SIGNPOST

Journal of Dementia and Mental Health Care of Older People

Contents:

It gives me great pleasure to welcome you and introduce the Summer 2016 edition of Signpost Journal with the theme of therapeutic interventions. It comes at a time when I transition towards older age and contemplate the state of mental health services for older people from the perspectives of health professional and potential user of services. My career as an Occupational Therapist began in September 1970 at St Loyes School of Occupational Therapy in Exeter and next year it will draw to a close. I am very proud to have spent my career as a member of a profession that champions living well in the face of the challenges of mental and physical health conditions at all ages. The last seven years working in older peoples services, including my role as Dementia Champion, has provided me with the most stimulating and rewarding experiences of my career.

Last week we celebrated by brother-in-laws 70th birthday. We reflected on the speed that life passes by, that we don't feel our age and certainly not as old as we perceived the ancient relatives of our childhood to be. Attitudes and expectations have changed so much over the years, we're living longer and feeling younger.

Who knows - I may be one of the increasing number of people living well as centenarians: in which case despite this talk of getting older I may now be only two thirds of my final age.

As we go to press, September 2016 will mark the fifth global World Alzheimer's Month, an international campaign to raise awareness and challenge stigma. The theme for World Alzheimer's Month 2016 is Remember Me. The annual United Nations' (UN) International Day of Older Persons will be celebrated as a 'special day' on October 1st to recognise the contributions of older persons and to examine issues that affect their lives. October 10th is World Mental Health Day which provides a platform every year to raise awareness of mental health issues around the world in support of mental health. While seasons change from Summer to Autumn the international landscape is alive and coloured with shades and tones of older peoples', dementia and mental health issues receiving increasing attention and support, news of cutting edge research, innovations in providing older peoples' and dementia friendly services. All this is heartening and offers grounds for certain optimism for the future.

The annual International Day of Older Persons was first celebrated in 1991, 25 years ago. This year's theme is 'Take a Stand Against Ageism'. I take the liberty of quoting in full from the World Health Organisation because of the impact that reading it had on me.

'For older people, ageism is an everyday, yet heart-breaking, challenge. Overlooked for employment, restricted from social services and stereotyped in the media, ageism marginalises and excludes older people in their communities, at the very time of life where enjoyment could be paramount.

Ageism is everywhere, yet is the most socially normalised of any prejudice. It begins when the media portrays old people as "senile" and "doddering" on television. It occurs when the doctor applies a more "relaxed" attitude towards screening an older person for preventable illness, or uses care guidelines meant for younger people. It manifests as the policymaker who, subconsciously or actively, prioritises against policies that would channel investments into infrastructure for ageing societies. These attitudes, pervasive yet invisible, lead to the marginalisation of older people within our communities and have negative impacts on their health and well-being.

More concerning is that older people who internalize ageist attitudes die sooner. Research reveals that older people who have negative attitudes towards aging live 7.5 years shorter than those with positive attitudes, and have poorer recovery from disability and disease (Levy BR, Slade MD, Kunkel SR, Kasl SV. Longevity increased by positive self-perceptions of aging. Journal of Personality and Social Psychology 2002 83(2):261-270). Older people who feel they are a burden may also perceive their lives to be less valuable, putting them at risk of depression and social isolation.'

A couple of years ago I was talking to my sister

about how I was looking forward to retirement and she said to me 'be careful what you wish for, when you retire you become invisible'. I was quite taken a back. My sister is an intelligent, articulate, active and socially engaged woman and yet she had clearly been touched by pervading ageism.

These are the darker shades of the landscape to which we all need to bring light. Progress is being made to improve the status and circumstances of older people, people living with dementia and mental health conditions in our societies but we have a long way to go. We have the added challenge of maintaining progress in the face of austerity and competing demands on the public purse with frequent concerns raised regarding the state of the care industry.

The editorial committee are very grateful to our authors and readers who care and are passionate about older peoples, mental health and dementia care issues and who together join the swell to profile and advance understanding, knowledge, skills and practice in supporting older people and people living with dementia and their carers to live well.

We have a coup with Roberta Caiazza and Ian Andrew James choosing Signpost to publish their work 'Untruths in dementia care: Ethical decision making process'. They provide a rationale and clarity for 'therapeutic lies' which can help to resolve some of the associated ethical dilemmas and allow us to meet people living with dementia in the moment of their truth wherever that truth is located within their ex-

perience.

Katie Rees, Dr Amy Howells and Gail Evans 'Providing mindful opportunities for Healthcare Professionals in Cardiff and Vale Mental Health Services' give us an insight into how learning and practicing mindfulness skills can improve wellbeing for staff and service users alike and enhance therapeutic engagement.

In his candid piece that I am going to refer to as his journey of enlightenment in working in older peoples services Brian O'Ceallaigh's 'A Trainee Clinical Psychologist's Reflections on Working with Older People' provides us with the observation that 'The older people I have met are simply adults who have been around for longer than others.' This is the kind of practitioner that I would like to meet if ever I need the support of older people's services.

Finally reading Dr Sarah Collier 'How important is spirituality and religion in the context of dementia and mental health care in 2016?' I am reminded that as students we were instructed that we were not to discuss religion and politics with our patients. In 2016 we are invited to consider supporting therapeutic religious and spiritual practice as protective factors in positive dementia and mental health care.

We have a treasure trove of ideas to challenge prejudices and provoke thought, conversation, quiet reflection, learning and innovation. I hope that you will enjoy these articles as much as I have and consider ways in which they might influence your future and the future of mental

health, older people and dementia services.

Many thanks to Matt Lewis and Angharad Jones for their diligence and hard work in sourcing and gathering the work and presenting this edition.

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Ian James is a Consultant Clinical Psychologist and Head of Older People's Psychology and Challenging Behaviour Teams in Newcastle. He is a Honorary Professor at University of Bradford and honorary lecturer at Newcastle University.

He trained at Aberdeen, Lancaster and Newcastle Universities, before commencing work at the Newcastle Cognitive therapy centre where he was employed as a clinician and researcher. He published widely on CBT competence and supervision, before moving into elderly services in 1997. Since then has been involved in developing services for community and inpatient services, and has produced clinical frameworks used across the UK and beyond (eg. Newcastle Model for the treatment of Challenging Behaviour).

Ian has published on challenging behaviour and has authored numerous books. He is a respected researcher and presenter, and has been involved in a number of initiatives with the various UK governments.

He is currently involved in a development of a new model of care called CAIT (Communication and interaction therapy) which he is disseminating in the North of England and across South Wales.

Roberta Caiazza is a Senior Clinical Psychologist working in Newcastle Older People Services.

Originally trained in Italy, she moved to the U.K. to undertake research in forensic psychology with interest in personality disorders and personality structure and its effect on therapeutic alliance.

She has been working in Older People Services since 2012, where she has been involved in research in communication strategies in particular in the use of deception and lies with patients affected by dementia.

Roberta has published in numerous journals and has been a speaker in national and international conferences, she has been involved in a number of initiatives and research projects with the Seconda Universita' degli studi di Napoli (Italy) and Newcastle University (UK).

Untruths in dementia care:
Ethical decision making process

<u>Aim</u>

Much has been discussed around the use of 'lies' in dementia care (James et al, 2006; Schermer, 2007; Wood-Mitchell et al. 2007; Tuckett, 2012). It appears, however, that despite over two decades of debate it has been difficult to move forward in the use of lies as therapeutic tools owing to ethical concerns (Sokol, 2007). The aim of this paper is to clar-

ify and differentiate the existing constructs related to lying in dementia care, and also to provide an example of a decision making heuristic to help in determining the acceptability of lying in health care settings

Introduction

While research into lying in dementia care commenced just over ten years ago (James et al, 2003; 2006), conversations about the unhelpful nature of the use of the 'total' truth in dementia care began a decade earlier (Blum, 1994). This resulted in the identification of categories of 'lying', in the form of various taxonomies.

Table 1 – Terms typically used in the taxonomies of lies

The Newcastle group (James, 2011) were one of the first teams to take an empirical perspective, and it side-stepped the debates with respect to the nomenclature by labelling all intentional untruths or deceptive practices as 'lies', whether verbal or non-verbal. Such a broad view was taken in order to purposefully prevent carers and clinicians splitting-hairs about what we should or should not regard as being dishonest. From within this very broad notion of lies came the notion of therapeutic lies, with its associated guidelines (James et al. 2006). Since then, parallel studies have investigated the attitude of health professionals towards the use of therapeutic lies (Caiazza, 2016; Culley et al. 2013; Elvish, James & Milne, 2010), and there is evidence of a high degree of concordance concerning the justification of using therapeutic lies as part of clinical interventions. As a matter of fact, empirical evidence shows that professional carers are able to identify circumstances when a 'therapeutic lies' should (could) be considered as a valid therapeutic intervention Culley et al (2013). Furthermore, a recent online interactive training programme, aimed chiefly at family carers, revealed that families welcomed the debate on lying (Futurelearn, 2016). And based on the comments posted on the online forums, the majority of the participants were in favor of lies; providing examples of their usage. Despite, such findings the General Medical Council (GMC) and Nursery Midwifery Council (NMC) continue to call into question the ethical implication of not choosing the truth when communicating with patients – "*You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.*" (GMC, 2013; item 68). Kitwood also addressed the use of deception, labelling it as 'Treachery' (Kitwood, 1997). He regarded it as characteristic of a malignant social psychology and, no matter the intentionality, it should be considered to be a form of distraction or manipulation that 'forces' the person with dementia into compliance (Kitwood, 1997).

Owing to the concerns raised, a series of guidelines on lies were developed in 2006 (James et al, 2006). They were further refined in 2013 (Culley et al. 2013), and are currently being changed significantly by the Newcastle group, taking into account features associated with memory and relationship-centered care practices (Mackenzie et al. 2015). In parallel the Newcastle team has also introduced a new concept called 'Dementia Orientated Reality' (DOR, Caiazza & James, 2015).

New Perspectives: The DOR

The DOR is embedded within the principles of personhood (Kitwood, 1997), in that it is a communication strategy that emphasizes the importance of understanding and meeting the needs of the person with dementia in their current re-

ality (James, 2015). In that sense, owing to the common phenomenon of time-shifting (ie. faulty retrieval processes leading someone to believe he/she is reliving an earlier period of his/her life), carers may need to communicate with someone who thinks she is 30. Thus the topics of conversation may reflect her belief that she is still working as a teacher, and has three young children.

To help distinguish DOR from other forms of lying, including therapeutic lying, a useful matrices has been established constructed of two intersecting continuum – Wellbeing and Formulation-led (ie. the use of biographical information in constructing a lie). The resulting quadrants are presented in Figure 1. The four categories of lies are: Outright lies, Manipulation, Lies of wellbeing and DOR; the latter two being forms of therapeutic lies.

Figure 1 – Lies quadrant: matrices of untruth
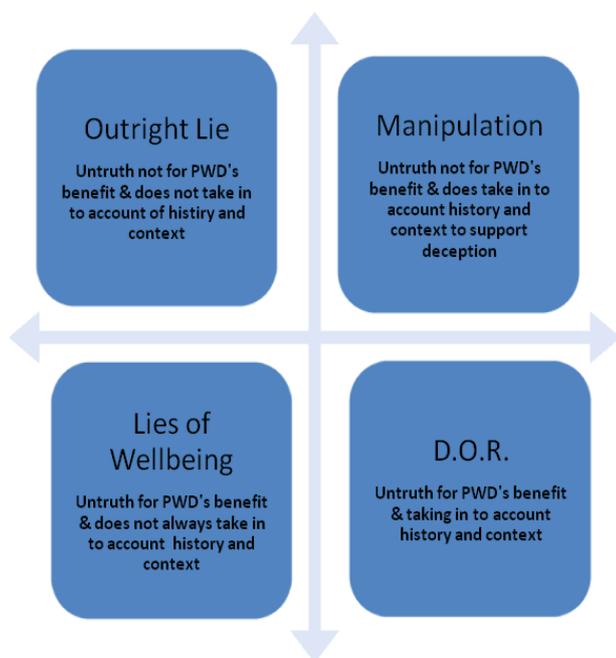
Outright lie: A carer-centred type of communication intended chiefly to benefit the carer rather than the person with dementia. The communication also does <u>NOT</u> take account of

the history and biographical details of the person with dementia. Example:

PWD: I need to go home and get ready for the kids coming home from school.
Career: If you go and sit down, I will call you a taxi.

Manipulation: A carer-centred form of communication benefiting the carer, but using biographical details to make the interaction more plausible. Example:

PWD: I need to go home and get ready for the kids coming home from school.
Career: If you go in the lounge and wait, I'll phone George (*her husband*) who will pick you up on his way home from the garage (*where George used to work*).

Lies of Wellbeing: A person-centred type of communication that aims to improve the wellbeing of the person with dementia, but does not use biographical information to enhance the communication. Example:

PWD: I need to go home and get ready for the kids coming home from school.
Career: It's school holidays, the kids are already at home. Don't worry there's no rush to get back home and we've just put the kettle on.

Dementia Orientated Reality (DOR): A person-centred form of communication that aims to improve the wellbeing of the person with dementia and ALWAYS takes account of the person's history and context. Example:

PWD: I need to go home and get ready for the kids coming home from school.
Career: Oh, but it's Monday today, your children are normally picked up by Jane, your sister, on Mondays. They always have great fun with their cousins… don't they [The information

used to construct this lie was obtained by consultation with the family].

As we can note from the examples, there is a clear difference between the four concepts. Outright lies and Manipulations are non-therapeutic because they are not aimed to be in the PWD's best interest, rather communicated for the convenience of the carer. This is obviously an unethical practice and these forms of lie should never be used; and here there is agreement with the NMC and GMC. In contrast, Lies of wellbeing and DOR can be labelled as therapeutic, because they both aim to meet the needs of the person with dementia. However, DORs should be regarded as the only truly ethical form of untruth because they have been formulated from having a knowledge of a person's past and thus are better targeted and more likely to meet the needs of the person with dementia.

Discussion

Via the matrices it is now possible to identify the various types of untruthful communication previously clustered under the umbrella term therapeutic lies. However, as can be seen we are not introducing a completely new concept, rather aiming to provide clarity around the ethical validity of using untruths in care settings. The need for this has risen from feedback from the various studies and workshops carried out over the last decade (Caiazza and James, 2015). The point of contention seemed to be with the nomenclature and also the lack of a definition of what should be regarded as therapeutic. Unfortunately, we had started to notice that carers had begun to use the term therapeutic lie to and describe all untruths. They appeared to be justifying their deceptions by merely placing the prefix 'therapeutic' prior to any form of deception.

Thus by introducing the concept of the DOR we feel confident that we have defined a therapeutic and ethical communication tool. Its characteristics allow us to communicate within an ethical framework because we are clearly using what the PWD is bringing to us in a meaningful way. We are working with the people accepting their reality and aiming to promote their wellbeing

Conclusion

In this article, we have argued that PWD benefit from carers taking the people's reality as the point of truth for communication. This paper aimed to draw a line upon the current debate concerning the rights and wrongs of lying in dementia care. Indeed, we feel that we have put a strong case that lies, in the form of DORs, should be endorsed. Moreover, because guidance is required to deliver DORs appropriately, we think that staff should be taught to use them effectively.

It is hoped that our matrices will help others understand what practices should never be used and when, and how, one should decide to interact in the person's best interests. While it is important that as health professionals we need to act in accordance with professional regulations in order to maintain high standards of care, it is vital that our approaches meet the needs of the people we are supporting and caring for. In that way can ensure that the four principles of autonomy, beneficence, non-maleficence and justice are operationalized clinically (Alzheimer Europe, 2009).

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Table 1

LIES	Description	Example
Outright lie (Vrij, 2000)	Information that is completely untrue, and there is no likelihood the event will come true.	*Please get up and dressed because your family are visiting later* [Carer has no knowledge that family are likely to visit].
Subtle lie (Vrij, 2000)	Lateral truths that are designed to mislead or conceal information.	*This tablet is like taking a vitamin to keep you healthy.*
Little White lies (Blum, 1994)	An untruth, which is perceived by the user to be a minor lie because 'qualifications' are used. Further, the actual message may be correct at some time in future.	*Go and sit down for a while, I think your favourite programme will be on TV soon. Your so may be coming today, so let's get your nice dress on.*
Going along (Blum, 1994)	Failing to correct a PWD's misperception of a situation.	*That will be fun!* [PWD informs staff member that she is going to meet her husband later – husband is actually deceased].
Not telling (Blum, 1994)	Failing to provide a PWD with information with the intention to manipulate their actions.	*It is a nice day, let's go for a drive in the car* [In reality the PWD is being taken for a hospital appointment].
Tricks (Schermer M. 2007).	Intentionally using a technique to produce a level of confusion that makes the PWD's behaviour more malleable.	Outpacing the PWD so that he/she is unable to understand what is being communicated.
Environmental manipulation (Remington et al., 2006)	Altering the environment in order to deceive and thereby manipulate the PWD's behaviour.	Painting a door a similar colour to the wall to disguise the exit.
Simulation presence (Woods & Ashley, 1995).	Using a recording (video or sound) of the family to simulate their presence.	Using a recording in the knowledge the PWD is going to think family members are actually present.
Dolls (James, 2011).	Facilitating the use of a doll and 'going along' with the PWD's belief that the doll is a real baby.	Using a doll in the knowledge the PWD perceives it to be a baby.

Amy (left) works in mental health services for older people as a clinical psychologist; she primarily works in the older adult Community Response Enhanced Assessment, Crisis and Treatment team and inpatient services at University Hospital Llandough.

Amy developed a personal and professional interest in mindfulness during her clinical training; over the last three years she has been given the opportunity to work with multi professional colleagues to develop the provision of mindfulness based therapies across Cardiff and Vale UHB primary and secondary mental health services.

Gail (right) is an Advanced Nurse Practitioner for Mental Health Services for Older People. Gail works with staff and patients in the community, day hospitals, REACT crisis team and Care home liaison. Prior to this she was a ward manager on Neuropsychiatry and the MHSOP Day Hospital Manager.

Gail has been practicing mindfulness for about 5 years and undertook the 8 week mindfulness based stress reduction (MBSR) course in Bangor University in 2012. She is currently studying for her MSc in Mindfulness in Bangor University and hopes to continue to bring in mindfulness to both her home and working life.

Katie has recently completed a placement year with Mental Health Services for Older People within the Cardiff and Vale University Health board.

She is about to commence her final year of her Undergraduate Psychology degree at Plymouth University. On completion she hopes to continue working within mental health services.

Neesha is an aspiring clinical psychologist who loves baking and hula hooping.

She enjoyed working as an assistant psychologist for her placement year in Adult and Older Adult Mental Health Services. Her current goal is to complete a psychology masters course

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Providing mindful opportunities for Healthcare Professionals in Cardiff and Vale Mental Health Services.

Introduction

Mindfulness can be defined as a way of purposely paying attention to the present moment and to whatever arises in the field of your ex-

perience in a non-judgemental way (Kabat-Zinn, 2003). Germer (2004) has suggested that developing mindfulness as a skill can enable an individual to connect to positive, negative and neutral experiences in a less reactive way. It has been suggested that this non judgemental approach to experiences can counteract the effects of stressors, by reducing orientation to the past or future, as this maladaptive coping mechanism has been associated with depression, anxiety and reduced emotional wellbeing (Hofmann, et al. 2010). Within Cardiff and Vale University Health Board (UHB) a 'Mindfulness for Well-being' six week course was developed in keeping with policy stipulating the need for partnership working across Health Boards, Local authorities, primary and secondary care to deliver appropriate age blind assessment and intervention for mental health difficulties (National Assembly for Wales, 2010; Welsh Government, 2012a, 2012b). The course was developed by a range of mental health professionals that had an established personal interest and practice in mindfulness meditation. The course has been delivered over six weekly sessions of two hours across community centres (e.g. city centre library, local church hall). Results have consistently demonstrated significant effect on psychometric outcome measures related to mental well being, depression and anxiety; qualitative feedback has also highlighted increased ability to cope with affective states such as worry (Lewis and Howells, 2015).

Given the efficacy of the 'Mindfulness for Well-being' group, and the emerging evidence base for mindfulness based therapies, consideration was given to providing mental health staff with opportunities to experience mindfulness. It was intended that developing opportunities for staff to experience mindfulness would, in turn, give further potential to expand the provision of mindfulness based therapies offered across

Cardiff and Vale UHB through developing personal interest and practice in healthcare professionals (as per UK Network for Mindfulness-Based Teachers good practice guidelines for teaching mindfulness based courses).

It was acknowledged that there could also be a potential secondary gain from providing opportunities for healthcare professionals to attend the 'Mindfulness for Well-being'; healthcare professionals often encounter the problem of sacrificing their own health and well-being due to the copious demands from their work. As a result of this mental health professionals can be particularly vulnerable to increased stress levels, maladaptive coping strategies and burnout in the workplace (Ruths et al., 2012). Beyond the affect on the individual, a lack of self-care and ability to manage stress can hinder a healthcare professional's ability to produce quality and empathic care to patients (Shapiro and Burnham, 2011). In the last decade, a growing body of evidence has suggested that mindfulness based intervention can have a positive effect on work-related stress in healthcare professionals (Shapiro et al. 2005; Cohen-Katz et al., 2004; Galantino et al., 2005). Attending a mindfulness program has been shown to reduce stress related psychological distress, lower burnout, increase wellbeing and help healthcare professionals develop and attitude of openness and non judgement (Martín-Asuero and García-Banda, 2010; Cohen-Katz et al., 2004).

Mindfulness training has also been shown to have a positive effect on an individual's professional skills, demonstrated in greater kindness towards and acceptance of clients and patients (Raab, 2014). Shapiro, Brown and Biegel, (2007) have suggested that mindfulness training has shown particular relevance to those delivering therapy and counselling, where compassion to ones self and others is vital for effec-

tive therapy. In their sample of 22 therapists in training, participants recorded significant increases in self compassion following an 8 week Mindfulness Based Stress Reduction (MBSR) programme. Furthermore, following mindfulness training clinical benefits can also be seen such as a sense of calm that demonstrates tolerance as well as an increased compassionate response to suffering (Didonna, 2009).

On account of this, 'Mindfulness for Well-Being' staff groups have been piloted within the local health board based on the six week group that has been delivered for people accessing primary and secondary mental health services in Cardiff and Vale UHB. The group has demonstrated it's effectiveness since its pilot in 2013.

Method

The program consisted of two hour sessions spanning six weeks. Sessions were held in an Academic Centre at Llandough Hospital. The course was facilitated by a Clinical Psychologist, an Advanced Nurse Practitioner and a Community Mental Health Nurse. Facilitators had clinical experience in delivering mindfulness-based therapies as well as personal experience of mindfulness. All staff contacted one of the three facilitators and a brief screening conversation helped to ensure people were aware of the personal commitment required and nature of the course. The groups were designed to provide an opportunity for staff to experience mindfulness as an approach, rather than a training opportunity. It was anticipated that staff would notice improvements in their well-being as well as developing their understanding of this approach and how it might help people they work with.

A mixed qualitative and quantitative design was employed. Standardised psychometric measures were used to evaluate changes in mindfulness using a within subjects comparison. Participants also provided qualitative feedback via semi-structured telephone interviews. A total of 43 participants completed evaluative measures across four groups. Participants completed a battery of standardised psychometric measures pre-intervention and post-intervention. The battery consisted of the Self Compassion Scale (SCS) and the Warwick Edinburgh Metal Well-being Scale (WEMWBS). The Five Facet Mindfulness Questionnaire Short Form (FFMQ-SF) was also used to monitor any improvement in participants' mindfulness skills.

Participants from two of the groups also provided qualitative feedback via a semi-structured telephone interviews. The interviews included a selection of open and closed questions that aimed to explore participants' expectations and goals prior to the course, their perceptions regarding the delivery of the course and the course overall. Participants had the opportunity to comment on the impact the course had on them and suggested possible improvements. Participants who attended at least 5 of the 6 weekly sessions were selected at random for the purpose of giving feedback; they were judged to be reliable in giving valid feedback because they had experienced sufficient content from the sessions. Three participants from the first two groups (a total of 6) gave feedback on the course. This was deemed to be an adequate number of people by the supervisor and researcher due to time and resources.

Results

A paired-samples t-test was conducted to compare the well-being, self-compassion and mindfulness variables before and after the mindfulness sessions. The results revealed are presented in Table 1. The results demonstrated a significant increase in well-being ($p<0.01$) and self-compassion scores ($p<0.01$) from pre- to

post- intervention. There also was a significant difference on the Non-React and Observe components on the FFMQ-SF (*p*<0.05). However, there were no significant changes on the other components.

Table 1: Results for well-being, self-compassion and mindfulness variables.

Measure	Pre Mean (SD)	Post Mean (SD)	Results of Statistical comparison (t-test)
WEMWBS	46.98(7.99)	50.57(7.73)	$t(41) = -4.336$, $p < 0.001$
Self Compassion Scale	73.5(13.78)	82.38(12.03)	$t(42) = -4.875$, $p < 0.001$
Mindfulness- Five Facets	14.51(3.03)	15.80(3.04)	$t(42) = -2.468$, $p = 0.018$
Non-React	13.06(4.00)	15.12(2.74)	$t(42) = -4.165$, $p < 0.001$
Observe	16.00(4.30)	15.78(3.78)	$t(42) = -0.401$, $p = 0.690$
Act Aware	17.40(3.07)	17.29(3.76)	$t(42) = 0.229$, $p = 0.820$
Describe	14.69(3.99)	15.61(3.88)	$t(42) = -1.388$, $p = 0.172$
Non-Judge			

Qualitative Data Analysis

Thematic analysis organises and describes data in rich detail, allowing the identification, analyses and reporting of themes within data. This study followed guidelines and six phases outlined by Braun and Clark (2006). Through the transcription of verbal data and detailed repeated reading, the researcher became familiar with the data. Initial codes were produced through identifying features in the data that appeared interesting to the researcher. The codes themselves were then analysed in detail and combined to form an underlying theme. Two meta-themes and six themes were identified, the results of which are located in Table 2.

Table 2. Table of the meta-themes and themes derived from the telephone interviews.

Meta-theme	Themes
1. Using Mindfulness	Learning
	Mindfulness with the Self
	Mindfulness in Work
	Mindfulness with Service Users
2. The Mindfulness course	Course Delivery
	Course Limitations

1.   Using Mindfulness

Learning

A number of participants who gave feedback revealed that they had prior knowledge of mindfulness before starting the course. However, all of the participants demonstrated their enthusiasm to learn something new from the course.

"I already practiced mindfulness before so my initial attitude going into this was to improve my practice"

"I had read about mindfulness beforehand but I wanted to see what it was like in practise"

"I suppose the course was a bit of a learning curve for me, I just wanted to get a better idea of what mindfulness is"

Mindfulness and the self

All of those that gave feedback believed that that they had taken something away with them and that it had benefitted them in their private life. They believed that the course had helped them become more self-aware so that they were better able to take care of themselves.

"The practices are great, I have to make time for myself in order to do them, and that's really benefitted me."

"….being mindful of our actions and not just going through the motions"

"I think I'm more aware of my own stress levels and of my own self care".

Mindfulness practices have been known to reduce stress. Following completion of the group participants spontaneously reported a reduction in stress.

"I don't show my anxiety or stress to service users, but I can appreciate that within myself I felt less stressed"

"I can go home….switch off from work…so I'm not carrying that stress around"

"Mindfulness brought with it an element of calmness"

Mindfulness in Work

In some cases, being more mindful of themselves helped them connect with service users, and think about the impact their behaviour could have on colleagues

"I bring mindfulness into who I am, and who my patients might be so I can better understand them"

"More self aware on how my behaviour can impact on others, like my colleagues".

Another participant suggested that mindfulness should be a part of regular practice and implementing the mindfulness practices while at work.

"...it should be adapted to all sectors of day hospitals and wards... should be a part of normal assessment and anxiety management".

Mindfulness with Service Users

All of the participants reported that by attending the course they felt more confident to make suitable referrals for mindfulness therapies for their service users.

"I have recommended mindfulness in the past without knowing anything about it…now I feel I would know when to recommend it to family, friends and service users."

"I would be likely to offer it to service users with anxiety"

Two of the participants believed themselves to be confident enough after the course to teach basic practices to service users.

"I think with individuals who have been ruminating about something for a long time, I would get them to practice Loving Kindness to themselves and others"

"I've had ideas about practicing mindfulness with my service users for a long time, now I feel I can put my ideas into practice and that they're more realistic"

2.   The Mindfulness Course

Course Delivery

All of the participants were extremely positive about how they felt the course had been delivered overall.

"Excellent"
"I learnt a lot, I'd give it 10/10"
"I had no problems with how it was delivered"

Course Limitations

Participants were also pleased with what had been covered within the course, although they did make some suggestions about the content that they felt they had missed out on.

"I would have liked to have seen a lot more practical mindfulness….like imaging writing your signature, ten different ways and being mindful of it"

"I would have liked more theory, about its origins etc. I felt like we just dived into it."

"We didn't really discuss situations where you could use mindfulness"

One participant suggested that a better location was needed for the sessions,

"The location was poor, the sun was too bright so the blinds were closed, which then made it too dark. It was also a bit cramped"

One participant also recommended that a different time of day would be better.

"I think an evening time would be better, that way I wouldn't have to worry about scheduling it around work, which can be difficult"

Similarly another participant made a suggestion that would eliminate the problem of having the sessions at a particular time every week.

"I think if you could condense the course into a couple of hours of 2 days, that would be a lot better than coming in once a week, and you could really commit to it"

Discussion

The results provide both qualitative and quantitative support for the value of 'Mindfulness for Well-being' staff groups. The results have demonstrated that attending a mindfulness course can lead to a significant increase in well-being scores, consistent with previous research (Cohen-Katz, 2004). This was also evident in the feedback from participants, who noted that they felt that they were taking better care of themselves since practising mindfulness.

The psychometric outcomes have also highlighted a significant increase in self-compassion scores following completion of the course, supporting the previous findings from Shapiro,

Brown and Biegel (2007). As they have stated previously, this can prove to be extremely beneficial for those working in healthcare, given that compassion to ones self and others is vital for effective therapy. The feedback from one participant has also given an insight into this, as they felt that by implementing mindfulness into their own lives they were better able to understand their patients. The qualitative feedback also supported previous findings that mindfulness training can increase empathy, awareness and calmness amongst staff (Didonna, 2009).

As stated previously, Germer (2004) has suggested that developing mindfulness as a skill can enable an individual to connect to all experiences in a less reactive way, and that this can counteract the effects of stressors. Although not all of the mindfulness skills increased significantly, there was a significant increase in the non-react and observe components. Therefore, an increase in the 'non-react' to inner experiences component could explain why participants qualitatively reported how using the practices has brought about a reduction of stress in their personal and professional experiences.

However, these findings have been hampered by some limitations; for example, acquiring qualitative data presented a number of problems given that it was completed over the telephone and this made multiple demands on being able to record responses and the speed at which someone participants spoke. At times it was difficult to note the entire answer and it was left to the researcher to remember the participants' exact words. This sometimes resulted in the researcher's estimating what was said. This could have been avoided by holding one final mindfulness session where participants could be interviewed in person, permitting the conversation to be recorded and eventually dictated. Another problem occurred when the researcher

was unable to reach certain attendees by telephone or when others were only available at a certain time. This resulted in some of the participants phoning the researcher later on as they were enthusiastic about giving feedback. As a result, the feedback may be more representative of those who were fully dedicated to the course rather than the entire group.

From this evaluation it would be reasonable to recommend that people are asked about their expectations either before the course or during the first session. This is because some participants were left disappointed that the course did not specifically cover areas where mindfulness might be useful for service users, despite this not being the intention of the group. In future, consideration should be given to developing a more robust design that would allow reflection of the potential impact for staff groups in clinical environments.

Overall, the results from the 'Mindfulness for Staff' groups have been positive. The feedback from the interviews has brought to attention the improvements participants feel as though they have made due to attending the course. It is also important to recognise the constructive feedback that was presented in this report for future 'Mindfulness for Well-being' groups. Further consideration will be given to developing opportunities for staff to engage with a brief follow up group to provide opportunities to reflect on personal practice, further involvement with professional training opportunities to extend personal and professional interest and signposting to community meditation groups that could help to sustain practice and personal development.

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My name is Brian O' Ceallaigh. As people can usually tell from my name, I was born and raised in Ireland.

I lived in Galway until I was 21, then moved to the UK. Since then I have lived and worked in Wales and around the south-west of England.

I currently live in Cardiff with my partner Olivia and our dog Amber. I am a keen runner and spend as much of my spare time as I can in the beautiful Welsh countryside.

A Trainee Clinical Psychologist's Reflections on Working with Older People

I write this as a trainee clinical psychologist coming to the end of my 5 month 'older adult's' placement in a memory assessment service. If I'm honest, I wasn't looking forward to my older adult's placement. Having recently lost a grandparent myself, whom I was very close to, I imagined I would struggle. At this time, I associated old age with a sense of things ending, with lifetimes of work and relationships coming to a close. I felt that I was just starting my life and didn't want to be reminded of the inconvenient truth that all things come to an end. I hadn't realised at the time the extent to which these and other stereotypes about ageing were operating just below the surface for me and for most other people.

I recall the first time I conducted an assessment with an older adult. I sat with a dull sense of apprehension. Would we understand one another? Would the session be derailed by stories of the past and reminiscence, while my carefully prepared neuropsychological tests gathered dust on the table? Would my supervisor think I had done a "good enough" job of engaging them? I needn't have worried. Instead, I was greeted with calm politeness, a wicked sense of humour and the tender sight of a loving couple doing their best to brace themselves for the changes a diagnosis of dementia may bring. This scene of normal life continuing in the face of adversity was my introduction to working in a memory assessment service and it was to become a recurring theme throughout my placement.

The breadth of older people I have met on this placement has taught me that to even use the phrase "older adults" is misleading. It implies a relatively homogeneous group who have much more in common with one another than not. This certainly has not been my experience of older people. The older people I have met are simply adults who have been around for longer than others. Like other adults, they have come from all walks of life and bring with them a depth and diversity of experiences. I have yet to meet an older person who I could say is broadly similar to another.

Through supervision and the work I have conducted with this client group, I have become more and more aware of how ageing is represented in our society. From ostensibly "benign" cartoon caricatures of the friendly grandmother

to Grandpa Simpson, we are surrounded by images of what old age should look like. This is, perhaps, unsurprising. As a society, we privilege youth and success. Where then does that leave those who are later in their life and no longer work? While at first glance these visions of older adults may seem harmless, they ultimately do a disservice to the older people they represent. With humour, it is possible to rob people of the opportunity to age as they see fit. Before my current placement I had no idea of the multitude of ways one might choose to spend their latter years. I had no idea that older people could continue to strive and achieve later in life. I would never have even thought to ask an older person about their sex life.

Part of my role as a trainee clinical psychologist involves conducting psychological therapy with clients. Here, more than anywhere else, I found my preconceptions challenged. I hadn't realised the extent to which I unknowingly subscribed to "the fallacy of good reasons", which is the mistaken belief that depression and anxiety are to be expected in later life. After all, older people have "good reasons" to feel that way. While this is fundamentally untrue (rates of wellbeing are higher in older adults than adults of working age), it doesn't stop it from being a subtly corrosive idea. I quickly learned that the expectations that therapists have about what is "achievable" for their clients are crucial in determining the outcome of therapy. With the best intentions, therapists can sabotage their client's potential progress through their own mistaken ideas about what is "normal for their age". Older adults are not all the same. Far from it. However, I have yet to meet an older adult who wasn't an expert in spotting the subtext in my conversations with them. What I left unsaid was none the less communicated. In many ways, I now believe the things we don't say to our clients are those which we communicate the loudest.

I have learned that old age is a time of some inevitable endings. Careers come to a close. Relationships end. People pass away. But I have continually been humbled by observing the dignity with which many older people navigate these challenges. Later life can be a time when people's fundamental sense of self becomes much more pronounced. Relationships strengthen as decades old bonds are tested in new ways. Many people continue to hold onto what defined them as people and the values they lived by until the end of their lives.

As my peers and I come towards the end of our placements, the tone of our conversations has shifted noticeably. In our early weeks, there was lots of anxious talk of how we would all manage. We wondered if the people we would meet might bring back painful memories of family members who had died. We all waited nervously for the moment when one of our "buttons" would be pressed. When we met somebody who confirmed our fears about later life, be that the death of a partner, loneliness or the loss of cognitive abilities. All of these things and more did happen. However, now when we ask each other "How are you coping with it?", the response is "Do you know what, I'm actually really enjoying it!" I think we have all observed in our own ways that while later life is fraught with challenges, it is also full of the overcoming of challenges. As those who work with older people, we can choose which of these we attend to in our interactions with our clients.

I now appreciate what people mean when they say that it is a privilege to work with older adults. Many older people carry a history of

lives well lived. Whether they realise it or not, older people have an enviable depth of wisdom which can only be gained from years of rising to the challenges of life. Over recent months, I have been continuously reminded of some memorable words from a previous colleague: "To work with older adults is to touch history".

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Clinical Trainee

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Dr Sarah has worked for 16 years as a qualified Clinical Psychologist specialising in the mental health issues of older people and their carers including dementia.

She is based at Neath and Port Talbot Older Adult Mental Health Service and provides in to the community and inpatient settings as part of Abertawe Bro Morgannwg University Health Board, (ABMUHB).

She currently chairs a special interest group at ABMUHB looking at the issue of spirituality in mental health and sits on the All Wales Special Interest Group on Spirituality and Health Care.

How important is spirituality and religion in the context of dementia and mental health care in 2016?

A Contentious Issue

'Never discuss religion and politics', is the advice sagely given to help ease the flow of social encounters. Over the past few decades, in mental and general health care, this advice seems to have permeated the system with evidence suggesting that staff have been apprehensive in discussing the spiritual and/ or religious with individuals using their services, (see RCN, 2010 survey of spirituality). This survey also revealed that ninety two percent of a sample of 4054 nursing staff across all specialties only sometimes felt that they met their patients' spiritual needs. The overwhelming conclusion was that nursing staff felt hesitant, lacked confidence and were inadequately prepared to meet the spiritual needs of their patients and yet eighty three percent of the sample agreed that this was a fundamental aspect to their role. Similar findings have also been observed in psychiatry. Nazir (2010) reported on a survey completed by seventy four Psychiatrists working within the Oxleas NHS Foundation Trust, which demonstrated that fifty percent of the participants did not discuss the topic at all with their patients. The sphere of dementia care appears no different. Upon reviewing the research literature, Doherty, (2006) concluded that little is done to assess, address and care for the spiritual needs of people with dementia or research them. Innes, Archibald and Murphy (2004) describe marginalised socio-cultural areas of dementia care and research including spirituality, which have been under-explored.

A difficulty in understanding and defining these concepts may be associated with these factors. The question remains as how to make the issue a meaningful and tangible concept that staff and clients can work collaboratively with and this article will consider this alongside the topic's relevance to the person, the evidence available and suggestions about how to take the issue forward.

Definitions

Many definitions exist in the literature. Sims and Cook (2009) provide an excellent summary and foray into the field and they note that some define spirituality as concerned with matters of meaning and purpose in life; others relating to truth and values; hope and connectedness and

that it is a personal dimension of experience that all people have that does not always have religion at the heart of it. Whereas religion, on the other hand encompasses a social / interpersonal, institutional, formal, outward tradition of shared beliefs, practices and experiences, although, even the definition of religion is open to debate, (Koenig et al., 2001).

Turning Tide

In mental health of late, there appears to be a turning tide with a growing interest in grappling with these more complex concepts and frameworks in an effort to understand and work with human experience and behaviour with a move away or elaboration of the more reductionist models of the past such as those proposed by the early behaviourists Pavlov and Skinner and in contrast to the views of Freud who ironically described the religious as 'illusions and insusceptible of proof' (1927). Even the preponderance of the 'medical model' is in some quarters gradually shifting towards a more holistic appreciation of the issues that the person partaking of mental health services brings. The Royal College of Psychiatry (2011) indicated the value of considering spirituality and religion as part of good clinical practice and have a Spirituality and Psychiatry Special Interest Group set up in 1999 within the college to consider such matters.

In Wales, over the past six years alone, the Welsh government have published the Strategy for Mental Health and Wellbeing in Wales (2012) that stated: 'agencies need to ensure that they have a fully integrated approach to deliver an effective, person centred holistic service model that addresses the needs of the individual…' p. 37 and more recently the generic Health and Care Standards (2015) endorsed the bio-psycho-social-spiritual, with detailed supporting guidance for health boards on implementing spiritual care in all health care settings including mental health.

The Person as a Spiritual/Religious Being

Patients and carers also relate the importance of the spiritual for them. Brooker and Latham (2015) quote directly from Christine Bryden's powerful account of her experience in caring for her husband who developed dementia, the book entitled 'Dancing with Dementia' suggests that the spiritual is at the core of a person: 'Each person with dementia is travelling a journey deep into the core of their spirit, away from the complex cognitive outer layer that once defined them, through the jumble and tangle of emotions created through their life experiences, into the centre of their being, into what truly gives them meaning in life' (Bryden, 2005, p. 11).

Others have described similar; 'The top layers are the most complex layers of our selfhood, and as they peel away, changes take place in the person with dementia, gradually revealing the quintessential, simpler and deeper layers, until the essence of the person is reached.' (Pointon, 2007 p.119.)

In a similar vein, Nicholls (2007) quotes from an individuals' experience: 'We who have experienced mental illness have all learned the same thing, whether our extreme mental states were inspiring or frightening. We know that we have reached the bare bones of spirit and of what it means to be human'. (Barker, Campbell and Davidson 1999, p.35).

Nicholls (2007) goes on to quote-p 104 in Pointon, (2007) 'As people who have lived through extremes of mental and emotional distress, we are tired of being categorized and feared, worn down by being voices in the wilderness –voices that cry out for a humane and holistic under-

standing of who we are, that embraces physical and spiritual as well as psychological and emotional well-being. After all, we carry everything that has ever happened to us in our bodies (Webster 2002), and many of us know only too well the spirit-breaking nature of some mental health services (cited in Barker and Buchanan-Barker 2003, p.60)'

In light of these powerful and emotionally laden quotes, the poignancy and pertinence of spirituality in the context of dementia and mental health are apparent. The relevance is also compounded by the fact of the life limiting nature of the dementing illness that can precipitate those deep and meaningful questions in life relating to the meaning of life, death and suffering in the human condition. The religious is also important to consider here.

Religion and the Population of Wales

Data from the census presented in Table 1 suggests that Wales is far from being a secular nation with many individuals ascribing to a Christian faith. Obviously this means different things to different people, but would suggest that service providers need to be mindful of this factor and that should encourage the mental health care practitioner to open a simple dialogue with the individual as to whether this is relevant to them and, if so, what it means in terms of their care and treatment.

Table 1: Religion in Wales

Religion	Number 2011	Percentage 2011
Christianity	1,763,299	57.6
No Religion	982,997	32.1
Islam	45,950	1.5
Hinduism	10,434	0.3
Sikhism	2,962	0.1
Judaism	2,064	0.1
Buddhism	9,117	0.3
Any Other Religion	12 705	0.4
Religion not Stated	233 928	7.6
Population	3,063,456	100.00

Source: UK Census 2011.
The 2011 Census also showed that eighty per cent of people aged 65 and over in England and Wales were Christians, highlighting the particular pertinence of this issue for this cohort.

Legislation

In 2010 the Welsh Government set to enshrine the holistic paradigm in law with the advent of the Mental Health Measure-Wales. This legislation gave care coordinators a holistic framework for care and treatment planning, with eight domains to be considered with individuals - namely i) accommodation, ii) education and training iii) finance, iv) medical including the psychological, v) parenting/caring responsibilities, vi) personal care and physical well being, vii) social, cultural and spiritual, and viii) work and occupation. There is a caveat though that care coordinators need only complete one domain with the individual to satisfy the requirements of the legislation. A concern exists amongst proponents of the holistic model that the spiritual can therefore 'be lost' within the care and treatment plan (CTP) as a whole and also within its own domain, with the social or cultural taking precedence; particularly for staff who may not feel as confident or adept in addressing the spiritual.

Person Centred Care

Interestingly, the bio-psycho-social has long been advocated in the field of dementia care. Tom Kitwood (1997) endorsed these other dimensions in addition to the established biological frameworks and such was the origin of what is called, person centred care. This concept of care is embedded in the principles or relationship and connectedness with the person with dementia and in care constructs that hold the person in esteem and value, this culture of care is sometimes deemed elusive on the ground (Brooker and Latham, 2015, 2006). There is a danger that the Mental Health Measure framework for Care and Treatment planning in dementia care becomes a mechanistic 'paper pencil exercise' simply engaged in to fulfil the requirements of the law and thereby losing the opportunity for it to be a meaningful exercise that captures the heart of the essence of the person and their relationships, including the spiritual, and thereby facilitating a person centred culture in dementia care in Wales. Indeed, there has been criticism in some quarters that the measure framework does not fit well with the needs of the older client and particularly with those of the person experiencing dementia. The foundation is however in place for mental health services to embrace this tool and make it meaningful for the benefit of people with dementia and their carers beyond the reductionist models of the past into the bio- psycho-social-spiritual realm. This is a challenge indeed for services that may be stretched during these times of austerity, and for staff who may only have a nominal understanding of some elements of the bio- psycho-social-spiritual. There is fruit to be had from working with the spiritual as we can see in the following section when considering the growing evidence that there are therapeutic benefits to exploring the spiritual with individuals (Koenig et al., 2012).

The Protective Nature of the Religious / Spiritual and their Contribution to Mental Well Being.

In terms of formulating an individual's mental health issue it is necessary to explore the factors that can be protective in order to help the individual capitalise on these for the purpose of their 'recovery' journey or allowing focus on that which can help them in the management of a more chronic condition like dementia. Harold Koenig, an American Professor of Psychiatry published two major seminal works into the evidence on religion (as opposed to spirituality) and health including mental health, (Koenig, McCulloch & Larson, 2001, & Koenig, King & Benner Carson, 2012). The first summarised data available from research drawn from the United States, Europe and Israel between 1800 -2000- thereby the Christian and Jewish faiths in the main. They found religion to be a protective factor in mental illness. Religion was positively correlated with a number of variables, including lower rates of depression, loneliness, suicide, anxiety, low self esteem and substance misuse amongst other variables. The more recent publication began to look at faiths other than that of Christianity and Judaism and revealed that between2000-2010, 2100 quantitative studies-(75% of the evidence available) largely confirmed and extended the original findings printed in the 2001 publication.

They also indicated strong evidence to suggest that that religious social support may be a more powerful variable than either non religious social support and financial status (see Lawrence and Head, 2009) but do indicate that the relationships and interactions between the variables are complex. They also highlight the potential adverse effects sometimes associated with strong religious faith - discussed below.

In the later publication (Koenig et al., 2012)

they draw the readers' attention to components of religious practice that relate to well being. They suggest that religion encourages positive emotions, thoughts and behaviours, hope, altruism, forgiveness, gratitude, and reduces focus on the self. Their research since has also identified strong relationships between religious indicators and sense of purpose, optimism, generosity, and gratitude (Koenig et al. 2014).

They also found that the evidence suggests that which is encouraged in some faiths is associated with better mental health in the long run, for example they highlighted the positive effect of forgiveness on health related variables and related Data emerging from the truth and reconciliation commission in South Africa that revealed depression, PTSD and other psychiatric disorders were significantly higher among people who demonstrated less forgiveness year after events than others. (Koenig et al. 2012). They took the 48 best studies out of 102 exploring this issue and also found 90% higher well being in the more religious and that religion was inversely related to depression in 39/54 studies between 2001-2010.

Much of what Koenig and colleagues (2012) describe appears consistent with the evidence available in psychology. The principles fit well with the theory behind cognitive behaviour therapy whereby the individual is encouraged to develop more positive thinking patterns and behaviours and in doing so can have a significant impact on mood (NICE guidance on depression and anxiety). Additional parallels can also be drawn with the evidence emerging from the field of positive psychology. This field is dedicated to establishing an understanding of the factors that contribute to well being and happiness, it has long been known what may contribute to mental ill health but not which propels individuals into a state of happiness and well being and understanding why some are able to maintain well being in the face of adverse life events whereas others are unable to.

However, a significant amount of research has begun to explore this matter and found the following; Lyubomirsky (2005) proposed that happiness levels are determined by a genetic component, (contributing fifty per cent), circumstances (contributing ten per cent) and activities, and practices (contributing forty percent). Martin Seligman, one of the key proponents within this field expanded on this theory in 2011 and published what he saw as the key correlates of wellbeing, namely:

P- Positive Emotion-scheduling in regular strategic uplifts – shown to have a beneficial impact on physiological and psychological variables.
E – Engagement- relating to engagement in activity, having something to absorb oneself in.
R – Relationships- having something to love, and show kindness to.
M – Meaning-being part of something bigger that gives one a sense of purpose in life.
A- Accomplishment-savouring small and large accomplishments in day to day life that are not necessarily linked with pleasurable activities.

One can immediately see that the theories allow for the possibility that the spiritual / religious can be integral here, Koenig et al (2012) report that 42/45 studies (93%) reported significant positive relationships between religiousness and purpose or meaning in life. Furthermore, religious organisations provide individuals for opportunity to access social support, relationships and opportunity for engagement with activities that can provide individuals with a sense of engagement, positive emotion and accomplishment.

If one reflects on this in the context of dementia it is often the case that the person and their carer may have been forced to forgo activities and spiritual practices with the advent of the

dementia but care and treatment planning could allow the opportunity to reflect on these factors and help people to either reclaim some ground or establish engagement in durable practices regardless of diminishing cognitive function and ability.

Individuals Utilise the Spiritual and Religious as Coping Mechanisms

The evidence also suggests that over half of individuals turn to religious and spiritual beliefs to help them in a crisis (Faulkner, 1997; cited in Powell, 2009); especially people with schizophrenia, (Koenig et al., 2012). Religion can provide people with answers to ultimate questions, assistance in making sense of things, a sense of control within the midst, predictability and a framework for seeing these experiences as an opportunity for growth (James and Wells, 2003) as well as offering guidance and positive role models for coping with challenging circumstances (Koenig et al. 2012).

There is also evidence to suggest that certain rituals can provide people with comfort and have a calming effect, including prayer (Mackenzie et al, 2000, Ai et al, 2002), mindfulness (Davis and Hayes, 2010; Hofman, 2010) and loving kindness meditation, (Friedrickson et al. 2008).

The Spiritual may be at the Heart of the Mental Health Issue

In terms of service efficacy, efficiency and of ethical considerations for addressing the heart of the matter with individuals accessing mental health services, this is an important issue for consideration.

Anandarajah & Hight (2001): 'Spiritual distress and spiritual crisis occur when individuals are unable to find sources of meaning, hope, love, peace, comfort, strength and connection in life or when conflict occurs between their beliefs and what is happening in their life.' This is particularly relevant in the context of dementia care.

'This distress can have a detrimental effect on physical and mental health. Medical illness and impending death can often trigger spiritual distress in patients and family members.' p.2 Aside from issues in the life cycle triggering existential crises that can be addressed at a spiritual level there are also adverse effects of religious/ spiritual beliefs that could be impacting on the individual. Koenig et al (2001 & 2012) found some evidence relating to adverse effects, mainly associated with, excessive devotion to the neglect of responsibilities, misinterpretations of scripture, rigid and legalistic thinking, and failure to seek appropriate medical help owing to reliance on religious rituals or counsel, (see Crowley and Jenkinson, 2009). The more aware of these factors mental health practitioners are then the more likely they are to address the most pertinent issue upon intervention.

It is also appropriate here to consider the pathways and relationships the mental health teams have with chaplaincy for the benefit of their expert knowledge and advice, and also with faith communities in terms of understanding and working with them to facilitate their understanding of mental health issues and care. Bearing in mind that people often have a longer relationship with their religious community than they do with mental health services over their lifetime.

The Religious/Spiritual Can Be Harnessed to Facilitate Recovery

Interventions that promote recovery and resilience are recommended e.g. in 'Psychological Therapies in Wales: Policy Implementation

Guide, 2012). Pargament, (2001) agrees and goes suggests that religion can be harnessed to help people in crisis. Koenig et al (2012) cite eight clinical trials five of which found that depressed patients receiving religious/spiritual interventions recovered significantly faster than people receiving secular treatments or controls. Out of 54 of the best studies they looked at, 39 (72%) reported significantly less depression or a reduction of depression in response to a religious or spiritual intervention. Those attending religious services weekly or more, prayed daily, studied bible 3 times per week & scored higher on intrinsic religiosity predicted 53% increase in speed of remission from depression.

Other research has also found spiritual meditation to be superior to secular meditation and relaxation (Wacholtz and Pargament, 2010).

A Proposed Service Framework for Spiritual Care Provision within Mental Health Services

The Welsh Assembly Government published detailed Standards for Spiritual Care Services in the NHS in Wales in 2009 with advice on how local health boards could address the spiritual needs of individuals using generic health care services- the guidance had a particular emphasis on the provision of inpatient hospital care and its application across Wales has been patchy, what follows is some tentative practical suggestions as to how mental health services can begin to address the spiritual in the context of their service. At ABMUHB a working group has developed a model summarised in Figure 1.

Figure 1: Tiered Model for Spiritual Assessment and Care Provision in Mental Health Services

Tier Three: Specialist Spiritual Assessment, Intervention and Consultation- Chaplaincy

Tier Two: Staff with Specialist Training in Spiritual Assessment and Intervention, such as Mindfulness, Christian

Tier 1: All Staff: Generic Assessment and Intervention with Spiritual Needs- Person Centered Compassionate Care

McSherry (2001) indicates that chaplaincy are the obvious providers of spiritual care and assessment but are too small a resource to engage with every individual utilising services, hence as Culliford and Eagger (2009) indicate '…suitably trained and experienced personnel are needed in every clinical team, and this means staff from all the different professional disciplines'. (p.28)

McSherry (2000) states that 'nurses already possess many skills required to take the initiative in dealing with patients' spiritual needs. What they sometimes lack is the confidence and education' (p.118). Therefore, what is required is a system of education on the topic and clinical governance procedures in place as a safeguard, with specialists in mental health chaplaincy overseeing the system and partaking of ongoing research into the field. Education needs to occur at different levels with all staff having a sound foundation of knowledge in spirituality and religion and an understanding of where to seek support on the issues when they require at Tier 1 of the system. Education for staff functioning at Tier 1 needs to encompass person centred care and compassion as the conduit for this provision.

Tier 2 allows staff with a special interest to develop their skills in spiritual and mental health

care provision, with experts in approaches such as mindfulness, Christian CBT and other approaches in dementia care such as that seen in Mackinlay and Trevitt (2015) who describe spiritual reminiscence in dementia care.

Taking this Forward

The following involves a consideration of what Tier 1 Spiritual Assessment and Care may involve, clearly, Tiers 2 and 3 are beyond the scope of this paper relating to more specialist areas of provision.

Tier 1 Spiritual Care Assessment

A detailed discussion of the tools for the assessment of individual spiritual/religious needs is described by Culliford and Eagger (2009), Eagger (2009) on the Royal College of Psychiatry website, which is worth studying, but a simple addition of some questions regarding spirituality to the generic assessment tools currently in use in services would start to obtain the information required for developing care and treatment plans in this domain. Questions such as, are you a spiritual/ religious person? How important is this to you? Do you think that these are important to take account of in your care and treatment? Alternatively one could ask about what gives the individual hope, meaning and purpose in life and during challenging times. The Anandarajah and Hight (2001) HOPE Tool is also a useful framework for the assessment of spiritual needs that has been developed for use in physical health care settings.

Tier 1 Spiritual Care Intervention

A useful nemonic for the consideration of spiritual care and treatment planning could be the following: R E A L as this should involve a 'real' authentic relationship with the individual con-

cerned at the heart of it.

R-Relationship: Spiritual care should be embedded in a meaningful genuine therapeutic relationship that involves, empathy, compassion, dignity, respect, positive regard, and non judgementalism. This appears the essence of what Kitwood (1997) refers to in terms of person centred dementia care that facilitates the individual's sense of personhood.

E- Expression: Spiritual care involves facilitating the expression of the patient's spirituality through various means such as prayer, rituals, reading sacred texts, art, creativity, meditation, yoga, Mindfulness. Thereby enabling individuals to have space to practice their religious rituals whether that involves reading sacred texts with them (if staff feel comfortable), finding audible versions should they be unable to read anymore, facilitating prayer, singing sacred songs. For people with no religious faith, care might involve helping them to express themselves through art, nature, music. This provision has to occur in the context of an open, accepting, non judgemental culture, hence clear strong leadership with a strong patient and carer voice is at the foundation of a culture of this nature.

A-Addressing barriers: Spiritual care involves addressing barriers that impact on wellbeing, such as feelings of hopelessness, lack of purpose and meaning, un-forgiveness and harnessing strengths for recovery. This might involve enabling the patient to re connect with previous spiritual practices / experiences / relationships using the care and treatment plan as the framework for this, gently addressing unhealthy spiritual beliefs and practices with the necessary safeguards in place to do this such as multi disciplinary discussion, consultation and input from chaplaincy/ relevant faith leaders. Some of this work is likely to be occurring

at a Tier 2 level with appropriately trained and supervised staff.

L-Linking: Spiritual Care, with the consent of the individual concerned can also be about linking with the wider community for support and guidance, within and outside of the organisation. This domain also relates to staff knowing their strengths and limits and of being aware of when to seek help by talking to another colleague within the service, linking and consulting with local faith leaders and community groups for information, support and assistance.
This element may involve local services developing directories on faith organisations in the locality and trusted community organisations to utilise for support and, where appropriate, intervention. This domain will also involve nurturing relationships with local faith leaders who could be suspicious of mental health services and organisations. Chaplaincy services may be a useful bridging conduit in these circumstances.

Tier 3 Provision: Chaplaincy

Key to the provision of spiritual care in any mental health or dementia service is chaplaincy and in particular, mental health chaplaincy specialists. Chaplaincy work within health boards support people of many faiths and those of no formal religion. They are also in a good position to oversee the necessary clinical governance arrangements required for this provision.
In terms of clinical provision, specialist chaplaincy involvement may be appropriate in cases -with individual consent- where there may be a complex interaction of mental health and spiritual variables at work in an individual's case, such as where the person may be putting themselves at risk because of their beliefs, as in the case of refusing treatment believing for divine healing, or in relation to severe levels of distress due to religious beliefs, such as believing one has committed an unpardonable sin or is

destined to go to hell.

Chaplaincy are also likely to be key in helping to ensure that the spiritual and support needs of staff are addressed in service planning models, integral to the safe and health function of the system meeting people's distress head on and in dealing with issue such as death, and dying and in helping individuals to face situations where there may be no easy answers available.

Summary

There is much to consider in this realm of the spiritual and religious, far too much to consider within this paper but it is hoped that this may help to open this avenue for discussion in the field of mental and dementia health care provision and facilitate thinking about ways to take this issue forward in mental health and dementia care settings.

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Who are you and what do you do?

My name is Bob Woods, and for the last 20 years I've been Professor of Clinical Psychology of Older People at Bangor University.

My job originally had three main, linked, elements: training clinical psychologists as part of the North Wales Clinical Psychology Programme team; working as a clinical psychologist in one of the Betsi Cadwaladr UHB Memory teams; and leading a research centre, the Dementia Services Development Centre (DSDC).

About three years ago now, I went part-time (three days per week) and retired from the first two roles, so I now focus on research related to dementia care.

If it is ever possible, could you describe a typical day?

A typical day in the office begins with driving from home on Anglesey across the Menai Suspension Bridge, marvelling at the ever changing view of Snowdonia, just a few minutes from our centre which has a great location next to the Menai Straits. Several coffees later, and hope-

fully a few e-mails answered, and the day proceeds through a succession of project meetings. Although our papers in journals seldom acknowledge it, research projects rarely run smoothly or to plan, so trouble-shooting is often the order of the day.

We have a great team at the DSDC, researchers and PhD students, and some exciting projects, ranging from large, international collaborations to small-scale evaluations of services developing in North Wales. The challenge for me is switching from one project to the next, but the team are very tolerant of my absent-mindedness!

As many of the projects are collaborative, many of the meetings involve teleconferences or Skype, keeping travel to a minimum. Occasionally there is an hour or two when I can work on a publication – maybe commenting on a draft prepared by a colleague, or sometimes writing from scratch. That generally happens more out of the office – even on trains – when there is not a constant stream of e-mails to distract and divert.

What do you most enjoy about your role?

It's the hands-on moments I probably enjoy most – when I'm able to actually analyse some data, whether it's numerical data from questionnaires or interview transcripts from qualitative interviews, especially if I end up being able to make some sense of it all. Working on projects with colleagues and collaborators – including people with dementia and carers – with whom we have built up relationships over the years, results in project meetings and events that can be fun and exciting as well as challenging.

Engaging with the public is also still very enjoyable, especially when we can work with col-

leagues in creative arts and music to highlight the contribution and voice of people living with dementia.

One of the things I love about Bangor University is that it is small enough for us to develop partnerships with the School of Music and with Pontio, our arts and innovation centre, culminating in some innovative projects and well-attended events.

What are the greatest challenges in your role?

There's no doubt our biggest challenge is sustainability. A successful research centre relies on a stream of external funding for research projects to employ its staff, most of whom are on short-term contracts. Our staff are our most valuable asset: people with their combination of research skills, knowledge of dementia and passion for improving dementia care are hard to find. So we try our best to maintain their employment, often juggling resources and finding last-minute stop gap solutions, which are less than ideal.

What has your role taught you about working with people with dementia?

People with dementia and their carers have taught me a great deal over the years, right from my first real extensive contact, during a brief stint as a nursing assistant in a mental hospital ward for people with dementia. Their courage and adaptability have demonstrated that there is hope in the midst of dementia, that quality of life is possible, and above all that it is possible for all of us to make a difference in dementia care.

When I started out, 40 years ago now, the accepted view was that there was nothing that could be done for people with dementia. I have been privileged to spend my career working on positive approaches and interventions that, although not a cure, lead to benefits that are in many cases measurable and certainly worthwhile.

Where would you like to go from here?

As I come closer to the day when I retire from this role, my greatest hope is that with all the attention now being given to dementia and the resulting opportunities (which I can't help wishing had come 20 years ago!) we will see further incremental improvement in dementia care and the potential for living well with dementia.

When you've been around a long time, it's tempting to see 'progress' as just another turn of the wheel, re-inventing or re-discovering old ways or truths, even to become a little cynical! But I don't think anyone would have envisaged the social movement around dementia that's happening now, with Dementia Friends and Dementia Friendly Communities, with the general public in many ways shaming those of us working in health and social care and challenging us to embrace the more enlightened and complex view of dementia that is now emerging.

So my hope is that we will continue to see real progress – in awareness, care and research.

My personal hope is that Bangor University will continue to be a leader in this field, but that will be for others to determine.

Professor Bob Woods
Professor of Clinical Psychology
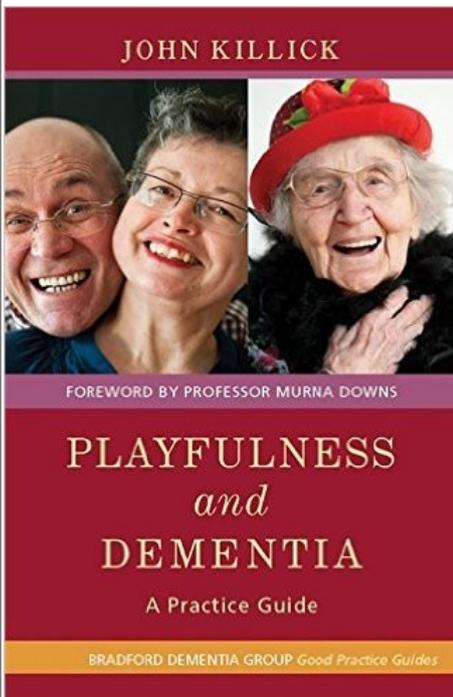**of Older People**
Bangor University.

Playfulness and Dementia: A Practical Guide. An Occupational Therapist's Guide to Sleep and Sleep Problems (Occupational Therapists Guides)

Author: John Killick
Publisher: Jessica Kingsley Publishers, Oct 2012 (120 pages)
ISBN: 978 1 84905 2239
Price: £16.99 Paperback / £16.49 Kindle

The only thing that made me want to stop reading *Playfulness and Dementia: A Practice Guide*, was a growing urge to call author and poet John Killick and say, "Can I come over and play?"

Advocating play for adults living with dementia is controversial, Killick admits. In the adult world, Killick writes, "Play has to contend with every kind of obstacle—the perception of childishness by others, and by the self; the idea that is it contradictory to the work ethic; the impressions that is it time-wasting…"

Killick, who has authored many seminal books on creativity and dementia, including *Dementia Positive*, skillfully defines, discusses, and debunks the social obstacles through a series of vivid examples that explore a multitude of art forms, viewpoints, and milieus.

"Play is the unfettering of mind and body. It is without purpose. It welcomes the unexpected," Killick explains. "Play is needed at all stages of life," he believes. "It enshrines so many possibilities: of learning new things about the world and the self; about reinvigorating the body through exercise and the mind through imaginative forays; about positive enjoyment that refreshes the spirit and helps to prolong active engagement; in social groups, it promotes bonding and encourages intimacy; it is a continual rediscovery of the basic principle of joy in simply being alive."

The other experts in the "playing" field agree. "Playfulness is what we should be doing all the time," writes Ian Cameron, from the Elderflowers project, a Scottish-based therapeutic clowning organization that works with those living with dementia and others. "It is through play that we learn and make mistakes….make mistakes freely, celebrate and enjoy them."

Woven throughout the examples and anecdotes are Killick's own creative suggestions that readers can easily adapt for all abilities. These ideas are suitable for one-on-one interactions or larger groups and they include:

- Using an array of playful hats to role-play and create spontaneous stories
- Telling silly jokes
- Pretending you're sniffing a flower and reacting, depending on whether the flower may smell heavenly or rotten
- Flitting around with a feather duster, cleaning the furniture, yourself, and finally, the person living with dementia
- Creating joyous laughter by engaging in

laughter yoga techniques
- Creating a light-hearted and repetitive scenario, where one of you is constantly "surprising" the other

For people living with dementia, the invitation to play can be enlivening. Killick describes this as the Sleeping Beauty Syndrome, saying, "The stimulus for play is often supplied by another individual. The person (with dementia) is awakened by a word or a gesture or a pattern of movement and then she is away on her own, sometimes as an almost unstoppable force. We need to be aware of what a significant role we can play in this process."

Whether the carers are professional artists, health care practitioners, family members, or friends, they play a vital part in making play safe, accessible, fun, and meaningful. "Plays well with others" is high praise in some circles and Killick's collaborative spirit shines through his review of the international literature on the subject, and in the myriad of artists and experts he cites and features. Equally compelling are his own personal experiences and the poignant stories from family, friends, carers, and from people living with dementia. These illustrations illustrate the power of play to bring out humor, creativity, connectedness, community, artistic expression, and depth in all participants.

Readers come away from *Playfulness and Dementia: A Practice Guide* brimming with ideas and ready to throw themselves into the soothing and necessary renewal of play.

Deborah Shouse
Speaker, Editor, Dementia Advocate

Deborah is a writer, speaker, editor and dementia advocate who lives in Kansas City, Mis-

souri. Deborah and her partner Ron Zoglin raised more than $80,000 for Alzheimer's programs by donating all proceeds from her initially self-published book, *Love in the Land of Dementia: Finding Hope in the Caregiver's Journey,* to dementia-based non-profits.

Central Recovery Press has since published an updated version of *Love in the Land.* Her latest book, *Connecting in the Land of Dementia: Creative Activities to Explore Together,* comes out in September 2016 and features several luminaries from the UK.

To learn more about Deborah's work, visit DementiaJourney.org

Facilitating Spiritual Reminiscence for People with Dementia: A learning Guide

Author: Elizabeth Mackinlay and Corinne Trevitt
Publisher: Jessica Kinsley Publishers, June 2015 (118 pages)
ISBN: 978 1 84905 5734
Price: £21.13 Paperback, £14.94 Kindle

In 'Facilitating Spiritual Reminiscence for People with Dementia: A Learning Guide', Anglican Priest, the Reverend Elizabeth MacKinlay and

Registered Nurse and Academic Associate for Ageing and Pastoral Studies, Corinne Trevitt (2015) summarise over a decade of their work that has involved listening to and talking with people with dementia. The book is a follow up to Mackinlay and Trevitt (2012) that emanated from a research venture entitled 'Finding meaning in the experience of dementia: The place of spiritual reminiscence work', which was part of an Australian Research Council linkage project.
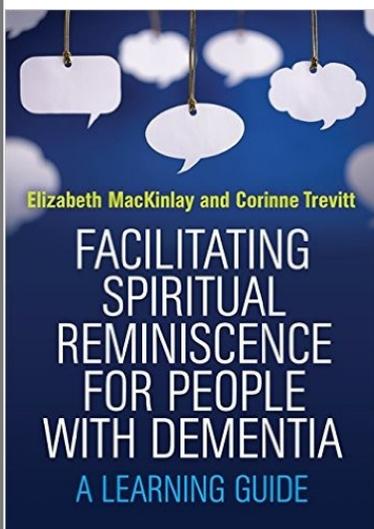
In this work, they provide an easy-to-read guide that is full of their pearls of wisdom gleaned from their experiences of running spiritual reminiscence groups with people with dementia in the care home setting. The book is divided into two main sections- the first gives the reader guidance in relation to working and communicating with people with dementia, both generally and in the spiritual sense and the second part of the book gives session by session direction on running a spiritual reminiscence group for people with dementia. The narrative is littered with direct quotes from previous group members and facilitators and enables the reader insight into the 'nuts and bolts' of the therapeutic exercise. The would be facilitator is encouraged to go on a journey with group members to enable them to find meaning in their experience of dementia and state that the emphaisis of the intervention is to focus on the person's emotional and spiritual dimensions as opposed to their cognitive losses. The book is representative of a shift in caring for the purely medicial or biological aspects to a person experiencing dementia to seeing the person as a whole and in caring for them in a holistic- bio-psycho-social-spiritual sense. It also comes from a position whereby it is possible to harness an individual's strengths.

The focus of the intervention is on those 'big' issues in life that make us human- those things that give us a sense of meaning and purpose as well as our hopes and fears.   They draw the reader's attention to evidence that the groups increased interactions among people with dementia for a period up to six months after – (see MacKinlay and Trevitt, 2012) and allowed attendees to strengthen their sense of connection and relationship with other group members, something that is so often lost with the onset of the disease and its sequelae.

The book also contains exercises highlighted in grey boxes for the reader or would be facilitator to reflect on, relating to the issues involved in running a group of this nature.

This intervention is not for the faint hearted and flies in the face of care settings that manifest with 'fixed smiling faces and superficial conversation', the book encourages the reader or would be facilitator to get to the heart of the matter with people with dementia in a spiritual sense, transcending the boundaries of faith and secularism into the very real things that make us human.

MacKinlay and Trevitt explain that in their ex-

perience, the intervention works well with people of faith and with those who ascribe to no faith as well as with those who have moderate degrees of cognitive issue as well as those individuals with intact cognitive abilities. They recommend a rolling programme of six themes over a twenty four week intervention for a small group of people experiencing dementia, health economists may balk at the lengthy nature of the programme but as Shakespeare has said 'Wisely and slow; they stumble that run fast'.

How can one traverse such topics as joy, hope, meaning, grief, death and dying in a cursory manner? The authors note that people with dementia are more able to talk about emotional and spiritual topics than those of a factual nature and don't shy away from the painful topics in life, including memory loss, dying, grief, guilt, increasing disability and fear. The aim of the intervention being to help group members transcend and integrate these losses and find meaning and connection with a deity, nature, art, or others, thereby facilitating spiritual growth and connectedness, whilst encouraging spiritual expression along the way. Consideration is given to communicating with people with dementia in metaphors and the importance of focusing on the meaning behind as opposed to the descriptive narrative. Self care and peer supervision is dwelt on at the end of chapter nine – essential if one is to venture down this path. This book is essential reading for those people wishing to connect therapeutically with people with dementia in a more meaningful, authentic way.

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Is it a watch? Is it a phone? It's...both.

It is possible now to buy watches that can do more than just tell you the time!

For example, if you're out and about and come into difficulties, this watch has an SOS button and a 2-way speaker phone. You are transferred to a healthcare professional who can talk to you through the watch. The watch also has GPS, so it's possible to track where you are and arrange help. Whether you want a family member to be alerted to your problem or you need medical assistance, both can be organised.

Angharad Jones and Matt Lewis

Assistant Psychologists

Cardiff and Vale UHB

Memory Walks across the U.K.

Over the autumn months, the Alzheimer's Society organise 'Memory Walks' at various locations across the U.K. People of all ages are invited to walk for either 2km or 10km to raise money for the charity. We have just had ours here in Cardiff and thousands of people who have been touched by Dementia in some way put their walking shoes on to march in celebration of loved ones living with Dementia and to raise money to reclaim the future.

Here is a list of the dates and locations of upcoming memory walks –
Carlisle – 1st of October 2016
Clumber Park – 1st of October 2016
Kent – 1st of October 2016
Essex – 2nd of October 2016
Leicester – 2nd of October 2016
Plymouth – 8th of October 2016
Brighton – 8th of October 2016
South Shields – 8th of October 2016
Surrey – 9th of October 2016
Bristol – 9th of October 2016
Gwent – 9th of October 2016
For more information, please visit
www.memorywalk.org.uk

Effective communication blog.

James McKillop, a founding member of the Scottish Dementia Working Group, has been living with Dementia for 15 years and has written a series of blogs sharing his insights about communicating with and supporting people with Dementia.

In the first blog, he talks about the importance of preparing for communication and interaction. Sometimes people are at their best at certain times of day – arrange to meet then. Send a letter, call them to remind them of your arrangement. James McKillop Blog 1

In the second part of his blog, James talks about how much the environment can impact upon communication and also of the emotional impact being in somewhere loud, unfamiliar, busy can have on someone living with Dementia. James McKillop Blog 2

The last instalment of James' blog, he talks about setting the best scene possible for communicating with somebody living with Dementia and he lists several things that we should be aware of, but are often not. Small things like ensuring the room is at a comfortable temperature, that they can see your face, that the lighting is adequate can make such a difference. James McKillop Blog 3

I found this blog extremely engaging and it has a lot of easy suggestions on how to make com-

municating with somebody living with Dementia a rewarding and rich experience.

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Dementia citizens research.

People with dementia from all over the UK still have time to sign up to Dementia Citizens and be part of research into how favourite music affects people's moods thanks to an app created for Playlist for Life, the Scottish music and dementia charity,

People living with dementia and their carers are invited to sign up now to take part in the Dementia Citizens project, recently launched by innovation foundation Nesta, by visiting: www.dementiacitizens.org

The Playlist for Life app uses Spotify to help people living with dementia find and listen to the most meaningful music for them and then organise it to affect their mood. Glasgow Caledonian University (GCU) is researching how this can be used to help improve care for people with dementia.

There is growing evidence that 'personally meaningful music' – the kind that takes you back to a time, person or place whenever you hear it – can be a powerful tool for people living with dementia. Playlist for Life was founded by writer and broadcaster Sally Magnusson in 2013 to bring the power of personal music to everyone with dementia in the UK.

Potential researchers will need an iOS smartphone or tablet (iPhone, iPads, iPod Touch) and will be given a Spotify account that they can keep afterwards, to keep listening to their music even when the experiment is over. Users of the apps during the next three months will help develop the technology and improve the user experience for people affected by dementia. -

The charity intends to develop new features for the app and make it available to the public later in the year.

Founder of Playlist for Life, writer and broadcaster Sally Magnusson said:

"**When I was caring for my mother with dementia, I noticed that music became the only thing keeping her with us. Old Scottish folk songs, hymns, the music of family parties. The music that was part of her life before the illness became a tool to help her live with the illness.**

"**I am delighted that Playlist for Life is now part of ground-breaking research into how this works through the Dementia Citizens platform and hope hundreds of people will sign up to take part so we can all learn more about what it can do.**"

For more information please contact: Sarah Metcalfe, Playlist for Life, 0141 418 7184

Information about Signpost

Anyone Can Contribute to Signpost

Including those who care for older people with mental health needs in hospital, residential homes and in the community.

Contributions

All contributions must demonstrate a positive attitude towards this group of people and their carers. Contributions can be made in the form of an article, care study, letter, question, announcement, review or other appropriate proposal.

Contact Details

Practice Development Unit, MHSOP, Llandough Hospital, Penarth, CF64 2XX.

Tel: 02920 715787

Email: Amanda.Furnish@wales.nhs.uk

Books Available for Review:

We currently have a number of books that require reviewing, if you are interested in providing a review please contact us. Thank you.

- Group and Individual Work with Older People. A practical guide to running successful activity-based programmes.
- People with Dementia, speak out.
- Can I tell you about Parkinson's Disease? A guide for family, friends and carers.
- Supporting People with Intellectual Disabilities Experiencing Loss and Bereavement (Theory and Compassionate Practice)
- Excellence in Dementia Care (2nd) - Research into Practice
- The Forgiveness Project - stories for a vengeful age
- A creative toolkit for communication in Dementia care
- Dancing with Dementia. My Story of Living Positively with Dementia
- Dementia Support for family and friends
- Introduction to the Psychology of Ageing for Non-Specialists
- Mind Clearing. The Key to Mindfulness Mastery.