Social Work and Social Services   David Challis

This paper attempts to define the social work function in work with those who suffer from Alzheimer's Disease and their families. The authors describe a model of three phases of the disease process which demand different responses from the social worker. These phases, 'forgetfulness', 'confusional', and 'dementia' reflect the irregular and progressive deterioration of functioning over a period of time. Within these phases two broad roles are required, differing in style and emphasis as the condition progresses. These are seen as first, case-management, the effective co-ordination of the interdisciplinary treatment of the patient and second, provision of a wide range of direct support to the patient and family, including assisting families to make realistic decisions about care and dealing with the emotional aspects of the disease by responding to loss, grief and bereavement.

The first phase of activity was during the phase of forgetfulness. This period was seen as unpredictable in time, possibly lasting up to ten years. It is characterised by subjective cognitive deficits, particularly impaired recent memory. At this time there is increased family and marital disruption and on occasions abuse of alcohol and medication. The social work role in this early phase is to recognise the problem, facilitate interdisciplinary assessment and to provide support and where appropriate counselling to the patient and family. The authors rightly place considerable emphasis upon comprehensive assessment to detect other possible causes of apparent mental impairment such as hearing deficits or drug intoxification. When definite diagnosis of the condition is made the focus of activity is seen as moving to provision of information and assistance to families in coming to terms with the problem. Also important is the identification of ways in which the patient's residual competence may be maximised.

The confusional phase is evident through increasing impairment on a broader front. Greater difficulty is experienced with both recent and remote memory and the recognition of names and faces, there is a decline in the capacity for abstraction, a loss of the ability to generalise and decline in self-care skills. Increased supervision is required and those living alone are at greater risk. Family patterns and roles, balanced over many years, become unviable and new responses are required. Of central concern in this phase is to structure care plans for the elderly

person and to preserve the family through such arrangements as regularly scheduled time away from the confused person. At the same time with the patient a range of activities are continued such as maintaining patterns and pastimes in which limited participation is still possible and ensuring the promotion of residual functioning with cues based upon reality orientation. Organising the regular involvement of a physician is also stressed as the effects of even minor episodes of illness can exacerbate behavioural problems.

The third and final phase is the dementia phase. The person becomes severely disoriented, cannot identify family and friends, often exhibits paranoid ideas and is prone to incontinence and wandering. There is a loss of the very personality traits which have rendered the person unique throughout their life. The provision of basic nursing care is seen as crucial and assistance should be given to caregivers in structuring all the care provided to maximise their degree of control over the situation. Sometimes carers' experiences of loss are seen to occur well before bodily death. Continuous monitoring and re-evaluation is required to identify when the provision of home care is no longer viable.

COMMENT

This paper is a helpful contribution to the literature on the roles which must be performed by social workers dealing with long-term care. It offers a model of the appropriacy of different types of intervention at different stages in the disease process which is a useful addition to the slowly growing literature about the family dynamics of the mentally impaired elderly[1] and the case-management process for this group.[2]

C. J. Gilleard, 'Predicting the outcome of psychogeriatric day care', *Gerontologist*, **25** (1985), 281–285.

This study attempted to identify factors associated with different outcomes for patients following their initial attendance at a day hospital. Outcome was defined as placement 6–7 months after initial attendance. There were three different outcomes identified: still attending regularly, ceased attending but still living at home and entered a long-term care institution.

The study was based upon a sample of 129 patients attending four Scottish day hospitals, the principal selection criterion being that each had a readily available primary supporter in contact at least three times

per week. Primary caregivers were interviewed when referral for day care was first made to collect a wide range of information including indicators of strain, mental state, quality of relationship with the elderly person and problem behaviour.

It was then attempted to predict the outcome for patients on the basis of their characteristics at the time of referral using discriminant function analysis. Poor self-care ability, a high level of professional care input and a poor social relationship each independently contributed to the probability of entry into a long-term care setting. The reverse was associated with ceasing attendance at day care and continued home care. Continued day hospital attendance was associated with continence in the elderly person, lack of anticipated disadvantages from hospital treatment and help from family members.

The author concludes that the relief of strain, a frequently quoted aim of day care, is likely to be insufficient to influence the destinational outcome of care in the absence of changes occurring in the factors which were the source of stress and strain in the first place. The apparent negative relationship between the degree of professional care and likelihood of avoiding institutionalisation, irrespective of self-care ability, was also seen as a problem. It indicates a failure of formal and informal care to intermesh and suggests that the mode of provision of the former may have driven out the latter. This was a concern voiced by Philip Abrams.[3] Day care appears to have been a desirable service for those carers in poor health, with a continent elderly person largely dependent upon family help. These carers were frequently spouses.

COMMENT

This paper, albeit only a small scale study, is helpful in its attempt to more finely discriminate those people most likely to benefit from one mode of care than another. At times services such as day hospitals and day care are seen as appropriate for dementing elderly people in very different circumstances. As this study indicates, a diversity of responses are required to meet the equally varied needs of elderly people and their informal carers.

G. Glosser and D. Wexler, 'Participants evaluation of educational/ support groups for families of patients with Alzheimer's Disease and other dementias', *Gerontologist*, **25** (1985), 232–236.

G. L. Schmidt and B. Keyes, 'Group psychotherapy with family caregivers of demented patients', *Gerontologist*, **25** (1985), 347–350.

These two papers are both concerned with support groups for the carers of elderly people suffering from dementia. The first of these reports the feedback from group members of a time-limited series of groups based upon eight weekly two hour sessions. There were three specific goals of the group sessions: to provide accurate information about the medical and behavioural aspects of the condition and its natural course; to teach family members relevant skills to manage the behavioural, legal, social and interpersonal problems associated with this progressive condition; to offer support and shared experience for their difficulties and feelings. The structure of the early sessions was relatively formal, the first introducing the range of problems and difficulties each carer experienced, the next four or five providing information about the nature of dementia, behaviour management, legal and nursing home placement issues. In the latter sessions only was there a focus upon carers subjective fears, effects upon themselves and their families and the extent to which these were shared problems.

It was noteworthy that the aspects valued most by participants were the provision of information about the condition, the opportunity to learn different coping strategies and discussion with and meeting people in similar situations. This latter effect was seen as a form of normalisation by many. However less patient-specific aspects of the groups were not highly valued. In these domains the benefit of attendance was not generalised so as to reduce family conflict or reduce carers loneliness and isolation. The authors conclude that these areas are perhaps more suitable for more individualised help and intervention. Furthermore, carers frequently were dissatisfied at the time limited approach, although since this led to the formation of a self help group it could be seen as catalytic. The workload implications for staff went beyond attendance and leadership of the groups, particularly after the final session.

The second paper reports a support group which was provided to relatives at a day hospital. Indeed it was a condition of attendance at the day hospital that at least one member of the family join a support group. In contrast to the group described in the first paper however, this was not clearly time limited. Sensing that the efficacy of the group had reached a plateau, after some time the group leaders attempted to move the group from a supportive stance to an actively therapeutic one. The focus became increasingly upon the carers feelings rather than the elderly person. The effect of this approach appears to have been to create two sub-groups, one pursuing the new therapeutic objectives and the other adhering to a focus based upon the dementing person. The authors argue that there is a collective defence in such groups which can lead to the avoidance of carers' pain by focusing upon the behaviours

of the patient. They suggest that, with effective leadership, considerable relief through emotional expression may be obtained but they acknowledge the risk that the intensity of feeling may risk overwhelming the whole group as well as individuals within it.

COMMENT

The first paper indicated ways in which carers could benefit through the experience of group participation and suggested that in certain areas of difficulty an individual approach may be more appropriate. The second indicates the validity of these conclusions when it described the process of how group leaders effectively changed the agenda of a group. The two papers indicate the crucial importance of clarity of objectives when establishing group support for the carers of dementing patients, and the resource implications which go beyond the group setting itself. Reading the two papers also raises the question of whether professionals are sometimes too desirous to attempt to peel away defence mechanisms without sufficient consideration whether what for some individuals is maladaptive behaviour may be for others appropriate adaptive behaviour.

K. Simmons, J. Ivry and M. Seltzer, 'Agency–family collaboration', *Gerontololgist*, **25** (1985), 343–346.

The need to establish partnerships of a creative kind between the formal and informal sectors of care has for long been a concern of social policy. The establishment of care systems which achieve this is more problematic. This paper reports preliminary observations from one such attempt in the United States. Two broad sets of tasks in care of the aged were identified, case-management and counselling. The latter was deemed to be by definition beyond the remit of the family. The objective was that a complementary relationship should be established in which the family, through training, assumes as much responsibility as possible for performing case-management tasks.

Care-plans were jointly constructed by social worker and family member who each signed a care schedule and the family member was expected to undertake at least one case-management task. Information and advice was provided to the family member by the social worker to facilitate the performance of case-management tasks. The study is being evaluated by a method of random allocation of cases to the new approach or traditional services. The early evidence appears to indicate

that experimental group families performed more case-management tasks and that these cases were of shorter duration than control group cases. However there was no difference between the two groups with regard to the number of case-management tasks undertaken by the social workers.

COMMENT

Criticisms of professional service allocation approaches in the United States have led some writers to argue for the replacement of discretion by a service-eligibility based upon standardised measures of dependency.[4] The approach described here seeks to align professional discretion with greater consumer involvement through sharing of case-management tasks. However the neat dichotomy drawn at the beginning of the paper may be less helpful than it may have appeared. In practice the distinction between counselling and case-management is a blurred one and it is arguably desirable that it should remain so. For example, some elderly people may express reluctance to accept needed services and counselling may be required to overcome this. Furthermore, certain aspects of counselling may be most effectively provided through or alongside the process of planning and meeting practical needs.

NOTES

1 Bergmann, K., Manchee, V. and Woods, R., Effects of family relationships on psychogeriatric patients, *Journal of the Royal Society of Medicine*, **77** (1984), 840–844.
2 Challis, D. and Davies, B., 'Home care of the frail elderly in the United Kingdom: matching resources to needs', in Reif, L. and Trager, B. (eds), *International Perspectives on Long Term Care*, Haworth Press, New York, 1985, Challis, D. and Davies, B., Long term care of the elderly: the Community Care Scheme, *British Journal of Social Work* (December, 1985).
3 Abrams, P., Community care: some research problems and priorities, *Policy and Politics*, **6** (1977), 125–151.
4 Frankfather, D. L., Smith, M. J. and Caro, F. G., *Family Care of the Elderly*, Heath, Lexington, Mass., 1981.

Personal Social Services Research Unit,
University of Kent