

This document describes the training programme used in the intervention reported in: K.J.Lyne, S.Moxon, I.Sinclair, P.Young, C.Kirk, & S.Ellison: 'Analysis of a care planning intervention for reducing depression in older people in residential care' *Aging & Mental Health*, July 2006, Volume 10, Issue 4, pages 394-403.

## **THE TRAINING PROGRAMME**

### ***Recognising and reducing depression in older people***

### ***Developing skills - Improving practice***

#### **Introduction**

The Training Programme used in this project was devised for, and piloted in, a small study following evaluation of a needs assessment of residential care-staff. It was developed and refined in that study and minor modifications were made following its evaluation. It was found to be acceptable to trainers and to care-staff and was judged favourably by an independent observer. It captured the interest of care-staff and home managers and was perceived by them and health and social services professional staff as a potentially valuable programme. It was developed with consideration of links at an educational level with other training that care-staff may be undertaking, such as National Vocational Qualifications, so that it enhances and is compatible with other input and does not duplicate it.

There is evidence that theoretical training undertaken in an external location tends to be perceived by care workers as not directly relevant to their own particular day-to-day work practice and consequently less effective in its application in situ (Collins and Price 1990); nor is the outcome found to be successful if there is little opportunity to put theory into practice under guidance e.g. Gask, Thompson and Usherwood (1994); Goudie and Pirie (1996). This training programme was therefore designed on the basis of implementation in a naturalistic setting with opportunity for care-staff to develop their skills within their capabilities with support and under supervision.

#### **Compilation of the Training Programme**

The Training programme was developed with two major components to be addressed in two related studies. The components focussed respectively on i) the recognition of depression and ii) the reduction of depression in elderly residents.

## ***Objectives of the Training Programme***

Objectives for the two major components of the training programme were formulated by the researcher with members of the training team:

### *i) The recognition of depression:*

- to perceive there is a problem.
- to identify the problem as depression rather than e.g. uncooperativeness.
- to have some view about what could be done to deal with the problem.
- to use a simple check list to assess depression.

### *ii) The reduction of depression:*

- to understand the principles of care-planning intervention.
- to be able to use the care-planning approach with support.
- to increase confidence that depression can be reduced in older people.

## **The Experimental Programme**

The programme for reducing the prevalence and incidence of depression in homes for older people contains three distinctive elements: a period of direct training for all care-staff to establish the necessary skill base; followed by a period of skills development through mentor supported learning to reinforce the training, and an approach to the management of depression which combines both psycho-social and medical insights.

The first element of the programme consists of a training course which is offered to all care-staff in the home. The syllabus incorporates definitions of depression; recognition of depression; getting to know the individual person; communicating with depressed older people; the effects of loss; the effects of depression on thinking, feeling and behaviour; the care-planning intervention from medical, psychological and social perspectives, and the use of specialist resources. It is delivered in four group-based 3-hour sessions in consecutive weeks. The programme aims to alert care-staff to the signs of depression, to enhance their ways of responding to these and to give them confidence in tackling depression within their capabilities. A copy of the training course time-table is presented in *Appendix TP.1*. The aims and objectives of each session are presented in *Appendix TP.2*.

The second element in the programme consists of mentoring. The care-staff/key-workers of the residents who are judged to be depressed are offered up to five hours of contact with a skilled mentor over an eight

week period. The mentors support and further train the care-staff/key-workers in a care-planning approach with the residents and provide telephone back-up where necessary. They also discuss with care-staff/key-workers referrals to other professionals should these be needed. Unlike traditional methods of treatment, where a mental health professional works with a resident directly to treat depression, in this study the mentor does not meet the resident. The Mentor Role is described in *Appendix TP.3*.

### ***The care-planning approach***

The essence of the care-planning approach to be evaluated is that care-staff work through a systematic process of assessment and treatment with a resident who is depressed. The framework for the approach was originally based on the work of Barrowclough and Fleming (1986) where the principle was to develop a more positive and person centred approach to people in care. That approach emphasised the importance of objectivity and observability in working with residents' strengths to meet their needs by means of achieving goals. This experimental programme, however, extends that approach to include making inferences about emotions and psychological need as it is felt that these are crucial factors in encouraging care-staff to see the world from a resident's point of view. Although care-staff may be aware of a resident's disabilities and deficits, they may not be aware of the resident's existing strengths or supports. They will therefore talk to the resident and identify their existing supports and strengths. Through discussion and observation many problem areas may be detected. Care-staff will then reframe any problems a resident may have in terms of identified needs. From this assessment, in conjunction with the resident, they will identify clear and objective goals for 'treatment'. They will discuss with the resident the reasons for their unhappiness and agree with them what might practically be done about it within the constraints of their current situation. Finally they will devise a plan for achieving these goals, tailored to the individual, which they can then work towards by using the resident's strengths. The notion is that if a goal is defined then it will be known when it is achieved. With the focus on identified needs rather than depressive symptomatology, the assumption is that if needs are met, mood will improve. Interventions may include medical help, social support, psychological support such as bereavement counselling and practical steps to maintain independence and self-esteem. The steps that may be taken are various and might involve adjustment to hearing aids, encouragement to engage more with other residents, or make outside visits and so on. In more severe depression, referral for assessment by the GP or psychiatrist may initiate medical intervention.

It was expected to be able to identify differential effects of the intervention programme on the range of care-staff/key-workers and identify factors likely to lead to a more successful outcome in implementation of the programme. It would be useful to know whether

working through this process enables care-staff to not only recognise depression and develop strategies for minimising this problem, but also to perceive residents as individuals with particular needs, rather than members of one homogenous group. This approach to intervention has potential to be an efficient use of mental health professionals' time.

### ***The multi-agency/disciplinary approach***

Since the initiation of the Community Mental Health movement, the importance of working across professional and agency boundaries has been acknowledged and a multi-agency/disciplinary approach has become quite common in the support of people with mental health problems with varying degrees of success. This experimental approach tests an adaptation of multi-agency/disciplinary working.

### **The Training Team**

The idea of experienced mental health professional staff being used as trainers and mentors in a programme working with a depressed resident through a member of care-staff, rather than meeting with the resident face-to-face is a new concept and one which it is acknowledged may not appeal to all psychiatric staff, nor indeed may they be able to operate comfortably in this way. As the challenge is considerable, only people sympathetic to the idea and enthusiastic to experiment with a different way of working were recruited to the Training Team. Trainers were all members of the Community Mental Health Team for the Elderly (CHMT) who met these criteria. The group was multi-disciplinary and included a consultant psychiatrist for the elderly, a senior psychiatric registrar, a consultant psychologist and a clinical psychologist for the elderly and three community psychiatric nurses. Mentors, all experienced in working with older people and with mental health and trainer/supervisory qualifications, included one occupational therapist, three community mental health workers - two in day care, one in residential care - two senior staff nurses in mental health, one from a Community Unit for the Elderly and one from a mental health acute adult admission ward, together with one team leader in a psychiatric hospital. The study therefore made optimum use of National Health Services' (NHS) staff working alongside those of Social Services in normal practice. All members of the training team were trained on the application of the package to ensure that they could provide for a natural cascading of both information and good practice.

### ***Integration of clinical staff into this service development approach***

The Pilot Study helped to clarify the mentor role; the expectations that care-staff may have of the role; the significance of the care-staff - mentor relationship; differences in approach to facilitation between

para-medical professional groups, and the ease of integration of the different agencies.

## **Procedures for Training and Mentoring**

*Training:* Members of the training team present the training package to care-staff in a room in the home in which they work. For practical reasons there are two sets of sessions per home to enable some care-staff to be free to care for residents whilst their colleagues attend the training. Care-staff are encouraged to bring their own case studies for use as examples in the training but to use past ones to avoid bias in the research. Both trainers and care-staff maintain structured logs throughout the training period and provide a review on their work post-training.

*Mentoring:* Members of the training team provide mentoring support for care-staff/key workers who are selected to work with depressed residents whilst the care-planning 'treatment' is carried out. Mentors meet with care-staff/key-workers on a one-to-one basis in the home in which they work, facilitating shift patterns and other organisational arrangements of the home. They do not meet with the residents. Mentors and care-staff/key-workers maintain structured logs throughout the intervention period and provide a review of their work post-mentoring.

## **Evaluation of the Training Programme**

The structured training and intervention logs, case-note/diary systems, have been designed specifically for the research for evaluative purposes to capture reflections of the care-staff, trainers and mentors as they progress through the programme.

Qualitative information will also be available from feedback questionnaires for trainers and mentors on issues of training and mentoring supervision. Post-fieldwork meetings of the researcher with all members of the training team will provide a review of the full training programme.

### *Assessment of care-staff knowledge*

There was a requirement for an effective way of examining care-staff/key-workers to see if they have actually learnt from the training programme and, if so, to what extent they are able to apply their knowledge. The needs-assessment demonstrated that care-staff/key-workers are reluctant to volunteer for any training that involves writing and spelling, so a written examination would seem to be an inappropriate option if the study is to encourage care-staff to take part. Their learning therefore is assessed from a variety of sources which

reflect their understanding of the approach and the level of their effective practice. These include

- projection from measured change in resident depression during the training and intervention periods; an estimation of care-staff understanding and implementation of the care-planning 'treatment'.
- assessment material from the structured logs on the full training programme.

Care-staff who complete the training programme successfully receive certificates of participation.

## **REFERENCES**

Barrowclough C and Fleming I (1986) *Goal planning with elderly people: making plans to meet individual needs*. Manchester, University Press.

Collins M and Price P (1990, January 4) A step in the right direction. *Community Care*, 18-19

Gask L, Usherwood T, and Thompson H (1994) *Evaluation of a training package in the assessment and management of depression in primary care*. Report submitted to the Department of Health.

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Goudie F and Pirie Z (1996) *Depression in older people in the community: evaluating a staff training package*. Sheffield, Family and Community Services.

## **APPENDICES**

Appendix TP1: Training Course Timetable

Appendix TP2: Aims and objectives of theoretical training sessions

Appendix TP3: The Mentoring Role

## THE TRAINING PROGRAMME (TP1)

### Training Course time-table

	<i>Date</i>	<i>(Time)</i>
<b><u>Session 1</u></b>	.....	.....

Introduction to the course

- What is depression?
- How can you recognise it?

Illustrated with case studies, slides, video clips and handouts.

	<i>Date</i>	<i>(Time)</i>
<b><u>Session 2</u></b>	.....	.....

- Finding out about the individual person
- Active listening:
  - Giving time
  - Accepting feelings
  - Accepting the person

- The effects of loss

Illustrated with demonstrations, case studies and cases from the group.

	<i>Date</i>	<i>(Time)</i>
<b><u>Session 3</u></b>	.....	.....

- The effects of depression on thinking, feeling and behaviour
- Re-defining problems in terms of the person's needs
- Identifying the person's strengths
- Using strengths and needs to plan goals for helping

Illustrated with case studies, slides, video clips and handouts

	<i>Date</i>	<i>(Time)</i>
<b><u>Session 4</u></b>	.....	.....

- Collaborative working with the person to achieve the goals for helping

Illustrated with case studies, slides, video clips and handouts

- Any questions?
- Overview, summary and conclusion of the course

*Two case studies, derived from real-life situations, are used throughout the training programme for reference purposes.*

## **THE TRAINING PROGRAMME (TP2)**

### **Aims and objectives of theoretical training sessions**

#### **Session 1**

- to be aware of how common depression is, especially in residential and nursing home residents.
- to realise the complexity of “depression” and that lots of different things can masquerade as depression.
- to gain knowledge of symptoms of depression.
- to have confidence in identifying symptoms of depression in residents.
- to recognise who the significant people are in the care of the depressed resident.
- to recognise something can be done to help people with depression.
- to have some idea of the possible treatments for depression.

#### **Session 2**

- to get participants to explore how listening and responding skills are useful in their day-to-day work.
- to improve participants understanding of the role of observing and reporting skills in support of mental health in older people.
- to enable participants to better understand various ways in which mental distress manifests itself.
- to enable participants to recognise and respond more effectively to behaviours that challenge them in their day-to-day work.
- to increase participants knowledge about grief and loss.
- to assist participants to work in more supportive ways with older people who are grieving.

### **Session 3**

- to understand how depression affects feelings, behaviour and thinking
- to identify ways of responding to negative statements
- to explain the principles of the intervention – a person centred approach to care-planning
- to be able to identify problems and redefine them in terms of needs
- to be able to identify a person's strengths
- to be able to choose a goal with which to work

### **Session 4**

- to review the previous session and clarify areas of uncertainty
- to review assignment from session 3 and identify any difficulties which need to be addressed
- to be able to develop a care plan
- to be able to think through putting a care plan into action
- to develop more confidence in replying to negative statements
- to integrate learning from the whole course

*Two case studies, derived from real-life situations, are used throughout the training programme for reference purposes.*

**RECOGNITION AND REDUCTION OF DEPRESSION IN OLDER PEOPLE**  
**Developing skills and improving practice**

**THE TRAINING PROGRAMME (TP3)**

**The Mentoring Role**

Unlike traditional methods of treatment where a mental health professional works with a resident to reduce levels of depression, the mentor does not meet directly with the resident but works on the depression with the member of care-staff.

(This means that a mentor needs to be comfortable with the philosophy of the Training Programme).

**Preparation for mentoring**

- ensure a good understanding of the content of the Training Course
- clarify any queries about the training course with relevant trainer(s)

**Fieldwork** AIM to

- support care staff
- facilitate good communication with care-staff
- facilitate good communication between care-staff and resident

Care-planning procedures:

- i) stimulate fact finding about the resident by care-staff
- ii) enable care-staff to identify a problem
- iii) if a problem, alert care-staff to what needs that is expressing
- iv) redefine the problem in terms of needs
- v) work out an action plan with resident and implement plan
- vi) check with care-staff whether action is helping

Mentor will challenge care-staff assumptions

**Enabling role**

The mentor will enable care-staff

- to actively listen to resident
- to understand a resident's situation
- to understand boundaries of disclosure
- to encourage conversation but to know when resident wants to be quiet
- to see a resident as an individual
- to recognise what is being communicated by behaviour
- raise awareness of people's feelings
- to understand how attitudes reflect what is going on behind them
- prompt care staff for how to think about intervention

**Practicalities**

- a mentor will be sensitive to the constraints of the home time-table on care-staff
- facilitate home arrangements (e.g. shifts/meal and bath-times)