

# Psychosocial Intervention: Memory Clinics and Evidence Based Practice

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25 March 2011

# Overview

- Psychosocial Intervention – Definition
- Early versus Later Interventions
- Examples of Evidence-based Early Interventions
- Applying Psychosocial Intervention

# Psychosocial Interventions

## What are they?

- Interventions involving interaction between people, to support cognition, emotion, interpersonal relationships and a sense of control
- In people with dementia and their family 'carers'
- Through valued, meaningful activity and social integration.

# Early Intervention - aims

- To reduce the risk of psychological and social disability later in the dementia process
- Suppress mood disorders by
  - Facilitating adjustment
  - Promoting health and well being
- Both the person and the carer
- 'Prophylactic' - not reporting concerns
- Effects seen later in the care process
  - Continuity of care and case management

# Later Interventions - aims

- To treat existing distress or disability
- ( BPSD / Challenging behaviour)
  
- Actively reduce (as opposed to suppress) distress or disability

# A 1<sup>st</sup> example

## Cognitive Rehabilitation in a Memory Clinic 1998

- Carer mood /stress: meta analysis Brodaty et al 2003: effect size for psychological morbidity in family carers 1.81 (0.94-2.67) for PSI vs usual care in a Community Mental Health Team

 *Aging & Mental Health* (1998); 2(3):199–211

ORIGINAL ARTICLE

**A preliminary study of the effects of early intervention with people with dementia and their families in a memory clinic**

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**Abstract**  
A brief individualized intervention comprising of information about diagnosis and prognosis, reinforcement of coping strategies, crisis prevention advice and memory management programmes was offered to newly diagnosed people with dementia and their families, prior to referral to the services of their local psychogeriatric community support team. The local psychogeriatric community support team of the experimental group. Carer likelihood of the breakdown of home and note an interesting relationship between memory ability in people with dementia and carer strain. Our results can only be fully understood in the context of methodological improvements. These are outlined, for the purpose of future replication.

# Cognitive rehabilitation in early stages of dementia

- Examples of personal rehabilitation goals
  - Using a notebook or diary to keep track of events
  - Keeping track of spectacles, keys, handbag
  - Managing medication
  - Making and using a memory book
  - Used clock to reassure herself (repeated phone calls)
  - Learned faces of support workers – prevented strangers entering the home

# 'Prophylactic' multi-component PSI in a Memory clinic - aims

- Maintain health and well being in older people with dementia
- Provided individualised support to both person and family 'carer'
- Case management - Interfaced with primary care for case management

# The meaning of dementia for older people & families: 50 dyads 2006

## **Loss of 'self'**

Mind [Insensibility]

Function [Mobility, Contenance]

Relationships & Meaningful Company

[Conversation, Doing things together]

## **Future - Uncertainty**

Family upset [plans for retirement 'dashed']

Care Home Inevitable [Put away, No meaningful activity or relationships]

# The meaning of dementia for older people & families: 50 dyads 2006

ARTICLE

## Facing the future

*A qualitative study of older people referred to a memory clinic prior to assessment and diagnosis*

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**Abstract** This article describes a qualitative study of the understandings of dementia held by a sample of 48 older people and 48 family members, who were interviewed separately, prior to assessment at a UK memory clinic. Most of the older people awaiting assessment described their lives as having purpose, meaning and pleasure for themselves and others. However, these individuals, who later received a diagnosis of a dementia, and their family members, perceived dementia as a loss of mind, associated it with loss of bodily functions (continence and mobility) and considered that it would negatively affect personal relationships and pleasure. For many, the consequences of dementia were predicted to be family upset, inactivity and an inevitable relocation to a care home. Most of the individuals and their family members showed a mutual concern for the future well-being of each other. The findings are reported with reference to an illness Representation model, which captures a participant's appraisal or perception of a "health threat", in other words, the possibility of a dementia diagnosis. Service developments are proposed that acknowledge the personal strengths and concerns of memory clinic attendees and their families during this liminal time of waiting for assessment and possible confirmation of dementia. Advice

dementia  
dementia  
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VOL 5(3) 3

# A 2<sup>nd</sup> example

## Individualised family-based multi-component programme

- The development of the intervention
  - Diagnostic Disclosure (Separating Brain from Mind in the dementia diagnosis)
  - Single-case studies from the previous study
  - Manual – up to 6 individual home-based sessions
  - Case Management – longitudinal tracking

# Memory Clinic Multi-component Intervention

- Diagnostic Disclosure - Separating Brain from Mind in the dementia diagnosis (experimental and control)
- Optional Workshop (s) on Understanding memory (PwD /family) and on emotion orientated communication
- Physical health promotion: diet and exercise medication management & timely treatment (minor health problems)
- Cognition - orientated interventions to enhance in-home episodic memory structure & use of memory aids
- Social withdrawal - preventing depression through pleasurable and meaningful activity (Behavior Activation)
- Case Management – Maintenance

# Randomised Controlled Trial of PSI: Memory Clinic - 50 dyads, 2000 Person with dementia - 6 & 12 months

- 'Memory' – both groups worsened  $F= 3.815$   
 $df,1,36$   $p=0.059$  ◇
- Mood – CMHT supported group depressed  
 $F=7.87$   $df,1,42$   $p=0.0048$  \*
- Behaviour – CMHT supported group - more  
behaviour problems  $F=8.883$   $df,1,42$   $p=0.008$  \* as  
the year progressed  $U=72$   $p=0.025$  \*◇

# Randomised Controlled Trial of PSI: Memory Clinic – 12 months Person with early dementia

- Psychotropic drugs – control group more  
35% up 48%; 36% down 32% *NS*
- Care at home - experimental group more  
92% vs 65%  $p=0.022$  \*

# Randomised Controlled Trial of PSI: Memory Clinic

## Carer

- Management (mood) – control group worse  
 $F=7.213$   $df,1,43$   $p=0.0102$  \*
- Management (mem & beh) control worse  
 $F=6.84$   $df,1,41$   $p=0.013$ \*
- Competence - control group worse  
 $F=4.809$   $df,1,35$   $p=0.035$  \*
- Carer coping with behaviour control worse over time  
 $F=5.033$   $df,1,32$   $p=0.032$  \*◇
- Carer mood *NS*

# Randomised Controlled Trial of PSI: Memory Clinic - Summary

Person with dementia - 12 months

- 'Memory' – both groups worsened
- Mood – CMHT supported group depressed
- Behaviour – CMHT supported group – more behaviour problems as the year progressed
- Psychotropic drugs – control group more  
35% up 48%; 36% down 32%
- Care at home - experimental group more  
92% vs 65% \*\*\* Survival Analysis at 10 year f/up

# A 3<sup>rd</sup> example

## Joint Reminiscence Groups

12 Sessions and 7 maintenance

Active, large group approach, involving people with dementia and carers; Volunteers also participate; Facilitators are supervised

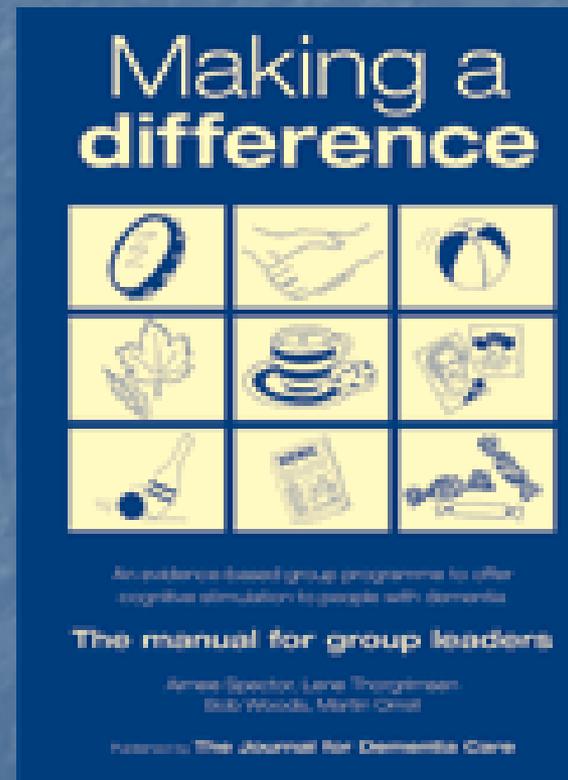
- Introductions – names and places
- Childhood and family life
- School days
- Starting work
- Going out and having fun
- Courting & marriage
- Homes, gardens & animals
- Food & cooking
- The next generation – babies & children
- Holidays and journeys
- Festivals & special days
- Rounding up & evaluation

# A 4<sup>th</sup> example

## Cognitive Stimulation

### NICE

- Recommended in NICE-SCIE Guideline in UK



# Themes from CST - 14 sessions (from Spector et al, 2006)

- 1 Physical games
- 2 Sound
- 3 My life
- 4 Food
- 5 Current affairs
- 6 Faces/scenes
- 7 Associated words; discussion
- 8 Being creative
- 9 Categorising Objects
- 10 Orientation
- 11 Using money
- 12 Number games
- 13 Word game
- 14 Team games, Quiz

# Cognitive Stimulation and Rehabilitation: 'men with dysexecutive symptoms'

Wilson et al

- Adapted to use memory aids in social situations
- Each had individual goals to achieve
- Adapted the CST programme
- In session behaviour improved
- Men reported improved satisfaction with their memory
- Partners only agreed once their own needs had been addressed

# A 5<sup>th</sup> type

## CMHN training in PSI (2008)

- 29 CMHNs Control Group; 9 Experimental Group – Trained; 6 CMHTs; Training – 6 sessions
- Problem Solving with Family Carers
- Functional Analysis (behaviour management)
- Group Supervised practice – weekly, fortnightly, monthly, 2 months, 3 months

# CMHN training in PSI (2008)

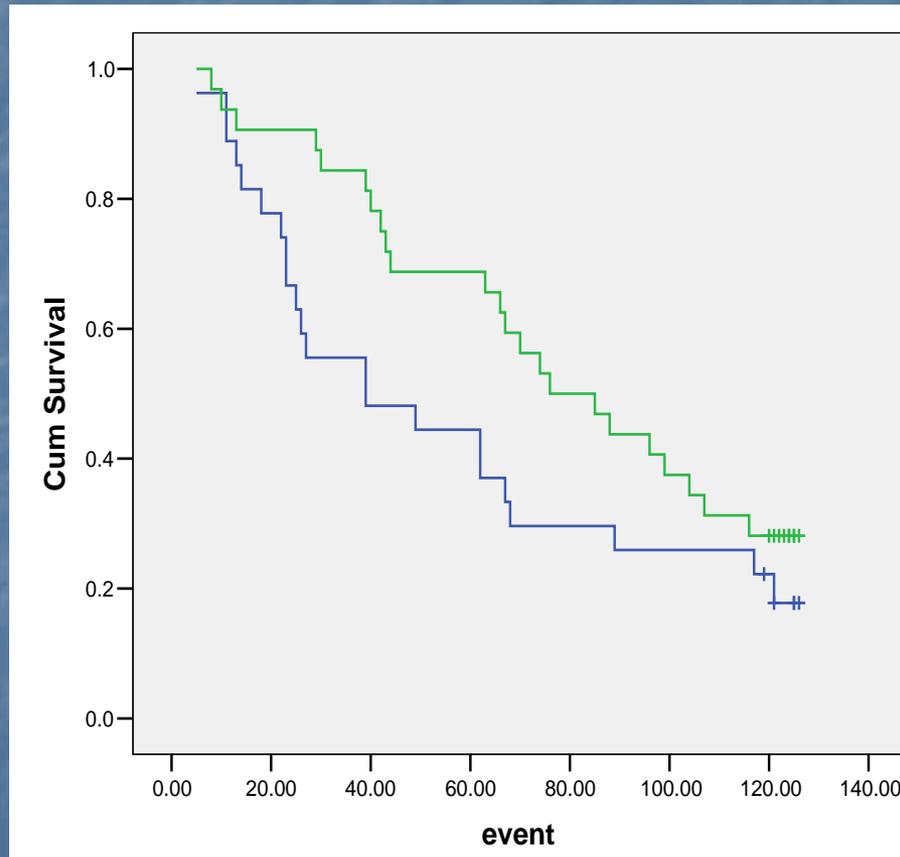
113 carers; 18 months

- Memory declined in both groups, greater decline over time in experimental group
- Behaviour problems & management – similar at 6 months; reduced in experimental over 18
- Carer anxiety: experimental worse at 6 months but no difference at 12 & 18 months
- Carer Depression: Intervention suppressed carer depression in experimental group by 12 & 18 months
- But outcome was dependent on the individual 'trained' CMNH

# Living well with dementia

## PSI for family carers .. 10 years on

Moniz-Cook et al



# What works in psychosocial interventions

## Family Carer Interventions

Brodaty et al 2003

- Involve both person and carer
- Focus on the carer's personal needs

## PSI for people with dementia

- Active involvement - person Vernooij Dassen et al 2008
- Individualised multi component intervention have better outcomes for patients Finnemra 2003

Care Co-ordination (continuity of care ) underpins most multi-component interventions

- Practitioner has access to regular specialist support

# Some Early Interventions

- Group Cognitive Stimulation PwD **Spector et al 2003**
- Individualised Cognitive Rehabilitation
- Multi-component individualised memory clinic
- In home occupational therapy **Graff et al 2006**
- Reminiscence Therapy Couples Groups **Woods et al**
- Timely information – people and carers
- Carer support groups
- Alzheimer's Cafes
- Volunteer and Be-friender activity schemes
- Group Psychotherapy
- Meeting centres **Droes et al 2004**
- Support groups PwD **Logsdon et al 2010**

# Case Management

- Counsellors  
1995  
Mittleman et al
- Home Help  
Vernooij Dassen et al 2000
- Specialist Nurse/Social Worker  
Callahan et al 2006
- Social Worker  
Vickrey et al 2006
- District Nurse  
Jansen et al 2007
- Community Mental Health Nurse  
2008  
Moniz-Cook et al
- Community Nurse  
Eloniemi-Sulkava et al 2009

# Assessment – practical approaches

- Family carer attributes can predict outcome (Netherlands: de Vught studies; US Mittleman studies)
- Personality profiles in people with dementia and family carers can predict psychological morbidity (Hilton & Moniz-Cook 2005; Harrison 2005)
- Some neuropsychological profiles in dementia can present particular problems for social integration – e.g. 'dysexecutive symptoms'

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## **Assessment and psychosocial intervention for older people with suspected dementia: a memory clinic perspective**

Esme Moniz-Cook

### **Introduction**

This chapter provides an overview of memory clinics in the United Kingdom, a conceptual basis for rehabilitation, and an update of a previous summary of psychosocial intervention (Moniz-Cook & Woods, 1997). The suggested aim of psychosocial interventions in memory clinics is to maximize life quality for older people with suspected dementia and their families by preventing future distress and disability, including the commonly reported behavioural challenges. The literature and clinical experience is used to guide the clinician on issues to be considered in assessment and application of individualized psychosocial intervention in practice.

### **Memory clinics and psychosocial intervention in dementia care**

Memory clinics are thought to have arisen in the United States in the 1970s to provide a specialized outpatient multidisciplinary memory assessment service for the early diagnosis of dementia. Historically in the US they were known as dementia clinics (e.g., Reding *et al.*, 1984). In the UK the term 'memory clinic' became popular in the 1980s, fuelled by the need to counteract stigma associated with old-age psychiatric dementia services and to thus enhance access by older people to early diagnostic evaluation for dementia (Dukes, 2003). They also exist for younger adults, usually in neurology departments (Kopelman & Crawford, 1996), but these are less concerned with psychiatric stigma. Memory clinics are now found worldwide (Jolley *et al.*, 2006), particularly in the UK, parts of Europe (e.g., the Netherlands and Switzerland), the US (including university-based 'memory disorders clinics'), and Australia.

**Table 18.1** A clinical guide to assessment for psychosocial intervention in a memory clinic. PC, Problem Checklist (see Agar *et al.*, 1997); RMBPC, Revised Memory and Behaviour Problem Checklist; RSS, Relative Stress Scale.

Domain	Qualitative assessment
1. Cognitive function, behavioural changes and 'memory' concerns	<p>1 Examine the cognitive subtests for strengths not scores (e.g., visual recognition memory and procedural memory may be better than verbal recall and episodic memory; the latter can be relatively strong in mild cognitive impairment and vascular dementia).</p> <p>2 Are reported concerns due to reduced cognitive functions on particular subtests, such as subtle dysexecutive/information-processing changes with reduced initiation ('apathy'), group conversation (e.g., at mealtimes) or task management (e.g., instrumental activities of daily living, such as managing financial affairs)?</p>
2. Personality, self/role identity, and coping style	<p>1 Use history, personality, and coping style to determine salient underlying need(s) to be addressed to prevent future anxiety or depression. What are the key aspects of (hopes and threats to) self/role identity and meaningful activity (e.g., professional/work-related, including household chores; leisure/pleasurable activity; social involvement and personal/family relationships)?</p> <p>2 What might be the natural coping styles and the risks of post-disclosure anxiety and emotional dependency (e.g., the need to maintain or to reconstruct the self; optimism/strategies of maximization versus minimization)?</p> <p>3 What is the person's perception of their age compared with their chronological age (e.g., physical/dress appearance; 'brightness of eye'; 'the age one feels in the mind')?</p> <p>4 What 'sense of agency' is present for those who are frail (e.g., the number/duration of health conditions and the patient's appraisal, coping, and perceived interdependency within the family)?</p> <p>5 What are the personal and emotional experiences of dementia in the family (e.g., looked after relative at home; relative admitted to care home; 'they didn't know their own family')?</p>
3. Mood	<p>Evaluate for clinical anxiety, depression and sleep disturbance.</p> <p>1 What are the person's views about drug treatments? Have there been previous mood problems? What are the perceptions of treatment and recovery?</p> <p>2 Have there been reductions in important social contacts? Loss of a pet? Increased 'significant health conditions'?</p> <p>3 What are perceptions of family strengths and skills (e.g., patterns for handling practical and emotional tasks and emotional alliances)?</p>

**Table 18.1** (continued) A clinical guide to assessment for psychosocial intervention in a memory clinic. PC, Problem Checklist (see Agar *et al.*, 1997); RMBPC, Revised Memory and Behaviour Problem Checklist; RSS, Relative Stress Scale.

Domain	Qualitative assessment
4. Carer characteristics	<p>As for Domains 2 and 3 above but with particular attention to co-residency and carer appraisal.</p> <p>1 Judge reported problems (PC or RMBPC number) versus level of distress (PC or RMBPC reaction; RSS; mood).</p> <p>2 Rank reported difficulties in order of distress (RMBPC; PC) for targeting collaborative psychosocial intervention.</p> <p>3 Judge family strengths and areas of conflict, including closeness, communication, levels of emotionality, problem-solving, and patterns for handling practical or emotional tasks.</p> <p>4 For conflict or strain, explore in detail the frequency of family contacts and sources of emotional and social support.</p>

First, the cognitive tests that historically are needed for a dementia diagnosis can be used to counteract the belief that total brain failure is inevitable. Most memory clinics have comprehensive protocols for neuropsychological investigation involving a range of tests (see, for example, Bucks & Loewenstein, 1999). In the UK and Europe the Cambridge Cognitive Examination (CAMCOG-R; Roth *et al.*, 1999) is a common and relatively brief cognitive measure used along with other tests with people aged over 75 years (see Verhey *et al.*, 2004). Neutralizing stigma may be achieved by separating neurological constructs (brain) from psychosocial constructs (self-identity or mind). Guidelines for this can be introduced at the first assessment (see box).

### Guidelines for neutralizing stigma: the first meeting

#### Prior to assessment (conducted together: 5 minutes)

- Acknowledge with empathy the understandable indignity, for some, of the cognitive testing procedure.
- Outline the potential for rehabilitation irrespective of diagnosis.
- Explain that baselines of cognitive function are one aspect of the assessment procedure and they also assist future diagnosis for those without a dementia diagnosis.
- Explain that testing allows for past experiences such as educational opportunity.

# A Clinical Guide

## 4 Domains

Moniz-Cook 2008

- [1] Memory 'Concerns' – cognitive / behavioural changes
- [ 2] Personality 'pre-morbid' / self / role identity / coping styles
- [3] Mood
- [4] Family / Carer Characteristics - Domains 2-3

# Memory Clinic

## Assessment for 'dosage' of Case management

- Knowledge of person's psychological profile
- Accurate Family profile
- Application of knowledge of predictors - i.e. protective factors / strengths as well as vulnerability in personal and family profiles and family relationships

Moniz-Cook (2008)

# Memory Clinic Intervention

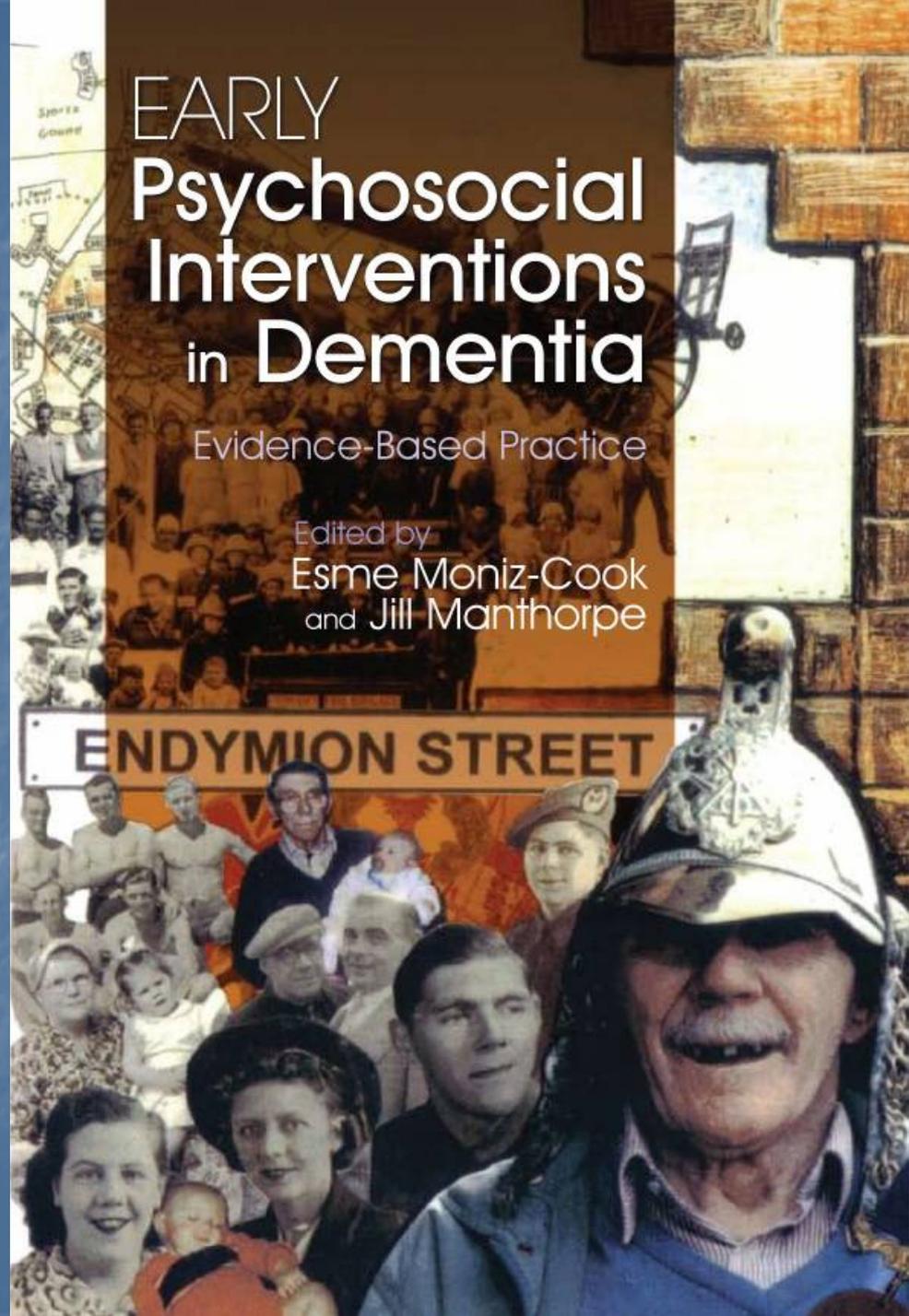
## next steps

- Evaluate methods of diagnostic disclosure and information giving
- Evaluate what 'dosage' of components are needed and who can deliver the components
- Evaluate added benefits of 'walk in' preventive carer education on meaning of behavioural symptoms
- Evaluate the effect ( and costs) of continued case management

# Dementia as a long term condition

- Protocols for therapies and psychosocial interventions - individuals and groups
- Practice Based Treatment Manuals -'Dosage' - guidance
- Therapists / Interventionists – trained and supervised
- Case Managers – also require specialist support
- Collaborative Care – across primary, secondary and tertiary settings

Developing  
Evidence  
based  
Practice



EARLY  
Psychosocial  
Interventions  
in Dementia

Evidence-Based Practice

Edited by  
Esme Moniz-Cook  
and Jill Manthorpe

ENDYMION STREET

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- Moniz-Cook ED & Manthorpe J Eds (2009) *Early Psychosocial Intervention in dementia care: evidence based practice* Jessica Kingsley – see chapters 1 & 3