

Republic for further training in cognitive-behavioural psychotherapy. Previous studies (Stern, 1993; Castle *et al*, 1994) drew attention to the specific deficits of training in cognitive-behavioural psychotherapy and supported the advice that there should be an increase of senior registrar posts in this speciality, so that future consultants will have some experience of cognitive-behavioural psychotherapy.

One hundred per cent of the sample recognised a need for improving psychotherapy training in Ireland. Some individual suggestions included a need to formalise a structured national training programme in psychotherapy, appointments of consultant psychotherapists in the Republic and support from the Irish Division of the College to promote psychotherapy training in psychiatry.

For a more structured and continuous means of assessing training in psychotherapy and ensuring that all non-consultant hospital doctors have adequate supervised training in all psychotherapies, previous papers have advocated the use of log-books (Royal College of Psychiatrists, 1995; Hamilton & Tracy, 1996; Sullivan *et al*, 1997). In this study 100% of non-consultant hospital doctors and 87% of consultants supported the use of log-books for documenting psychotherapy training.

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Information and advice received by carers of younger people with dementia

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Aims and method Retrospective information on advice and information received post-diagnosis was obtained from 40 carers of younger people with dementia, using a semi-structured interview.

Results Twelve carers received services from old age psychiatry, the remaining 28 from predominantly adult

psychiatry or neurology. Those in receipt of old age services reported greater adequacy of diagnostic information, higher levels of advice giving and more frequent referral to social services.

Clinical implications While old age services were more successful on the parameters examined, the gradually

emergent nature of the diagnosis may be a crucial factor in the lack of information and advice received by the comparison group.

The term early-onset dementia is used to describe any dementing disorder which begins before the arbitrary cut-off point of 65 years of age. There is no clear consensus as to which service should be responsible for the diagnosis and management of younger people with dementia, people being variably referred to neurology, general adult psychiatry or old age psychiatry. This may leave younger people with dementia and their carers either with services without specialist knowledge of dementia, or services designed for older people (Alzheimer's Disease Society, 1995).

Studies of carers' needs in early-onset dementia have found that advice, information, emotional support and practical help is inadequate (e.g. Sperlinger & Furst, 1994). Because younger people with dementia are physically fitter, more likely to be working and often still bearing financial and family responsibilities their service needs are high (Baldwin, 1994).

The aim of the study was to compare early-onset dementia carers' reports of the information and advice they received from either old age psychiatry services or other services (typically general adult psychiatry or neurology) within the catchment area of a mental health trust.

The study

Old age psychiatrists, neurologists and general adult psychiatrists were asked to provide details of all known cases of early-onset dementia resident within the area served by the Norfolk Mental Health Care NHS Trust (population 500 000). Cases had to have a formal diagnosis of dementia (excluding head injury and alcohol-related dementia), made by a consultant psychiatrist or neurologist and to have presented to their general practitioner (GP) with initial symptoms of early-onset dementia before the age of 65 years.

Carers were interviewed using a semi-structured interview adapted from Sperling & Furst (1994) to determine their views on satisfaction with services, adequacy of diagnostic information and advice on specific issues.

Findings

Twelve carers were identified who received services from old age psychiatry at the time of diagnosis, all of whom agreed to be interviewed (100% response rate). Thirty-six carers were identified receiving services from elsewhere, of whom, 28 agreed to be interviewed (general adult psychiatry, 16; neurology, 10; unknown, 2), a

response rate of 77%. Altogether, 40 carers were interviewed.

The mean age of sufferers was 61.15 years (s.d. 7.50, range 45–70) at the time of the study. For the old age psychiatry group the mean age was 65.43 years (s.d. 3.31, range 59–69) and for the comparison group, 59.95 years (s.d. 7.74, range 45–60). The age difference was significant ($t=4.82$, $P<0.001$). Twenty-one sufferers were female, 19 male. The mean time since diagnosis was 4.04 years (s.d. 3.12, range six months–nine years); mean and range were similar for both groups.

Of the 40 carers, 29 were female (19 wives, seven daughters, one daughter-in-law, one sister) and 12 male (11 husbands, one son). Spouse and non-spouse carers were equally distributed between the two groups. Carers were asked to rate satisfaction with their GPs' response to initial presentation using a five-point rating scale, where 1=very dissatisfied and 5=very satisfied. The mean rating was 3.55 (s.d. 1.65), with a median of 4; 'fairly satisfied'. Thirteen carers were dissatisfied with GP response, of whom 12 complained of long delays before consultant referral. The mean waiting time until secondary care referral was nine months. Being referred late (several months or more) was significantly associated with a 'dissatisfied' rating ($\chi^2=6.26$, $P<0.05$).

Carers were asked about the information they received after diagnosis, which is shown in Table 1. The frequency distribution of adequate/inadequate responses was significantly different, the old age psychiatry group being more likely to have received adequate information ($\chi^2=6.97$, $P<0.01$). Advice about a number of specific issues is shown in Table 2.

Carers were asked to rate overall satisfaction with services, on the same five-point scale described above. The mean rating for the old age psychiatry group was 3.66 (s.d. 1.04), median rating 5, 'very satisfied', and for the comparison group 3.11 (s.d. 1.42), median rating 4, 'fairly satisfied'. When invited to make comments; 29 carers generated 36 negative comments. Of these, the most common related to delays from

Table 1. Carers' views on adequacy of diagnostic information

	Old age psychiatry (n=12)	Other service (n=28)
Adequate verbal information	10 (83%)	4 (14%)
Written information	4 (33%)	0
Inadequate information	2 (17%)	24 (86%)
Do not know/cannot remember	0	2 (7%)
Referred to social services	10 (83%)	11 (39%)

Table 2. Advice received by carers on specific issues

	Old age service (n=12)	Other service (n=28)
Enduring power of attorney	10 (83%)	6 (21%)
Benefit entitlement	4 (33%)	4 (14%)
Ability to work (where applicable)	3 (100%)	1 (7%)
Ability to make a will	6 (50%)	3 (11%)
Fitness to drive (where applicable)	4 (80%)	8 (40%)

seeing a consultant to obtaining a diagnosis (14), then poor information (13), lack of practical help (5), and medical staff being rude or dismissive (3).

Comment

The study is limited by the smaller sample size and older age of the old age psychiatry sample relative to the comparison group. Carers' views on local services may not be generalisable to other parts of the country. The findings are dependent on the accuracy of carers' memories of events, sometimes from many years ago, and may be biased by subsequent events. Only 48 cases of early-onset dementia could be identified in a catchment population of 500 000, considerably lower than current estimates (Alzheimer's Disease Society). The low numbers identified in this study suggests that many sufferers are not in contact with secondary care, which may in itself be indicative of the poor service provision available for early-onset dementia.

With these cautions, the results of this study support the view that old age psychiatry seems better able to provide for people with early-onset dementia, as evidenced by better diagnostic

information, higher rates of referral to social services and more frequent advice on financial/occupational issues such as benefits, enduring power of attorney and work.

Despite this, few sufferers and carers had access to old age psychiatry services, which may in part be due to unresolved conflicts about resources. The low levels of information and advice received by the comparison group, and the finding that delays in making a diagnosis are the key source of carer dissatisfaction, may both relate to the gradually emergent nature of the disorder. The lower index of suspicion in younger people, the prevalence of rarer causes and the frequently non-specific nature of the prodromal symptoms may result in long involvement with other services before a diagnosis is made. Sufferers and carers may then be reluctant to break existing relationships and may see referral to old age psychiatry as stigmatising.

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Facilitating a staff support group on an oncology ward: some observations

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Aims and method In this paper an experience of facilitating a weekly support group for nursing staff on

an oncology ward is described. A brief overview of burnout among oncology nurses is followed by a