a person with dementia and the difficulties they face, the information gathered from observations has been used by the HTS teams to establish and develop their own understanding of situations and clients’ needs. This reduces the need to rely on the information provided by the referrer or care staff. HTS teams have, therefore, been enabled to identify what the difficulties may be and how these may differ from the perspectives of others, such as care staff or relatives involved.

Identifying factors which contribute or undermine an individual’s well-being

The language of DCM has been used to reframe and understand a person’s symptoms and expressions, which have sometimes been found to be related to unmet needs. For example, one individual was referred to a HTS because he was screaming and calling out. HTS were able to understand his behaviour as an expression of need for some attention from the staff team in his residential environment. The DCM tool supported this by demonstrating a lack of interaction during this individual’s day.

The observations using DCM have enabled information to be collated on what is helpful for a client as well as what is unhelpful. When this information has been shared with care staff, this has enabled more effective care plans to be developed, with detailed suggestions for how staff can respond to an individual and provide appropriate support and reassurance. Often this involves pre-empting any difficulties that may arise, for example, meeting an individual’s need for interaction before they express their need through behaviour which might be difficult for staff to manage. Once
these suggestions have been shared and incorporated into care plans, HTS will sometimes conduct another map, in order to identify whether positive change has taken place.

Further, by conducting DCM observations, HTS have been able to identify when care plans within residential settings are not clear, which has resulted in different members of the staff team adopting different strategies to try to support an individual’s needs. For example, staff providing contradictory responses to an individual’s calling out or questions, which resulted in confusion for the person. On this occasion it was also identified that the care staff did not have a full appreciation of the individual’s needs and perspective, and would benefit from better co-ordination and organisation of the staff team.

**As an aid to HTS intervention planning**

Generally HTS staff will undertake several hours of mapping in order to gain an understanding of the person and their environment. This mapping would typically be undertaken by several members of the team, allowing a comprehensive and thoughtful HTS intervention plan to be created jointly by the multi-disciplinary team.

The HTS also works to support individuals leaving hospital, offering assistance to them during the transition as well as ensuring that any supportive strategies are transferred to a new care setting. In order to ensure that the individual is well known to staff prior to the transition, it has been identified that it can be helpful to use DCM to understand the person’s perspective and the positive strategies in place for working with them. Information gathered by HTS staff through using DCM has been transferred to staff in new care settings by means of a presentation about the individual prior to their move, which encourages the incorporation of DCM knowledge into the care plans for the individual.

**Benefits for managers of residential homes**

Recently a local home manager from a large care provider sat beside a member of HTS staff during a map, to enable discussion to take place regarding what was being observed. The focus of the map was a gentleman who staff at the home reported to be very loud and to shout on numerous occasions. This was the first time that HTS have achieved such collaboration with a home manager. It was clearly evident that the manager found it beneficial to take the time to observe the environment, noticing issues such as the extremely loud television in the communal lounge and continual thoroughfare of home staff walking through the middle of the lounge, some without acknowledging the residents. Whilst many of the manager’s observations were related to the environment and the organisation, they were important to developing a more person centred care setting. During a later visit to this home, it became apparent that there had been some changes. The care staff appeared to be more open in their interpretations of the client’s actions and motivations than they had been previously. This was demonstrated when the client was observed to be vocalising loudly, and members of staff were heard to comment that this client sometimes sings and sometimes talks to himself. It was deduced that some of the person centred language and understanding from the process of DCM had been disseminated by HTS staff to the care staff, leading to a positive impact for the individual.

Following this example, it seems evident that introducing DCM into residential environments allows an opportunity for care staff to access more person-centred care training, to improve their understanding of dementia and their care practice. In addition, it is possible that with the recent publicity of DCM and new guidelines for assessing care, more residential environments may wish to become involved in the process of DCM. Recent publications include PAS 800, Use of DCM for improved person-centred care in a care provider organisation – Guide, 2010,
developed by the University of Bradford in partnership with the British Standards Institute, and the Short Observational Framework for Inspection (SOFI; Bradford Dementia Group & The Commission for Social Care Inspection, 2006). The SOFI tool is closely related to DCM and is used by the Care Quality Commission (CQC) to assess levels of care in residential environments, which could have a considerable impact on the interest in DCM from residential home managers.

The challenges of using DCM

Preparing residential homes for mapping

Although managers and care staff may be agreeable for the client to be mapped in their environment, it is essential that they understand the role of both the HTS and DCM. HTS teams have been challenged by care staff who request for the difficulties to be resolved or cured. Part of the preparation before mapping needs to be the development of an understanding that a shared action plan can be developed which will require collaborative working for positive changes to be made and that without this the situation is unlikely to improve.

Using DCM within the Home Treatment Service has involved considerable dedication and sensitivity by staff. Some of the care staff in residential homes have been unsure about the use of DCM in their environments, feeling scrutinised and criticised. Some care staff have commented that they believe their care practice has worsened as a consequence of being observed and the pressure that they feel as a result. This clearly requires a great deal of sensitivity from HTS staff, and emphasises the need to have sufficiently gained acceptance and understanding from care staff prior to beginning DCM. The preparation work needs to involve educating the staff team, not just the managers, and spending enough time in the environment to become trusted. Muller-Hergl (2004) outlines the role of the mapper as a ‘trusted stranger’, someone who is an outsider to the care environment being mapped, experienced in dementia care and has a firm belief in the possibility of change. This is a role which HTS staff may aspire to achieve, since often the team are referred to as experts to assist in situations where other options have failed to improve the situation. It is, therefore, easy to adopt the role of expert. One way in which HTS have begun to work towards the role of trusted stranger has already been outlined, in mapping alongside the manager of a large care home. It is hoped that this is something which will be repeated, allowing a shared understanding, language and insight to develop alongside a trusting and supportive relationship.

Practical considerations

The HTS have found that some of the smaller residential homes have very intimate shared lounges, which accommodate a small number of residents. In these situations it appears that the presence of a member of HTS staff conducting a map would be intrusive, feeling uncomfortable for both the residents and the mapper. In these occasions it is important to consider whether this is an appropriate environment to map, even though it may be a communal area.

Another key challenge to using DCM within the HTS is time. Whilst three of the HTS teams have two or more trained mappers, at least at basic user status, it can be challenging to incorporate the amount of DCM that would be ideal to develop a good understanding of the person and situation, and enable effective intervention plans and contributions to care plans to be achieved. Whilst HTS staff and managers can see the benefits of DCM and endeavour to incorporate it as much as possible, there are understandably resource limits. There are occasions when it is identified that a client may benefit from a period of DCM, but the teams are unable to resource this due to low staffing or high caseloads at that particular time.

It is important to recognise that DCM as a tool has its limitations. It cannot be seen to be an analytical tool, but more a tool which provides insight into an individual’s well-
being. The level of insight gained is controversial. Whilst a six-hour map can seem to provide a great deal of insight into an individual’s day, it has also been argued that this does not reflect or indicate what may occur outside of these six hours. Edwards and Fox (2001), whilst commenting on DCM in a research context, highlight that mapping is generally conducted within office hours, not allowing situations in the evenings, nights or early hours of the morning to be observed. Currently the HTS work between 8.30 a.m. and 5.00 p.m., although there is some amount of flexibility. When no difficulties are observed during a HTS map of an individual, care staff will frequently comment that we should be present during the night to understand the situation more fully. It is possible that future changes to the HTS might incorporate 24-hour working, which may assist in some of these situations. DCM is a tool which can be used specifically at the times of day when difficulties occur, providing that these are within communal areas.

The emotional impact of DCM on mappers
DCM is clearly a very powerful observational tool. It is, therefore, vital to consider the emotional impact that such a tool has on the observer conducting the map. It is likely that at some time a mapper will observe poor practice or considerable distress, which will generate their own feelings of sadness or anger. This consideration is supported by an article in the Nursing Times in which a mapper was interviewed and described a mapping session as ‘an emotional wrangle’ (Nursing Times, 2006). It is important to plan for these situations and ensure that staff who map are debriefed, or receive formal supervision, to provide a way of processing and making sense of the information they have observed and the feelings this has generated. Part of such arrangements should include clear procedures for managing any safeguarding issues which may also arise. Whilst HTS staff have previously had access to some group supervision sessions, the development of this within our trust is still in its very early stages. Formal DCM supervision is something which we would aspire towards.

The future for DCM in the Home Treatment Service
The use of DCM in the HTS is also evolving and expanding as the service grows and finds its niche within existing services and systems; however, DCM is already used within the service for assessment, intervention planning and monitoring outcomes. The extent to which this tool is used is reflected in the development of a KMPT policy for use of DCM with the Home Treatment Services to ensure that all the required procedures are adhered to.

KMPT has also recently invested in advanced level training for 20 members of staff within the trust, demonstrating its commitment to using DCM to improve dementia care within the locality. It has also been proposed that KMPT will introduce DCM across the majority of its inpatient and day treatment areas over the next year, demonstrating their commitment to using this tool.

Conclusion
Whilst DCM may have many challenges, it remains a person-centred tool which fits well with the philosophy of the HTS. Its increasing use may well identify further issues which need resolving, but despite the current limitations of resources, using DCM appears to remain beneficial and advantageous for our clients.

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Christine Slaughter is an assistant psychologist who formerly worked in the Home Treatment Service.
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Moving forward: Post-diagnostic groups for people with a mild dementia

Katie Snow

When I became a member of the Maidstone Memory Clinic team, I decided with my colleagues to build on the work I had undertaken for my undergraduate dissertation, which evaluated a post-diagnostic group in Medway. Although Maidstone had run a few post-diagnostic groups in the past, on my arrival most of this work was undertaken with individuals and families. Given my previous experience the Memory Clinic team readily agreed that a nursing colleague and I should set up a new group for people recently diagnosed with a mild dementia.

Following Kitwood’s (1997) person-centred approach to dementia care, there has been an increase in the use of psychotherapeutic interventions for people with dementia (Cheston, 1998). However, there is a scarcity of literature surrounding the effectiveness of such groups (Husband, 1999; Moniz-Cook & Woods, 1997).

I aim here to give a brief summary of my attempt to evaluate groups for people with dementia and the developments that followed.

Background
A diagnosis of a dementia can have major implications for the person and their family and, therefore, disclosure should be viewed as a process rather than a one-off event. The person has to adapt to the cognitive losses and mood changes as well as to the social impact of the condition (Cheston, 1998). Cayton (1993) suggests that a diagnosis of a dementia can move the person into another group in the eyes of society. Husband (2000) found that people with a diagnosis of dementia experienced feelings of humiliation, embarrassment and loss of independence. Husband (1999) argues that ongoing support is needed to meet the psychological impact of a diagnosis. With Memory Clinics providing specialist assessment, people are receiving a diagnosis of dementia in the earlier stages, when cognitions are relatively intact. With the emergence of this new client group, services must tailor post-diagnostic services accordingly.

A person’s ability to cope with their diagnosis and the changes it brings can be helped with a supportive social environment (Kitwood, 1990). One approach to supporting people with dementia in the early stages is through group therapy. It is cost-effective and more importantly, offers additional therapeutic benefits which individual therapy cannot. It gives the person a sense of belonging (Brooker & Duce, 2000) and provides the person with emotional bonding, enhanced self-esteem and sense of hope (Toseland, 1995). Yalom (1985) proposed 11 therapeutic group factors. One of these, Universality, refers to the normalising effect of meeting people with the same condition.

Snyder et al. (1995) evaluated an eight-week support group for patient-carer dyads which covered educational and psychological aspects. The positive themes which emerged from the verbal feedback were purposefulness, gratification for being offered support, belonging and surviving. Yale (1995) evaluated an eight-week support group for people with early stage Alzheimer’s disease. Although no statistical significance was found compared to the control group, clinical interviews showed increased self-esteem, sense of belonging and well-being. In comparison, the control group reported feelings of isolation and not being able to face their diagnosis.
Developing the ‘Memory Strategies Group’ in Medway

In response to the Medway Memory Clinic increasingly diagnosing people with a mild dementia, a time-limited, 10-week psycho-educational group was set up by members of the clinical team – ‘The ‘Memory Strategies Group’.

The aims of the group were as follows:
1. Increase the person’s understanding of dementia and help people come to terms with their diagnosis.
2. Provide people with a secure environment where they can share their concerns.
3. Support people to help them adapt to having memory problems and prepare for future changes.
4. Teach memory strategies to help the person adapt to having memory problems and manage in social situations.
5. Increase awareness of support and services available.

The research was aimed at evaluating the group with a focus on the following areas: well-being, psychological problems, life functioning, anxiety, depression and quality of life. In addition, it aimed to gain the person’s perspective of each session.

Method

Participants were people referred to the Memory Strategies Group, between January 2008 and December 2008. Four groups were evaluated, totalling 21 participants. Participants were in the mild to moderate stages of a dementia, with an MMSE (Folstein & Cockrell, 1988) of 17 or above. Due to the cognitive impairments of people with dementia, the reliability of the responses of the participants has been questioned. However, Kiyak and Mozley (1999) conclude that people in the mild to moderate stages of dementia can understand questions and self-report aspects of their own life.

A within-subjects, repeated measures design was used. Participants completed the following established outcome measures, before and after the 10-week group:

- Clinical Outcomes in Routine Evaluation, No Risk – CORE-NR (Evans et al., 2002). This measure tapped into: Subjective Well-being (four items), Problems (12 items), Functioning (12 items). The risk items were omitted from the questionnaire as risk assessments are carried out separately.
- Hospital Anxiety and Depression Scale – HADS (Zigmond & Snaith, 1983).
- Quality of Life Assessment Schedule – QOLAS (Selai et al., 2000).

A five-minute discussion was generated at the end of each session with the question, ‘How did you find today’s group?’. The verbal responses were recorded by the facilitator and analysed using Content Analysis Methodology (Stemler, 2001).

Results

In the pre- versus post-measure of the CORE-NR, a significant improvement was found in the subjective well-being domain ($p \leq 0.025$). No other significant change was identified in the other domains on the CORE-NR. The results were also analysed using Barkham’s (2003) benchmarks for levers of distress. The findings showed a predominantly positive change in the domains of: well-being, problems/symptoms and life functioning.

The Quality of Life Assessment Schedule showed no significant change. Quality of life was not positively nor negatively affected by the group, it stayed the same; the mean difference being close to zero ($m=0.108$). In the HADS, no significant change was identified in either the anxiety or depression domain.

Weekly feedback

Three main themes were identified from the weekly verbal feedback: social support, emotional support and educational aspect (see Table 1).
Summary
The research showed that the Memory Strategies Group significantly improved participants’ well-being \((p \leq 0.025)\). In particular verbal feedback showed that they valued the groups highly and felt that they had benefited from the experience. These findings support the studies by Yale (1995), Yalom (1985) and Toselands (1995). It could be argued that no change in HAD and QUOLAS scores showed that mood and quality of life remained stable despite the gravity of the diagnosis and the losses experienced by participants.

New beginnings in Maidstone
When the Maidstone Memory Clinic team agreed that we should run a post-diagnostic counselling group my colleague and I based our programme largely on the Memory Strategy Group programme previously used in Medway. However, due to the high demand of people needing post-diagnostic support, the programme was shortened to eight weeks (see Table 2). From my experience of post-diagnostic work, a recurring theme was the impact of the diagnosis on relationships and communication and this was, therefore, added into the group programme. We also had to come up with a name. Although we covered strategies for

<table>
<thead>
<tr>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Support</strong></td>
<td></td>
</tr>
<tr>
<td>Sharing problems/ experiences</td>
<td>12</td>
</tr>
<tr>
<td>Not alone (all in the same boat)</td>
<td>8</td>
</tr>
<tr>
<td>Relate to others</td>
<td>2</td>
</tr>
<tr>
<td>Meeting/ socialising with people</td>
<td>2</td>
</tr>
<tr>
<td>Like a family</td>
<td>2</td>
</tr>
<tr>
<td><strong>Emotional Support</strong></td>
<td></td>
</tr>
<tr>
<td>Relaxing</td>
<td>6</td>
</tr>
<tr>
<td>Miscellaneous (helped with anger/frustration, sensitive, removed sharp edge of pain, feel positive for coming, feel a failure)</td>
<td>5</td>
</tr>
<tr>
<td>Comforting</td>
<td>2</td>
</tr>
<tr>
<td>Talking about feelings</td>
<td>2</td>
</tr>
<tr>
<td><strong>Educational aspect</strong></td>
<td></td>
</tr>
<tr>
<td>Liked course content/ strategies</td>
<td>15</td>
</tr>
<tr>
<td>Helpful/useful</td>
<td>8</td>
</tr>
<tr>
<td>Miscellaneous comments about recommendations (bigger group, can’t read board, not as good as last week, cannot remember people’s names, want more information, want relaxation tapes)</td>
<td>6</td>
</tr>
<tr>
<td>Miscellaneous comments about session (OK, what expected from session)</td>
<td>2</td>
</tr>
<tr>
<td>Unclassifiable</td>
<td></td>
</tr>
<tr>
<td>Positive feedback (good, interesting, fun, enjoyed it)</td>
<td>57</td>
</tr>
<tr>
<td>Not as bad as I expected</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 1: Weekly verbal feedback: ‘How did you find today’s group?’
remembering, what group members valued most was being together and sharing experiences. Adopting the 2009 National Dementia Strategy title, the group was called ‘Living Well with Dementia’, placing emphasis on the fact that people can ‘live’ a full life after a diagnosis.

The first ‘Living Well with Dementia Group’ began in December 2009 with four enthusiastic members. Although we had a topic for discussion each week, we learnt to be flexible around these since it was important to respond to the need of group members to discuss what was foremost on their minds at any one time.

As we neared the end of the programme, the four group members expressed a strong desire to stay in touch. Fortunately, the problem of finding a venue and organising meetings were resolved when our local Alzheimer’s branch was given funding to run an ongoing peer support group for people with mild dementia. The group members were all eager to attend, they swapped telephone numbers and two even shared a lift to the first meeting! To date, they are all still attending. We are now in full swing with our second Living Well with Dementia Group and a member of the last group ‘wanted to give something back’ to others and offered to come and talk about his experiences and the new peer support group.

**Final thought**

What strikes me most in my experience of running post-diagnostic groups is that the desire for continued support is often prominent. Such groups give the person a purpose, sense of identity and people feel ‘understood’; understandably people don’t want this to end. Kitwood (1997) proposes that humans have five fundamental psychological needs: comfort, attachment, inclusion, occupation and identity. I believe groups for people recently diagnosed with a mild to moderate dementia can offer all of these.

**Acknowledgements**

I would like to thank Dirk Janssen and Reinhard Guss for supporting and advising me on my undergraduate research project. I would also like to thank Carolyn Smyth for helping me prepare this article. Last, but not least, thanks to Mark Kitchenham, my co-facilitator, for sharing my enthusiasm in running the Living Well with Dementia Group.

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**Table 2: ‘Living Well with Dementia’ – Programme.**

<table>
<thead>
<tr>
<th>Week Number</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction session (ice-breaker, aims, ground rules)</td>
</tr>
<tr>
<td>2</td>
<td>How memory works and when it goes wrong</td>
</tr>
<tr>
<td>3</td>
<td>What is dementia/impact of receiving a diagnosis</td>
</tr>
<tr>
<td>4</td>
<td>Coping and adjusting</td>
</tr>
<tr>
<td>5</td>
<td>Relationships and communication</td>
</tr>
<tr>
<td>6</td>
<td>Well-being (including healthy living and relaxation)</td>
</tr>
<tr>
<td>7</td>
<td>Financial matters and support services</td>
</tr>
<tr>
<td>8</td>
<td>Review and goodbyes</td>
</tr>
</tbody>
</table>

*For a full copy of the programme, please contact the author.*
References


**The Dover/Deal Memory Support Group: Client and relative feedback**

Christine Slaughter

There is considerable evidence available to support early interventions for people with dementia and their relatives/carers who support them, and indeed such interventions are recommended in the recently published guidelines, *Living Well with Dementia: A National Strategy* (DoH, 2009). The strategy emphasises the importance of early interventions which provide both information and support, and reports evidence that these interventions improve the quality of life of people with dementia (Banerjee et al., 2007), as well as reducing care home admissions (Mittelman et al., 2007).

Evidence specifically supporting interventions for people with dementia and their relatives/carers in a group setting is also plentiful. For example, Illingworth and Forrest (2008) described a six-session information and support group for people in the early stages of dementia and their supporters. At the end of the group clients reported using more memory aids; depression and anxiety levels had reduced and couples reported that they were coping better.

Similarly, Zarit et al. (2004) described a 10-session ‘memory club’ for eight to 10 people with dementia to attend with their care partners. Attendees reported that the most helpful aspect was sharing experiences and feelings with people in similar situations.

Similar findings have been reported by Snyder et al. (1995), Lees (2006) and Logsdon et al. (2007). Most recently, Roberts and Silverio (2009) reported the evaluation of a support programme for those with early stage Alzheimer’s disease and their care partners. Seventy-four participants provided feedback, with 99 per cent reporting to have found the group helpful. At three-month follow-up participants were more likely than a control group to be engaged in coping behaviours, such as legal planning and attending support groups.

Jones et al. (2002) summarised the aims of supportive groups for people with dementia as providing an opportunity to meet with others in similar circumstances, share experiences, learn coping strategies from one another and facilitate adjustment.

**The Dover/Deal Group Programme**

Since 2008 a regular seven-session group programme, known locally as the ‘Client and Carer Memory Support Group’ has been supporting individuals with dementia and their relatives, who have been referred largely through the memory clinic. Over the course of 2008 and 2009 the group has been attended by 36 clients, 97 per cent of whom were supported by a friend or relative. The programme has continued to adapt and evolve following feedback from the attendees, and as a result of reflection by the staff team involved in organising and facilitating the sessions.

The group programme has included information about memory and memory strategies, outside speakers explaining about their services (Social Services, Assistive Technology Service, local Carers Support Services) and information about medication and the importance of a healthy lifestyle. Whilst the group aims to provide people with information to support them on their journey, it also aims to provide peer support networks and therapeutic support, together with a positive social experience to help to build confidence and restore self-esteem.
The group begins with everyone together for an hour, during which time any visiting speakers attend. The second hour is spent in two smaller groups (clients with dementia and relatives/carers) to allow for discussion expanding on set topics, but also of relevant concerns and issues.

**Feedback from Group Members**

During 2009 the group ran on three occasions, with all attendees being asked to complete feedback questionnaires (see Appendix) in their final sessions and outcome measures in the first and final sessions. Evaluation questionnaires were received from 29 people in total (13 clients and 16 relatives), a response rate of 74 per cent. Not everyone could attend the final sessions, and whilst their forms were sent to them in the post, few were returned.

- 88 per cent of relatives and 85 per cent of clients reported that they found the group sessions ‘very helpful’.
- 100 per cent of relatives and 86 per cent of clients stated that they would recommend the group to someone in a similar situation to themselves.
- When asked which parts of the sessions they found most helpful 31 per cent of carers stated the speakers had been most helpful, whilst another 31 per cent of carers stated that the split sessions talking with other carers was most helpful.
- 31 per cent of clients found it helpful to talk with others in a similar situation, and 38 per cent of clients reported that everything had been helpful.
- One client specifically commented that a memory association game and memory strategy exercise had been most helpful.
- One relative commented: ‘The group was well organised – the girls taking part were always helpful and caring to both parties and I don’t think there can be any improvements that need to be made. I have learnt so much from the sessions and feel more confident in myself how to deal with my partner. The weeks were enjoyable but went by too quickly.’

Whilst this feedback was very pleasing to see, as it appears that the group has been largely meeting the needs of those who attended, it is important to consider how the group can be further improved for the future. When asked what had been unhelpful, two relatives commented that they would have liked more information about what was happening in the clients’ group. Providing a more detailed recap at the beginning of each session which allows more detail to be provided on the activities that took place might be helpful for some relatives. This information would largely be restricted to the activities that took place or broad topics discussed. Issues from the carers’ group are not recapped within the whole group for confidentiality reasons, and this issue applies similarly to clients, who may wish to use the separate group as an opportunity to express frustrations about their situations or relatives. This, therefore, needs careful handling by the staff involved in facilitating the group, and any plans made to deal with this will need to be flexible as each group will be different. It may be appropriate to explore whether there are any other issues which trigger these concerns for relatives, such as any anxieties about being separated from the person they accompanied.

An alternative way of providing the recap at the beginning of each group session would be through a written handout summarising the previous week. This idea has been successfully piloted in other local groups.

Other comments which were made included the need for more consideration of hearing impairments, perhaps by asking guest speakers to speak more clearly or by installing a hearing loop in the group room. These are certainly very important issues as the group needs to be equally accessible, and this will be discussed prior to the next groups due to be held in 2010.

**Plans for 2010**

In addition to those issues previously mentioned, for 2010 we have extended the programme to eight sessions in order to rearrange the programme of speakers and
include representation from a wider range of organisations. New speakers who have agreed to attend include local voluntary organisations, a legal advisor and a driving standards assessor.

We will continue to gain feedback from those who attend the 2010 groups and it will be interesting to see whether the changes made are beneficial. The current plan is to use the same feedback questionnaire so that comparisons across the years can be made.

**Summary**

Overall the group appears to be a valuable and essential resource for clients who have recently received a diagnosis of dementia and their relatives. This evaluation data adds to the current evidence base in support of group interventions for individuals with an early diagnosis of dementia and their relatives. Further, the data show that the format of inviting speakers from outside organisations, having some time as a large group and some time in separate peer groups has so far been successful.

The group continues to strive to meet the needs of the local population, and is consistent with both national guidelines (such as *Living Well with Dementia: A National Strategy*, DoH, 2009) and the existing evidence base. It is hoped that the group will continue to evolve and improve throughout the year to come.

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**References**


Appendix: Memory Support Group Evaluation Questionnaire

In order to improve the services that we offer, it would be very helpful to have your honest reactions to the group sessions you have just attended.

Are you …
… a person experiencing memory difficulties? □
… a person who supports someone with memory difficulties? □ (Please tick)

1. How helpful did you find the group sessions?

<table>
<thead>
<tr>
<th>Very unhelpful</th>
<th>A bit unhelpful</th>
<th>Neither helpful or unhelpful</th>
<th>A bit helpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

2. How much did you learn from the sessions?

<table>
<thead>
<tr>
<th>Nothing at all</th>
<th>A little</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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</tr>
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</table>

3. How relevant did you feel the sessions were to you?

<table>
<thead>
<tr>
<th>Completely irrelevant</th>
<th>A little relevant or irrelevant</th>
<th>Neither relevant or irrelevant</th>
<th>A bit relevant</th>
<th>Very relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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</table>

4. To what extent did the group meet your expectations?

<table>
<thead>
<tr>
<th>Not met at all</th>
<th>A little met</th>
<th>Fully met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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</table>

5. Which parts of the sessions did you find most helpful? Why?

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

6. Which parts of the sessions did you find unhelpful?

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

7. Would you recommend this group to others in a similar situation to you?

Yes □ No □

8. Please add any other comments about the group that you would like to make.

This can help us to improve the group for next time.

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Thank you for completing this. We value your feedback. Please return this to one of the staff members present.
Managing bereavement: A consultation with the nursing staff of a medical ward for older people

Helen Stirk, Ian Kneebone & Donna Penn

A consultation took place with nursing staff of a medical ward for older people to establish guidance on managing bereavement. Recommendations were developed for the support of relatives and to assist staff reactions.

Introduction

The BASIS for this consultation was a project undertaken to assess the extent of psychological input needed on a community medical rehabilitation ward (Gratton & Kneebone, 2009). In addition to identifying a need amongst patients for intervention for depression, anxiety and other psychological problems, the results of discussions held with staff suggested that they might also welcome support from psychology in managing bereavement. More specifically this included determining how best to work with families whose loved ones were expected to die and how to support for staff in the way they managed these situations at a personal level.

To date little training for staff working with older people in medical wards on how to manage bereavement and bereaved relatives appears to occur (Stephen et al., 2009). Indeed specific to nursing staff needs there is a narrative within the nursing profession that being a good nurse means that you can meet the death of patients with equanimity, that it is possible to remove the professional self from the personal self (Jones, 2001). There are some areas of the nursing profession where training in managing bereavement is offered, for example, within midwifery, ITU and Accident and Emergency, where the deaths of young people are often encountered (Shorter & Stayt, 2010; Smith, 2009; Mortlock, 2005; Purves & Edwards, 2005). There is also a different ethos within the palliative care sector where all aspects of death, both for patients and staff are carefully considered (Claxton-Oldfield et al., 2007). It seems strange, therefore, that bereavement training for those involved with the care of older adults should be so sparse; as if because it is a natural thing for older people to die, it should not be upsetting.

Method

The ward

The ward is a 16-bed community rehabilitation ward. It originally operated as a ‘step-down’ ward where patients were transferred from acute settings to complete their rehabilitation. Such patients were normally expected to recover and return to the community. However, over the last five years, the ward had also accepted patients from the community who had specific difficulties that require a stay in hospital and hence the ward had become a ‘step-up, step-down’. This change has led to the admission of patients with greater medical problems who were more likely to die than the original rehabilitation patients. At the time of the consultation, the majority of the ward’s patients were ‘step-up’ patients. In addition to the nursing staff, the multidisciplinary team includes physiotherapists, occupational therapists and medical staff. The latter are GPs from the local practice and provide the majority of the medical care on the ward, with consultants from a variety of locations providing additional support when needed.
**The Consultant**
The consultant was a mature age clinical psychology trainee, in her second year of training. As well as qualifications in psychology, she had a PhD in biophysics and had experience leading groups in both mainstream and special schools, as well as in a research environment.

**Consultation procedure**
Michie and Abraham (2004) stress the importance of undertaking background work in understanding the theoretical and practical aspects of the consultancy. For the current work this involved:
- Undertaking a literature survey of academic work, policy documents and online resources such as the MacMillan Nurses website (www.macmillan.org.uk).
- Consulting with a bereavement counsellor from the local Palliative Care Service.
- Presenting an outline of the issues involved to an Older Adult Special Interest Group and requesting their input regarding possible ways forward for the consultation.
- Informal discussion with the ward staff.
- Formal discussion with the ward matron.
A collaborative consultation approach was chosen for the project. This is consultation where the consultant works with the consultee and others to complement their skills (Brunning et al., 1990). Michie and Abraham (2004) suggest that this is the preferred way of working with staff teams as it ensures that the project enhances the learning experience of the consultees and also develops a reflective approach to consultancy. They also suggest that it is a useful approach in complex situations and where the consultee’s expertise, in some aspects of the problem, exceed those of the consultant.

The formal consultation took place in two workshops of one hour each, held two weeks apart. The whole staff team were invited to these including those who were off-duty or on holiday. The off-duty rota was also arranged so that all staff from the ward could attend.

The workshops were held in a staff sitting room as this was an informal space and large enough to accommodate the whole team.

The first workshop was intended to draw on staff experience to encourage their engagement with and ownership of the consultation process. Staff were asked to discuss recent bereavements on the ward in small groups of two or three and then to share their experiences with the whole group. Key points from the discussion were written on flip charts as a record of the discussions and for use in the second workshop if needed.

Two weeks were left between the sessions to enable staff to reflect and off-duty rotas to be arranged so that all staff could attend the second session.

The process of the consultation was evaluated via informal observation of staff comments and a formal semi-structured interview with the ward matron.

**Results**

**Bereavement counsellor**
The bereavement counsellor for the local palliative care service raised the possibility of a self-sustaining group on the ward that could meet to discuss the deaths of patients and provide staff with a reflective space in which to discuss their reactions to the death and any other emotional issues that it might highlight for them. Such groups have been successful in the palliative care sector (Running et al., 2008) but are not universally provided. MacMillan nurses, for example, do not routinely have supervision but benefit when they do (Jones, 2001).

**Older people interest group**
The Special Interest Group for Older Adults meeting highlighted the value of staff using their own experiences, and determining their own course of action. It was considered this would help any planned changes to be enacted.
Staff team and ward matron
Informal discussions with the team established that attention to bereavement on the ward was still warranted. In discussions with the ward matron, it was determined likely the most useful way forward would be via workshops where the issues of bereavement could be openly discussed away from the distractions of the ward environment.

Consultation
Twelve nurses attended the first workshop; two sisters, five staff nurses, four health care assistants and the ward matron. These numbers included night staff who had come in during the day and staff who had come in while on leave. All but one of those attending the original workshop attended the second.

Staff were unsure about what to expect from a workshop as they were used to more didactic methods of training; however, they seemed to welcome the focus on their own experiences and the assertion that they were the experts and that the consultant’s role was to facilitate their discussion. They were happy to discuss their experience based around the themes of ‘What went well?’, ‘What went less well?’ and ‘What we could do differently’. Each of the groups had identified a different episode to discuss that had highlighted important aspects of bereavement for them. These were shared openly with the whole group and met with understanding and recognition by the other members of the staff team.

As discussion progressed, the depth of knowledge and experience within the team became evident, as did the importance that was placed on helping both patients and relatives through difficult times and how rewarding it could be when things went well. At the end of the first meeting it was suggested by one of the ward staff that this shared experience and expertise could be written in the form of guidance that could be placed on the ward for future reference. As this was a positive idea that originated from the staff and also tied in with Department of Health’s guidance on bereavement (Department of Health, 2005), it seemed to be an ideal theme for the second workshop. The information recorded on flip charts during the first session was taken away and analysed for themes that could be discussed in the second workshop to help form this guidance.

As can be seen in Table 1, three broad themes were identified from the first workshop, these being: Communication, Staff Needs and Practicalities. Communication included both communication to and from those affected by the death; staff needs considered the dilemmas and priorities for nurses; and practicalities, the pragmatics of managing death and bereavement. The contents of each of these themes were written on flip charts to guide discussions in the second session. The original flipcharts from the first workshop, with the themes highlighted in different colours were also displayed on the walls during the second session to emphasise the fact that the discussions in the second workshop originated from the discussions in the first and were, therefore, from the staff’s own experiences. The issues raised by the staff in each of these areas were discussed and ways forward were found. These were then put together to form the basis of guidance.

Guidance
Following discussions with the ward matron, draft guidance was developed, using, as far as possible, the same language that had been used by the staff. The draft guidance was given to the ward matron for her input and to check its compliance with local guidelines on, for example, decisions surrounding quality versus quantity of a patient’s life. The final guidance can be seen in the Appendix. It maps onto the themes identified in the first workshop; that is, it provided guidelines on communication, managing staff needs and dealing with practicalities.

Process evaluation
Staff were noted to informally comment on how good it was to meet as a whole team,
Table 1: Themes from the Bereavement Workshop.

<table>
<thead>
<tr>
<th>Communication</th>
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<tbody>
<tr>
<td>Being available</td>
</tr>
<tr>
<td>Listening</td>
</tr>
<tr>
<td>Providing information</td>
</tr>
<tr>
<td>Non-verbal communication (showing that the patient is cared about in practical ways)</td>
</tr>
<tr>
<td>Understanding the patient’s and relative’s reaction to the news</td>
</tr>
<tr>
<td>Responding appropriately to patients and relatives needs.</td>
</tr>
<tr>
<td>Managing expectations</td>
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<tr>
<td>Explaining procedures around the time of death</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff needs</th>
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</thead>
<tbody>
<tr>
<td>Nurses may be the first to know when someone is dying.</td>
</tr>
<tr>
<td>Quality vs. quantity of life</td>
</tr>
<tr>
<td>Different roles in the staff team have different priorities</td>
</tr>
<tr>
<td>Difficulties of responding to relatives who are hostile to the staff team</td>
</tr>
<tr>
<td>Difficulties of dealing with conflict between relatives</td>
</tr>
<tr>
<td>Responding to feelings of guilt that a patient has gone elsewhere to die (e.g. a hospice or an acute hospital)</td>
</tr>
<tr>
<td>Personal loss for staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practicalities</th>
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</thead>
<tbody>
<tr>
<td>Is the patient likely to need to move to a different location prior to death?</td>
</tr>
<tr>
<td>Medical treatment, e.g. pain relief</td>
</tr>
<tr>
<td>Involvement of other professionals, e.g. doctors, Macmillan nurses</td>
</tr>
<tr>
<td>Arrangements regarding viewing the body, funeral arrangements</td>
</tr>
<tr>
<td>Treatment of patient’s possessions</td>
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</table>

something that had never been possible before. They also commented on the value of discussing a difficult subject openly in a supportive, non-critical environment. It was mentioned how easy it can be to think you are the only person finding the loss of a patient difficult, or perhaps having problems in managing the reactions of some relatives. Knowing that other members of staff also had similar difficulties, and that it might be valuable to talk about these, was viewed as helpful.

Key points from the semi-structured interview with the ward matron were as follows:

- The collaborative approach to developing the consultation was seen as refreshing and the way the procedure had been tailored specifically to the needs of the ward, increased its effectiveness.
- The workshops had ‘got people thinking’ and ‘opened minds’. They had enabled staff an opportunity to stop and think and to see that there may be other ways of doing things.
- The suggestion that there could be discussion groups following the death of a patient was particularly pleasing. The ward matron considered the provision of this space would allow for ‘reflective learning’.

The feedback from the ward matron was, therefore, positive as had been the informal comments of the other staff.
Discussion
Consideration of the needs of patients, families and staff in the context of death on a community hospital ward, were considered in a consultation with ward nursing staff. As evidenced by the number that attended both workshops, staff embraced the opportunity for involvement; even those who were off duty or on annual leave were present, including night staff. This seemed to be a reflection of the commitment of staff to their roles as nurses as well as their interest in the subject area and the chance to meet together as a team. Three themes were identified (communication, staff needs and practicalities) that informed the development of guidance for both the management of families and of staff reactions. Being developed by staff this guidance appears highly sympathetic to their needs and those of the ward and is thus is likely to be implemented.

This work supports psychologists embracing working in health care settings via consultation. Follow-up is indicated to determine the longer-term impact of the guidance developed. Other ward staff might be included in future consultations.

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References
Appendix: Bereavement guidance for the ward

This guidance arises from staff discussions during two workshops on bereavement. The guidance is arranged around themes that came out of staff experiences of bereavement on the ward. These themes were Communication, Staff Needs and Practicalities.

Communication

● When having private conversations with relatives regarding the actual or potential death of a patient:
  – Switch telephone through to alternative extension.
  – Place new ‘Family Meeting in Progress’ notice on office door and alert all staff who might enter the ward to its meaning.

● When giving information to relatives:
  – Check what relatives and patients already know and understand.
  – Continue to use ‘yellow sheet’ system in notes to ensure messages are consistent and ensure any messages given to relatives are communicated at handovers.
  – If unsure, check before communicating.

● Giving relatives skills to help patients where requested and appropriate.
  – Staff noted that relatives have different needs and expectations about the extent to which they become involved in their loved one’s care and were skilled at providing appropriate support where needed. They felt that it was important for them to be able to help relatives to care for their loved ones in this way.

● Enabling relatives to be present at the time of death if wished.
  – Staff took a great deal of time and trouble to enable relatives to be with their loved ones when they died if this was requested. They were aware that relatives’ memories around this time would form part of the grieving process and were an important part of how a relative would remember their loved one.
  – If appropriate, it was suggested that a question could be added to admissions process so that all ward staff were aware of relatives’ wishes.

Staff needs

● When it is realised that a patient is likely to die.
  – Discussions around the deaths of patients revealed that the nursing staff were often the first to recognise that a patient was close to dying as they worked so closely with them on a daily basis. This information was shared with colleagues, in part to alert them to the changing needs of the patients and the possibility that relatives may need to be informed, and in part to enable mutual support where needed amongst the team.
  – The use of invasive treatments with patients close to death was particularly difficult for the team as these decisions are made by medical staff. When staff realised that the balance of a patient’s quality versus quantity of life had become an issue, this needed to be communicated to medical staff by senior nursing staff so that it could be properly addressed by the medical staff with the patients and their relatives. This is particularly important where the On Call service is being used, or the doctors do not know the patient well.

● Dealing with conflict. Some of the most difficult situations around bereavements occur when relatives are, or become, hostile to the nursing staff. It was recognised that the reasons for this reaction were often complex, with anger frequently being a part of grieving.
Anger might also originate from relatives’ past experiences in similar situations. The staff team had encountered a number of these situations and had found ways of working with distressed relatives that were helpful:

- When relatives are being hostile, be mindful not to react immediately, take a mental step back and work out why they are behaving in this way (see attached sheet on the different ways in which patients and relatives may react to the news that the patient is likely to die). It may then be possible to react with empathy to the relative’s situation rather than responding to their anger.

- Where staff have encountered a hostile or otherwise worrying reaction from relatives of patients, this needs to be discussed at handover where the problem and any potential solution can be discussed: forewarned is forearmed.

- When there is conflict between family members, nursing staff need to listen to relatives concerns, respond with empathy, but remain neutral. The family may be referred to a family forum if this is likely to be beneficial. They may also be referred to the Bereavement course at the Beacon Centre once this is running.

- Following the death of a patient.
  - Within 48 hours of the death of a patient or if patient or relatives are having difficulty coming to term with a potential death, a team debrief should be arranged. This is a group for discussing the case for nursing and other staff that may have been involved. The purpose of this meeting is to talk through the events surrounding the death, to find the positives and to enable reflective learning.

**Practicalities**

- Medical procedures around the time of death are often vividly remembered by relatives, and it is useful for them to understand their purpose.

- If appropriate, it would be useful to add into the admissions procedure a question regarding the preferred place of death for the patient. This may be at home, in hospital, or in a hospice. This also may also enable a wider discussion about the possibility of a patient dying.

- Being aware of other professionals that may usefully be involved, for example, MacMillan nurses, chaplains. It may be also useful to ask whether the patient would like a visit from the chaplain, or other religious leader at admission.

- The return of patient’s possessions following their death is a difficult moment and can be the cause of much distress. On the ward possessions are handed over in attractive, ‘non-hospital’ carrier bags and this practice should continue.
THIS PAPER presents an edited version of the findings of a survey undertaken in the summer of 2009 in Kent & Medway NHS & Social Care Partnership Trust. The survey was used as a means for gathering basic information about Community Mental Health Team colleagues’ awareness, experience, understanding and interpretation of the term ‘personality disorder.’ Colleagues from Community Mental Health Teams for Older People in the West (Maidstone North & South; Tunbridge Wells; Sevenoaks & Tonbridge; Dartford & Gravesham) and Medway Directorates of the Trust were selected. It was hoped that the information received would shed light on the prevalence of personality disorder among the older people accessing secondary care mental health services, clarify current provision and identify service needs.

Background to the Survey
The NICE draft document for the treatment and management of people with a borderline personality disorder (NICE, 2008) failed to make any reference to older people. Systematic studies on personality disorder in older people may have been rare (Mordekar & Spence, 2008), but the existence of personality disorder in later life has long been acknowledged (Abrams & Horowitz, 1996; Ames & Molinari, 1994; Molinari & Marmion, 1993). The reason NICE did not include older people in their guidelines is likely to be complex and beyond the scope of this paper; Deborah Morris’ comprehensive paper considers the complexity of personality disorder in later life and draws attention to the few studies available (Morris, 2009). The NICE draft document, as mentioned above, did, however, motivate a group of psychological therapists (a clinical psychologist and a psychotherapist from the West, a clinical psychologist from Medway and a clinical psychologist from the East and Costal Directorates of the Trust) with a special interest in this area of work to pool their ideas and consider how they might take a more active role to clarify current provision, identify service gaps and consider a way forward. The psychological therapists in the West and Medway Trust Directorates were able to meet at regular intervals and therefore, the survey was used with these two directorates only.

Methodology
Design
A semi-structured questionnaire was devised and forwarded to Community Mental Health Team colleagues in the West and Medway Directorates by their team clinical psychologist. The questionnaire invited respondents to consider the generic term ‘personality disorder’ and whether older patients on their caseload came to mind upon hearing this term, whilst also considering what characteristics led them to make this link. Respondents were then asked to estimate the numbers of patients on their caseload.
comment on diagnosis and the diagnostic tools used, consider their experience of working as a team, their level of confidence in this area of their work, clarify the treatments used and share their views on the usefulness of these.

**Data processing**
Quantitative data was presented in graph form and considered accordingly. An Interpretive Phenomenological Analysis approach was used to manage and influence qualitative data processing (Smith, 1995). This process involved extracting themes from the material associated with the question and then grouping them together before categorising.

**Results and discussion**

**Response and prevalence rates**
From approximately 71 questionnaires distributed, 29 (41 per cent) were returned from the five Community Mental Health Teams targeted. Some clinical psychologists could not be certain when asked to clarify the exact numbers of questionnaires distributed and, therefore, the response rate cannot be completely accurate. Respondents’ comprise three psychiatrists, 14 community mental health nurses (CMHN), two social workers, two support workers, three psychologists, two occupational therapists (OT), two psychological therapists (a cognitive behaviour therapist and a counsellor) and one respondent did not identify their profession.

Respondents were invited to consider whether any of their older patients came to mind upon hearing the term personality ‘disorder’ and if so, to then estimate the numbers on their caseload. A striking 83 per cent (24) of respondents believed they were working with an older person with a personality disorder; 14 per cent of those considered they were working with between six and ten people, whilst three per cent, a psychiatrist, claimed to be working with more than ten people. Results suggest that 17 per cent of these respondents believed they were working with six or more older people with a personality disorder. This number is consistent with the few studies available and referred to by Deborah Morris (Morris, 2009) confirming that personality disorder in later life is likely to be more common than previous estimations suggest.

**Diagnosis**
Respondents were asked to comment on whether a formal diagnosis had been made. Figure 1 presents a breakdown of responses to diagnosis by profession.

Of the respondents that said they had an older person with a personality disorder on their caseload (83 per cent), 29 per cent also believed a formal diagnosis of personality disorder had been made; all three psychiatrists said formal diagnosis was made, making up 43 per cent of the total claiming formal diagnosis had taken place.

What had led respondents to suspect their patients had a personality disorder was considered and commented on; comments were grouped into five categories using the core symptoms from the current definitive diagnosis of borderline personality disorder (APA, 2000). These comprise – ‘Impulsive Aggression and Affect Instability’, ‘Emotional and Behavioural Deregulation’, ‘Identity Disturbance’, ‘Interpersonal Difficulties’; the category, ‘Cognitive Distortions’, had been offered to replace the ‘cognitive impairments’ core symptom to avoid any link with dementia. The category ‘Other’ was added to accommodate comments that did not fit comfortably with the core symptom categories.

Many respondents used terms such as, ‘attention seeking’, ‘resistive’, ‘challenging’, ‘manipulative’, ‘maladaptive’, ‘sabotaging’, ‘unwillingness’, ‘non-compliance’, ‘repetitive’, ‘not open’, ‘bizarre mannerisms’, ‘defensive and protective thinking styles’, and so forth. The use of these terms may correlate with respondents’ subjective experience and result from both the respondents’ and the wider societal view of what constitutes the normal range of acceptable behaviour. They may also be seen as a manifestation of the frustrations that many professionals can feel when attempting
to work with people who are likely to be experiencing considerable intra-psychic disturbance along with the associated external chaos often created around them.

The potentially self-damaging behaviours common among people with borderline personality disorder such as sexual promiscuity, reckless driving, binge eating, uncontrolled spending and so forth were not among the suggestions offered; one respondent did refer to substance misuse. Frantic efforts to avoid real or imagined abandonment, severe dissociative symptoms and self-mutilating behaviour, such as cutting, were also not mentioned; one respondent did refer to ‘splitting’. There was no reference to the chronic feelings of emptiness and worthlessness that many people with a personality disorder experience and is often seen in older depressed people contemplating multiple losses, and the end of life. With the exception of two comments that were placed in the ‘Identity Disturbance’ category, no other reference was made to the difficulties associated with identity. Self-image or sense of self can be severely impaired in people with a borderline personality disorder or perhaps exaggerated in someone with a narcissistic personality disorder (APA, 2000). Identity is likely to change, to some degree, as the body and the brain ages, but how the present cohort of older people experience their ageing process was not clear from respondents’ comments. These responses appear to be consistent with the belief that the presentation of personality disorder in older people differs from that in younger people and confirms that self-destructive behaviours such as sexual impulsivity and physical acts of aggression among older people are rare (Segal et al., 2006). Psychological defences may have matured and become rigid at much earlier stages in the older person’s development and, therefore, it is possible that impulse control among older people, in general, has remained in tack. This could be why the majority of older patients seen today avoid engaging in more profound self-damaging behaviours and perhaps have been more inclined towards using more subtle forms of self-attack. Small overdoses of prescribed medication, self-harming gestures or threats, self-criticism, social withdrawal, biting one’s lip till it bleeds or picking at one’s skin, neglecting self-nourishing needs when not taking adequate food.
and water, inducing other people to anger and criticism as in passive aggression, among others may be more typical of the experience of older person with a personality disorder. However, comments offered could not confirm the existence of these subtleties, but the quantity and quality of respondents’ subjective comments might suggest they have been internalising their patients’ subtle projections.

**Diagnostic tools**

Respondents were invited to comment on the diagnostic tools used. Forty-five per cent of the respondents that said diagnosis had taken place, made a comment. Themes from the respondents’ comments were identified and placed into the following categories: ‘Formal Diagnostic Tools’, ‘Clinical Judgement’, and ‘Uncertain’.

Eighteen per cent of respondents didn’t know what diagnostic tools had been used, all of whom were community mental health nurses. The DSM-IV (Diagnostic Statistical Manual – 4th edition), SCID (Structured Clinical Interview for DSM-IV Axis II PD) and ICD-10 (International Classification of Disorders – 10) were referred to by three respondents, two of whom were psychiatrists and the other was the unknown respondent. One psychiatrist indicated that the ICD-10 was ‘not a formal diagnostic tool’ and referred to making use of clinical interview and consultation with others to assist diagnosis. The use of categorical approaches such as, the DSM-IV and ICD-10, to inform the diagnosis of personality disorder in isolation is limiting (Clark et al., 1997); this may be the reason the psychiatrist commented as noted above.

The other psychiatrist, referred only to ‘psychiatric, psychological’, although what was meant by this was unclear. With the exception of the two psychiatrists and the unknown respondent, no other professional group made reference to these or any other formal instruments. The other respondents suggested diagnosis was made ‘out of area’, ‘just mentioned in MDT meetings or among professionals’, made ‘through the normal assessment process’, referred to in someone’s ‘army discharge papers’ and ‘clinical judgement would identify symptoms’. It is not known whether formulation and diagnosis was shared with patients to inform treatment; this would have been a useful question to have asked. However, from the respondents’ comments, an assumption could be made that formulation and diagnosis was not shared with patients to shape treatment.

**Confidence**

Respondents were asked whether they felt confident in their work with older patients with a personality disorder and then to make comments on this if they wished – Figure 2 outlines responses by profession.

Thirty-eight per cent of respondents felt confident compared with 41 per cent that did not feel confident in their work with someone with a personality disorder. The respondents that said they felt confident also acknowledged in the comments column that they felt some degree of uncertainty in their work. Themes from the comments offered were grouped and placed into ‘skills’, ‘support’ and ‘belief’ categories. The two occupational therapists that said they felt confident also expressed ‘unease’ and highlighted the need for training. It was interesting that both support workers felt confident and yet all 41 per cent of the respondents that did not feel confident were trained professionals; with the exception of the unknown respondent, these respondents comprise 66 per cent psychiatrists and 64 per cent community mental health nurses. None of the psychiatrists offered any comment and only two community mental health nurses made comment suggesting they didn’t have a ‘great deal of experience/expertise’ and tended to ‘involve others with more knowledge to advise.’ In could be assumed that the two untrained respondents felt confident because they have the support of the patient’s care co-ordinator, who will be a trained member of staff and that the trained members of staff do not feel confident
because responsibility for these often difficult patients falls to them.

It is important to note that the responses highlighted an anomaly in the design of the questionnaire, as four of the five respondents that said they didn’t have anyone with a personality disorder on their caseload answered this question. Three of those said they didn’t feel confident. Despite this variable, the fact that these respondents decided to answer this question may be relevant. One social worker did refer to having previously worked with people with a personality disorder.

**Teamwork**

Respondents were asked to comment on teamwork. The intention here was to clarify whether the respondents were working in isolation or as part of a team with these patients and if so, to then clarify the professional identity of the others involved and then calculate how many professionals were involved at one time. The manner of response identified anomalies with the design of the questionnaire and, therefore, information received was difficult to analyse. Following a lengthy process of analysis, some useful information was extracted and discussed in the original survey report. For the benefit of this paper, it can be confirmed that 92 per cent of respondents working with someone with a personality disorder generally work as part of a team and psychiatrists, psychologists and community mental health nurses are generally often involved in this type of team work. It was also calculated that 75 per cent of the respondents suggested there have been four or more professionals involved in the care of an older person with a personality disorder at one time and occasions when this number can rise to as many as eight.

Respondents were then asked whether they encounter any difficulties working as a team and then comment if they wished. It was calculated that the numbers of respondents that said they had encountered team difficulties (38 per cent) was equal to those that said they did not experience difficulties (38 per cent). Themes from the respondents’ comments were identified and placed into ‘team practice’ and ‘clinical pressures’ categories. Comments placed in the Team Practice category ranged from, ‘uncertainty of roles’, ‘inconsistency of approach’, ‘use of labels’, ‘use of medication’, ‘lack of cohesion’, to a ‘lack of expertise.’ Comments such as, feeling ‘powerless’, ‘manipulated’, issues relating to ‘risk’, ‘resources’, ‘disengagement’ and ‘working in isolation’ were place in the Clinical Pressures category.
**Treatment**

Respondents were asked to identify the treatments their older patients had received and then give their views on the helpfulness of these treatments. Table 1 presents a breakdown of the modes of treatments that the 24 respondents said were used with the older patients they suspected had a personality disorder. The mode of treatment has been abbreviated for ease and is clarified below as follows:

- **Meds** = Medication
- **CBT** = Cognitive Behaviour Therapy
- **AM** = Anxiety Management
- **PT** = Psychotherapy
- **Co** = Counselling
- **SG** = Support Groups
- **Sup W Input** = Support Worker Input
- **RM** = Risk Management
- **Rfx** = Reflexology

Medication was reported to be the most commonly used treatment with CBT and anxiety management as joint second; only one respondent, a community mental health nurse, did not highlight medication as a treatment. It was noted that medication, anxiety management and CBT were examples offered as treatment options in the question and, therefore, this may account for the high response rate.

The term ‘treatment’ appears to have been interpreted as referring to a variety of care interventions by two psychiatrists and one community mental health nurse as they also highlighted advice, respite, chiropody, care support and out-patient appointments as treatments. It is worth noting that these are not specific treatments for people with a personality disorder, although may be very beneficial additional interventions. The reason why two psychiatrists and one community mental health nurse highlighted these types of interventions may have resulted from a misinterpretation of the question. It may also be possible that there is little in the way of specific treatment on offer to assist professionals’ in their work and that they are doing the best they can with the resources available. It is recognised that the containment support workers and community mental health nurses offer is an essential part of the care and treatment of people with a personality disorder although this was not

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<th>Profession</th>
<th>Meds</th>
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Table 1: Breakdown of the modes of treatment used with older people.
mentioned; containment and support may not have been seen to hold any value or perhaps, it's a luxury no longer available to staff working in today's NHS. Respondents were then asked to share their views on the helpfulness of the treatments they highlighted. Responses include a mix of attitudes regarding treatment. Themes were identified and categorised accordingly into, ‘Most Helpful’, ‘Of Some Help’, ‘Less Helpful’ and ‘Suggestions’. The decision to separate comments perceived as helpful into ‘most helpful’ and ‘of some help’ categories was taken to highlight the degree to which it was perceived respondents felt these treatments were helpful. For example, comments such as, ‘they work sometimes’, ‘medication is only useful in reducing symptoms of depression and anxiety in some people’, ‘they are helpful as an initial plan’, ‘they provide some degree to containment’ among others, were placed in the ‘Of Some Help’ category. Responses suggest there are differing experiences of the usefulness of medication, with some respondents commenting on the value of medication and others highlighting issues with medication. The respondents that said, ‘they work sometimes’, ‘not always obviously helpful’, ‘fragmented’, ‘limited’, among others, specified medication, anxiety management and CBT in their list of treatments offered; reflexology and relaxation therapy were also offered by some of these respondents. It could be assumed that medication, anxiety management and CBT have been highlighted in this way because they were the most commonly used treatments. Comments placed in the ‘Suggestions’ category presented a range of ideas on changing practices and improving services and these include, offering patients an ‘individual assessment’, ‘care co-ordinated by a professional who is confident in their knowledge base’, ‘they require on-going treatment’, ‘we should work more closely as a team in formulating the individual’s difficulties’ and ‘I think it would be helpful to have a diagnosis clearly stated.’ The fact that these were mentioned might suggest there are problems in these areas.

**Conclusion**

This survey attempted to estimate the number of older people with a personality disorder currently accessing secondary mental health care and identify service needs. The data analysis process identified a number of questionnaire design and distribution anomalies, which may have affected the validity of this survey. The response rate may not be completely representative of the sample targeted and responses to some questions were ambiguous. However, the report attempted to consider respondents' contributions and extract useful data for consideration with this in mind although it is accepted that, for the purpose of this newsletter, the editing process might have led to the loss or misrepresentation of some material from the original survey report.

A large majority of respondents are estimated to be working with older people with a personality disorder. This figure is consistent with the growing evidence that prevalence rates have been largely underestimated. The qualitative data collated and examined from respondents’ comments on symptom pathology confirms that the presentation of personality disorder in older people is multi-faceted. Characteristics differ to some degree from what is seen in younger adults and do not correlate comfortably with the current criteria for diagnosing borderline personality disorder. It is recognised that the survey was focusing on personality disorder in general, and not specifically borderline personality disorder and, therefore, responses are likely to reflect this. It is also noted that symptom pathology present in older people was not being matched against that present in younger people.

Responses to the questions on diagnosis suggest that a coherent approach to assessment and diagnosis does not exist at present and, therefore, respondents would appear to be relying mainly on their subjective experience to assist formulation and diagnosis. Respondents’ subjective experience may be comparable to that experienced by professionals working with younger people with a
borderline personality disorder. It was not within the scope of this survey to consider whether formulation and diagnosis was shared with the older people accessing these services or whether diagnosis was used therapeutically to tailor care accordingly, although respondents’ comments might suggest that discussions of this nature had not taken place. It is recognised that sharing formulation and diagnosis with patients would have been an area worthy of consideration for the purpose of this survey.

The information taken from the questions associated with ‘teamwork’ suggests there can be a considerable number of professionals involved in the care of someone with a personality disorder at the same time and responses reveal that coordination of care, among other things, has proven to be difficult. The analysis of the data suggests there’s a need to develop a more coherent team approach to working with this group of people, as on occasions, team boundaries would appear to have ruptured and this seems to have had a compromising effect on the professional’s confidence and clinical practice.

The section on ‘treatment’ was difficult to analyse objectively as many treatment options offered are not specific treatments for people with a personality disorder, although may be beneficial. In the absence of more specific treatments for older people with a personality disorder, it would appear that the majority of respondents have been utilising every resource available, including using team colleagues to support and assist their practice. This may also account for the high incidence of medication use; medication is relatively easy to administer and to monitor and can help ease distress. The information extracted from the qualitative data on the ‘helpfulness’ of the treatments presented in Table 1, highlighted mixed views. Furthermore, some respondents highlighted the need to develop skills and expertise to assist their practice and there appeared to be a consensus from respondents’ comments that they would benefit from guidance, support and training as all qualified respondents did not feel confident in this area of their work.

It is accepted that the anomalies associated with the design of the questionnaire may have distorted the results to some degree. However, a large proportion of respondents consider they are working with older people with a personality disorder and that this work in community mental health teams is complex. If a more coherent and consistent approach to assessment, diagnosis and treatment was available professionals may feel better equipped to identify and work confidently with older people with a personality disorder. If this could be achieved, changes in practice and a more accurate and effective use of resources could result.

**Outcome**

The most significant outcome following the inception of the NICE guidelines for the treatment and management of borderline personality disorder (2009), and also from this survey, has been the introduction of ‘PACT’ (Personality, Assessment & Consultation Team – see Jo King’s paper elsewhere in this Newsletter). Much work has still to be done to raise the profile of personality disorder in older people in Kent & Medway NHS & Social Care Partnership Trust and pool ideas and resources to add weight to the argument that this area of work requires more attention. We’re not there yet, but it is hoped that the ‘PACT’ will help pave the way.

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PSIGE Newsletter, No. 111, July 2010
Personality Disorder: Developing services through the re-distribution of resources

Jo King

This is a story about how small ideas can give rise to bigger things. It happened in the Older People’s Mental Health Services in Kent & Medway Partnership Trust. When the NICE Guidelines for Borderline Personality Disorder were published in January 2009 the Clinical Governance/NICE Implementation Committee turned to the Clinical Psychology Services for Older People and asked us how we could contribute to the implementation of this guideline. People who know the guideline will have seen that the role of the psychology is deeply embedded in it. However, with there generally being only one qualified clinical psychologist in each CMHT, it was difficult to imagine how they could spread themselves as thin as to provide any sort of psychological intervention for significant numbers of people with personality disorder, or even specifically, borderline personality disorder.

The Trust is divided into three parts: East, West and Medway, the latter being the smallest area of the three with three CMHTs. The West at that stage had five and now has only four CMHTs while the East has six. Because the Trust is very spread out and it was difficult for a psychologist/therapist from each CMHT to meet on a regular basis, three of us (Liz Gordon, Alison Kirkpatrick and myself) from the West and Medway, decided to form a small committee to see what ideas we could come up with. What we decided to focus on, based on our own experiences, was the fact that people with personality disorders are often difficult to manage, that they often consume more of the team’s time, energy and resources than other types of patients and that, in fact, personality disorder is often, within teams, regarded as ‘a diagnosis of exclusion’ (NIHME, 2003).

At the same time as we established our committee, the Trust took the initiative of running a full-day conference on borderline personality disorder. This was in November 2009. Our Older People’s Clinical Psychology Specialty was asked, at very short notice, to put on a workshop to cover the over 65s aspect of borderline personality disorder. This turned out to be a useful exercise for generating new ideas and for gathering together research findings about personality disorders in older people. It also produced the results of a survey undertaken in the West and Medway (co-ordinated by Liz Gordon – see article elsewhere in this Newsletter) about CMHT staff attitudes toward, sense of confidence in dealing with, and estimations of numbers of people with personality disorders. All this information was used for the conference workshop and later re-used in a modified form at a follow-on workshop in February 2010.

From these workshops our ideas began to crystallise. Within the constraints of having no extra resources at our disposal, since the Trust was trying desperately to achieve Foundation Trust status and needed a capital surplus to do this, we decided we could best use our skills if we provided support to the staff working with people with personality disorders rather than the patients themselves. We did not envisage this as us simply going back to our teams and making ourselves available for supervision; we wanted it to be more than that. We felt that what psychology is especially able to offer in a team context is supervision through reflective practice. It is a skill psychologists hone in their training years and afterwards.

Since the guidelines make it clear that dealing with patients with personality disor-
Personality Disorder: Developing services through the re-distribution of resources

Personality Disorder requires a group approach we foresaw that the psychologist in any particular team might well be one of the CMHT members involved in the care of a ‘difficult-to-manage’ patient. We felt this could compromise their reflective stance because of our belief that supervisory reflective practice is likely be more effective when the facilitator is able to be slightly separate from the team or group they are acting as facilitator for. Being slightly separate meant that they would be less likely to get involved in the team dynamics with which we would be working.

So we felt that if a team needed supervision around the management of a difficult patient, two psychologists from a single or two separate teams other than their own, would get involved. In other words, this was going to require across-locality working.

We had also decided that we would do the supervision in pairs, or rather ‘consultancy’, as we preferred to call it, because as our ideas developed we recognised that our approach was going to involve more than just supervision. We felt having at least three people available to do a consultancy gave us more flexibility in deciding which two would meet with a particular team. We also decided that when we met with a team, in an effort to model what we felt might be important issues in the team, we would be very clear about our roles and about the process. We felt this would have a containing effect for a team that we could assume to be struggling in one way or other – otherwise they wouldn’t have called on our help.

In terms of the consultancy process, we developed a referral form in which we made sure we got clear information about risk issues and whether a risk assessment had been done, as well as the names of all the staff involved in the patient’s care and their roles, and in particular, who the care co-ordinator was. We insisted that the team ‘buy in’ to the service by completing the form and by all of them committing to having all the staff present at the meeting. In practice, this has not always happened. The tone we wanted to set for the meeting was for teams to take ownership of the process and for us to be merely the facilitators.

From our discussions and Liz’s survey mentioned earlier, we became aware of two other ways in which we could contribute to helping teams deal with ‘difficult-to-manage’ patients, namely assessment and training. But before I go on let me explain my change of terminology from the initial ‘borderline personality disorder’ to ‘personality disorder’ to ‘difficult-to-manage patients’. Although the initial impetus for developing this service came from the NICE Guidelines for Borderline Personality Disorders and the Trust’s own NICE Implementation Team, in the course of our deliberations we came to accept that it made more sense to work with the broader scope of personality disorders rather than just ‘borderline’ patients as it is often difficult to specify the type of personality disorder that is presents in older patients. There is literature to validate our stance, but we also recognised that older patients often present differently to younger patients (Morris, 2009). We were aware that types of personality disorder are often not specified when a diagnosis is given, but also, and perhaps more frequently, a diagnosis is avoided altogether. We thought there were two main reasons for this: one was that personality disorders are stigmatising, and the second was that the staff member involved may not have the confidence to speak in terms of a possible diagnosis for fear of being wrong, and perhaps to the detriment of the patient. Our inclusive approach, therefore, was in line with the NIMHE guideline, Personality Disorder: No longer a diagnosis of exclusion (NIMHE, 2003). We felt it was more helpful for staff and patients to know what they are struggling to manage, than to try and deal with something that cannot be spoken about. However, we did recognise that making a diagnosis can sometimes be difficult, not just from an emotional point of view but also a professional one. To this end we felt, as psychologists, we would be well placed to apply recognised psychometric tests that, taken together with the history
and the clinical presentation, could be helpful in delineating the diagnosis where this seemed appropriate. The test that we found suited our purposes was the Millon. The Millon, or more correctly, the Millon Multi-axial Inventory-III (3rd ed., 1997) is a self-administered inventory that produces three types of scales. The first group of scales give an indication of the patient’s approach in responding to the questionnaire – were they too positive or too negative, too open or too closed? The second group of scales provides a picture of the person’s enduring personality traits or their personality style. This group of scales is useful in diagnosing a personality or Axis II disorder, with the types of disorders corresponding to those in the DSM-IV. The third group of scales deals with the person’s current functioning, the Axis I disorders. The Millon is especially useful in helping a clinician decide whether they should be paying more attention to the Axis I or Axis II issues.

The psychometric assessment brought another element to our intervention which we believe psychologists have grappled with more than other professions, namely, pre-diagnostic counselling. We felt that if, in conjunction with the staff team, it was decided that we should do personality testing in order to establish a diagnosis or provide more information about the patient’s personality functioning, then it was important this should be done with the patient’s consent. This would require involving the patient and enabling him or her to make an informed choice about taking the test, what the implications might be and to do this with a clear and sympathetic explanation of the process and any diagnostic results that might come up. We felt it was important for the care co-ordinator to obtain the patient’s permission and to prepare them for the psychometric assessment before they meet the psychologist who does further pre-diagnostic counselling.

We did not want to use a questionnaire that only targets personality disorders as we thought it more useful to have an in-depth understanding of the patient’s functioning. We felt this was more in keeping with a ‘person-centred’ approach where the individual’s total functioning comes under scrutiny, including the extent to which enduring personality patterns or traits have helped the person to cope or come to terms with their environment. In keeping with the Recovery Model (Turner-Crowson, 2002) we felt it was important to emphasise the patient’s positive attributes. Also we felt it was important because of the stigmatisation that accompanies the term ‘personality disorder’ to begin by talking of our referrals as ‘difficult to manage cases’. This would give patients the chance to gradually come to terms with their diagnosis, where it seemed appropriate to introduce it into the process, rather than to label them before we had even met them. In this regard, it is interesting to have come across a similar service in Cambridge that has been named the Complex Cases Service (www.complexcases.org). After debating whether or not ‘personality disorder’ should be used in the title of our service we adopted the name the Personality Assessment and Consultancy Team or PACT. We felt the drawback to this was that other professionals may not identify it as a service to help them deal with patients with personality disorders, but we hoped that in due course, if we succeeded in what we were trying to do the name would carry its own associations.

In further refining our intervention we decided to use a ‘stepped’ approach. The assumption is that all staff teams begin at Step 1, that is, Supervision or Consultation. They may decide that this is all they need or they may decide to progress to Step 2, which offers Pre-diagnostic Counselling and Assessment. Again this may be as far as they wish to go once they have the outcome of the formal assessment and diagnosis, or they may proceed to Step 3. PACT’s approach is not to get involved in treatment at an individual level but to support teams in providing this themselves. Step 3, which we want to develop in the future when Steps 1 and 2 have been consolidated, would involve an across-
locality therapeutic group, possibly progressing to a Therapeutic Community model, which would serve patients whom we feel would benefit from long-term group intervention.

A fuller discussion of the three steps involved in our stepped model is given below.

**Step 1 – Consultation:** The PACT team meets with staff teams to discuss a complex case and provide guidance to assist staff with containing and managing difficulties, part of which may include assisting staff with devising ‘Care Plans’ and ‘Action/Contingency Plans’ to manage risk during crises. The process begins by having all the staff involved in the patient’s care sitting down with the two members of PACT available for the consultation. One of the PACT practitioners sets the scene and then listens to the team present the case, while the other one observes and may ask questions at the end to clarify the picture (a version of the co-consultancy model). At this point the process is interrupted while staff team take a break and the PACT practitioners discuss what they have just heard and formulate a response. The CMHT and the PACT team come together again after about half-an-hour. The PACT team convey to the staff team what they think the issues are, as well as providing guidance on what might be a useful approach with the patient involved. Particular attention will be paid to the dynamics in the team and how these contribute to the staff’s approach to the patient. If appropriate, this is discussed with the team. The staff team may be offered follow-up supervision, and consideration is given then or later at follow-up, to the appropriateness of proceeding to Step 2.

**Step 2 – Consultation and Assessment:** The assessment and diagnostic process enables the PACT team and the CMHT to develop a deeper understanding of the patient’s difficulties and personality type. If formal assessment and diagnosis is considered to be in the patient’s best interest, the PACT practitioners advise the staff about preparing their patient for assessment. A staff member does some preliminary pre-diagnostic counselling and obtains the patient’s consent for meeting with the PACT team.

After the PACT practitioners have done further pre-diagnostic counselling and created a rapport with the patient, the Millon is administered and scored. The patient is then invited to a feedback session, either on their own or with the staff team. An explanation of the test results, a formulation of the patient’s problems, how these impact on their life and on their relationships with other people, including the staff involved, whether this suggests a diagnosis, are all points covered in the feedback session. If the patient elects not to have the team at the feedback session a staff team session is arranged. As before, the consultancy team makes recommendations to the staff to assist future patient care and treatment and offers follow-up supervision, where this seems necessary.

**Step 3 – Treatment with the PACT:** As previously mentioned this aspect of the service is still being considered. It will involve group intervention and will probably rely on Schema Therapy, Mentalisation-Based Treatment, and the STEPPS approach. An Outreach Group and a Therapeutic Community, as mentioned above, are possible future developments.

**Step 4 – Training:** There are two aspects to the training. One is aspirational and will evolve out of Step 3, where, once we are more confident with the therapeutic techniques discussed above, we can offer training to staff teams. The second is more embedded in our own model for delivering this service. Our aim is to develop a team of PACT practitioners drawing from the psychologists and therapists in the Clinical Psychology Service for Older People. The way we intend to do this is by ‘modelling’ our approach to other practitioners. When a referral is received, the psychologist or
therapist wanting to join the consultancy team will be paired with one of the three existing members (Liz, Alison or myself) and will take on the observer’s role in Steps 1 and 2. They will repeat this until they feel confident enough to be paired with someone else who wants to join the PACT team. In this way we will develop a group of PACT practitioners skilled in offering a service to teams who are having difficulty with managing particular patients.

**Step 5 – Service evaluation:** This is actually not a different step but is embedded in the previous steps. It relates to the development of a team of practitioners skilled in providing supervision and support to staff teams. We want to develop the service and evaluate it at the same time, by using Action Research. Action Research traditionally resides in the field of education, but we want to use its methods in this context. It is based on a process of reflection – feedback – change – reflection. We will present a particular piece of consultation work to the broader Clinical Psychology for Older People Service and ask them to reflect on their observations of the process. This will be fed back to the PACT team, who will try and incorporate it into their practice with their next referral. The consultancy process that results from that referral will in turn be presented to the whole team for its feedback, in a continuous loop.

Anyone reading this will have noticed that much of what has been presented here is aspirational. We have the skeleton of a service and lots of enthusiasm to go with it – watch this space to see where our attempts to develop a service without extra resources end up!

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**References**


This short paper is an initial response to interest and enquiries received from colleagues following a workshop on professional self-care commissioned by South Thames PSIGE earlier this year. We approached the writing of this paper in the way we would the design of a workshop, as a distillation of ‘work in progress’, beginning with our own and our colleagues’ direct experience and working outwards. We are grateful to PSIGE South Thames for offering us this opportunity to describe and reflect upon the impact of this application of the Co-consultation Method, which is currently little known as an accessible form of individual and team development within the clinical psychology profession.

We both originally trained as clinical psychologists. One of us (SD) then moved into organisational and management development consultancy, much of it with the NHS. The other (RD) trained as a psychoanalyst and continued to work in the NHS and independently with a specialist interest in later life.

The current climate within the NHS is often experienced as inimical to thinking and the basic tenets of reflective practice. Space to think is increasingly hard to develop and protect. We have noticed a concomitant curiosity and hunger from determined, motivated colleagues to find ways of continuing to survive personally and professionally in these lean times.

This outline of co-consultation as a cost-effective ‘professional health and safety risk lifebuoy’ complements RD’s earlier paper (2009). Co-consultation is a further addition to professional health and safety armoury given the increased risk to staff of stress and burn-out in the current climate. It can be drawn on by hard pressed professionals at all levels seeking to keep themselves afloat amidst the tough demands and pressures of the recession. It is clear that colleagues are increasingly going to need to take responsibility for their own professional self-care, with severe pressures on time and funding for CPD in many NHS and Social Care Trusts.

We will describe some aspects of the Professional Self-Care workshop and our preliminary thoughts on the process. We hope that it will be of help to you in your own practice and place of work.

The Workshop
Core to our workshop and training approach is a detailed centring and articulation of each individual’s clinical and managerial practice. This lies at the heart of the unfolding process as the day develops, with workshop design ensuring that leading preoccupations, pressures and themes identified by participants are articulated and addressed.

The Process
One of us (RD) was approached to run a workshop on professional self-care for South Thames PSIGE. Her reflections on the process are:

‘The challenge, as workshop organiser, was how to communicate the importance of providing an opportunity for protected thinking space as a powerful means of containing each individual...’
staff member’s experience. This is the essence of my work running long-term, psychodynamically informed work-discussion groups for staff. I sought a way of offering every workshop participant the opportunity of speaking, of observing and of reflecting back within the limits and possibilities offered by a one-day workshop.

SD introduced me to the co-consultation method, which she had used extensively in her development work with leaders and managers. It offered a means of giving participants an opportunity to speak about their experience and, crucially, to feel their experience had been fully taken in and attended to. The method seemed congruent with my approach as a psychoanalyst to working with individuals and groups. Together we considered how it might be applied to the brief PSIGE had given me.

At the beginning of the South Thames PSIGE day, drawing on mindfulness practice (Segal, Williams & Teasdale, 2002; Santorelli, 1999), I invited colleagues to sit quietly and look back at the previous day, week, month and year considering what had been happening for each person in their own place of work. From a cognitive-behavioural perspective, this acts as a memory prompt. Psychoanalytically, we are beginning free association: each person can allow whatever they want to come to the forefront of their mind, and that is valued as the basis for the work of the day. This quiet, associative space provides a foundation stone for all that follows.

Participants form groups of three. Each member of the group takes, in turn, the role of Speaker, Listener or Observer.

1. Speaker: talks for 10 minutes about particular challenges and pressures that came to mind during the thinking period at the beginning of the day.
2. Listener: listens carefully to the Speaker’s words and how they are said, then briefly reflects back the essence of what was heard as accurately as possible once the Speaker has finished talking.
3. Observer: observes and then comments very briefly on the interaction between speaker and listener.

The roles rotate, giving each member the opportunity to speak, listen and observe. Participants come back together in a large group plenary to reflect on the whole experience, with a particular emphasis on what it was like to inhabit each role. The approach was experienced as surprisingly powerful and helpful. Initial anxieties were sometimes experienced in the Speaker role, followed by relief at being fully listened to. The roles rotated within each trio. Taking up each role in turn gave continued insights and a sense of perspective. The Listener role was, to an extent, familiar from clinical practice. The Observer role was more novel, and experienced as the most complex role to take up.

It was surprising to many that so much of value, in terms of each person’s individual and shared experience, could be derived from such a brief (15 to 20 minutes per round) and tightly time-boundaried experience.’

Origins and history
Co-consultation derives from practitioner development. Designs of the sort used in the professional self-care workshop have been an integral part of SD’s work as an organisational consultant for many years. She was first introduced to this approach by colleagues at the King’s Fund, and in the world of Group Relations. The origins are at least two-fold. One strand derives from the development of methods for Action Learning Sets, drawing on the work of Reg Revans (see, for example, Pedlar, 1983; McGill & Beaty, 1992; Young, 2010), tending to be relatively cognitive-behavioural, and codified in experiential learning methodology (Kolb, 1984). In a similar vein are Donald Schön’s work on the reflective practitioner as a model for developing professional competence (Schön, 1991) and process consultation, originally developed by Edgar Schein (Schein, 1999) and colleagues at MIT some four decades ago, and now widely taught and applied in organisational development. The other strand lies within a psychodynamic and systemic tradition from work in Group Relations begun by the Tavistock Institute and subsequently developed by networks of individuals and organisations world-wide (www.grouprelations.com). An interesting
connection is Revans’ early work with Eric Trist of the Tavistock Institute, for the National Coal Board, and the continuing relevance of Bion’s (1963) theory of container-contained for individuals, groups and organisations.

Schön (1991) describes the nature of good professional practice and the way in which it is acquired. Rather than health and social care, his starting points include architecture and music. He suggests that the pursuit of good practice in the real and messy world we work in seems ‘Of the greatest human concern.’ He likens this world vividly to ‘a swampy lowland’ where messy and confusing problems often defy technical solution, unlike the ‘high, hard ground (where) manageable problems lend themselves to solution through the application of research based theory and technique.’

Much of the recent literature on co-consultation in professional practice and development focuses on the use of shared expertise. Less widely recognised is the importance of emotional containment in professional practice. Our experience strongly suggests that it is of fundamental importance in all human services, especially those working with people who present with psychological needs. Yet it was in the airline industry nearly 30 years ago that the concept of ‘emotional labour’ was first widely applied (Georgiades & Macdonnell, 1998). We have been struck by the powerful and valuable learning experience which this method yields in working with clinical psychology colleagues, and, at the same time, puzzled and intrigued that it is not more widely known.

Why is it powerful and valuable? Some hypotheses

For us, the experience of offering this approach in workshops with clinical colleagues is at least as striking as their own experience of using it. We have a number of hypotheses to offer about what may be happening and why it is particularly valuable at this time.

1. Older people and those who work with them are faced with profound issues of deterioration and loss, and strong external pressures to minimise their significance. They are likely to be particularly vulnerable to ongoing marginalisation. This could be seen as a manifestation of powerful institutional or systemic defences that protect against a truthful awareness of appropriate dependency needs for staff as well as clients (Obholzer, 2005; Menzies-Lyth, 1988; Davenhill, 2007). Where they exist, regular facilitated groups for staff to discuss such feelings and issues are highly valued. However, they are not routinely provided for clinical psychologists or other NHS and social care professionals working with people who are older.

2. Co-consultation provides some degree of containment of the strong feelings (transference and counter-transference) inevitably engendered in staff working at a high level of complexity in old age services with patients, families and staff teams.

3. Feedback from workshop participants emphasised the degree of relief and containment for the person in the ‘Speaker’ role in discovering that their experience could be taken in by the Listener, and for the relationship between Speaker and Listener to be further processed, digested and reflected back by the person in the Observer role.

4. By taking up the roles of Listener and Observer, people are able to distance themselves a little from the intensity of experience, and to have space to think, to articulate, and thus to process and to understand better the emotions and dynamics of the work setting.

5. Together, the members of the trio and then the whole group discover that previously unarticulated and often fragmented experience (thoughts and feelings) can be put into words and thus become available for learning. This process diminishes stress and anxiety.
6. It is likely that the safe environment for disclosure which the co-consultation creates enables participants to discover that their experiences are not unique. The creation of fellow-feeling which follows can in itself function to relieve anxiety and build connection.

7. No solutions are sought, and none are offered in co-consultation. Containment and a degree of empathy are powerful in themselves, for reasons familiar to us all from our training and work with our clients and patients.

Ruch (2007) clarifies this process further. Her paper on containment in child social work resonates with the dynamic processes we have noticed in running professional self-care workshops for psychologists working at the other end of life. She writes, ‘The containing experience is initially channelled through the relationship between the person(s) acting as the container, but there is potential for the individual to internalise the experience and process thoughts and feeling in a dynamic and inter-related way (Pietroni, 1995) … The linking of feelings and thoughts generates emotional and cognitive development – thoughtfulness – and contributes to the construction of structures for thinking … Immediate solutions to sources of anxiety may not be forthcoming, but the experience of containment is sufficient to offer relief and enables individuals to keep going (Hughes & Pengelly, 1997). Containing contexts offer practitioners the opportunity to confront the obstacles that hinder the development of reflective practice.’

We conclude that structured, time-boundaryed co-consultation offers a valuable and effective contribution to professional self-care, which costs only the time which it takes to do. We are grateful to South Thames PSIGE for stimulating us to describe in this introductory article, how it was used in the workshop, and to begin to think about why colleagues working as psychologists with older adults found it so powerful. Our thinking continues, informed by further practice.

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References


THE Division of Clinical Psychology (DCP) works to represent your views at a local and national level, to inform you and consult with you about national issues and support continual professional development (CPD). It tries to advance your development as a practitioner, promote your profession, disseminate information, develop standards of good practice, influence national policies and co-ordinate responses to national policies on behalf of the profession. As part of the British Psychological Society (BPS), your professional body, the DCP works for you as a clinical psychologist and does a great deal more than the new Health Professions Council (HPC), which went live as a regulator on 1 July 2009.

In essence, the main aim of the DCP is to promote clinical psychologists as the experts in psychological health and well-being. In contrast, the HPC, which regulates a total of 14 health professions, aims to protect the public (rather than supporting you) by maintaining and publishing a public register, investigating complaints, and approving and upholding standards of education and training. Its work is done in conjunction with appropriate professional bodies, such as the DCP/BPS, for example, its standards of practice are drawn from professional standards developed by the DCP/BPS. The HPC, therefore, listens to and to some extent relies on the DCP/BPS. How then is the DCP organised?

DCP structure
The DCP has about 9000 members and is currently chaired by Jenny Taylor. It is made up of various bodies:

- DCP Executive Committee made up of the Chairs of the Four Nations (England, Scotland, Wales and Northern Ireland), Unit Directors (e.g. Policy Unit, Professional Standards Unit, Membership Services Unit and Professional Governance Panel), honorary secretary and honorary treasurer and SULC member.
- Service User and Carer Liaison Committee (SULC).
- Five DCP service area leads: Child, Adult, Older People, Clinical Health, People with Learning Disabilities.
- Specialist Faculties.
- Branches – co-terminus with strategic health authorities (SHA).

PSIGE and the DCP
As you can see from the above, Older People is a faculty of the DCP and is able to report back your views to the national committees as well as having PSIGE representation on local DCP branches. You are, therefore, able to influence national policies relating to older people through the DCP.

Work related to older people is seen throughout the organisation. For example, the Professional Governance Panel (PGP) has commented on draft documents on Guidelines for Dementia Assessment in Learning Disabilities and Assessment of Effort in Cognitive Testing (see website). Recently, a policy on ‘Appraisal for Screening for Alzheimer’s disease’ was commented on. In the past, the DCP has been allocated places as stakeholders on DOH consultation committees for national
polices relating to older people – in addition to places allocated to PSIGE, thereby strengthening our voice.

Your local DCP branch can also help you fund CPD activities in your area and often contributes to local PSIGE events. There are also future plans for a joint national conference between the DCP and SIGs. If you are interested, please get involved.

For further information, please see the DCP website which will have a list of publications, conferences and events as well as information about your local DCP branch in the members’ area.

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Division of Clinical Psychology
www.bps.org.uk/dcp/
Forthcoming Events

JULY 2010
9/10 Annual ACAT Conference. University of Hertfordshire, Hatfield.
20–23 BABCP Conference. Manchester. (Ken Laidlaw CBT with Older People, 20 June; PSIGE IAPT Stream, 21 June)

SEPTEMBER 2010
9  PSIGE Training and Development Subcommittee Meeting. Guy’s Hospital, London.
10 IAPT with Older People, PSIGE Training Event, Southwark Training Centre’s Lecture Hall, Maudsley Hospital Site.
22–24 PSIGE National Committee Strategy Meeting. Parcevall Hall, Appletreewick, Skipton, North Yorkshire BD23 6DG.
22 IAPT in Scotland. Claire Donaghey, Donna Gillroy and Vicky Thirlby (NES Scotland Psychology rep Geraldine Bienowski, Angela Harris, Katherine Quinn)

NOVEMBER 2010
24 Psychotherapeutic Work with people with Dementia. Rik Cheston, PSIGE Training Event, Archway House, Cardiff.

DECEMBER 2010
1–3 DCP Annual Conference. Lowry Hotel, Manchester.

MARCH 2011
22–23 Therapy with Older People Joint Charlie Waller Institute, PSIGE Training Event.

JUNE 2011
16–17 PSIGE AGM and Conference hosted by PSIGE Scotland. Lorne Kelvin Park Hotel, Glasgow.
Notes for Contributors

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

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

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

References should follow conventional format as in journals such as Psychological Review:
(1) Book reference:

(2) Journal article:

(3) Paper in a book:

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

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

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

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

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

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

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

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

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

When submitting articles please send the following information:
Full name;
Affiliation (title, place of work);
Contact details (should you be willing to be contacted by the membership);
Acknowledgements (as appropriate).

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

All contributions should be sent to: louisa_shirley@hotmail.com
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