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Since graduating from the clinical psychology postgraduate program at the University of Queensland in Brisbane, Australia, I have had the pleasure of gaining experience working in aged care in both Australia and the United Kingdom. I qualified as a clinical psychologist in 2013, and worked firstly for the dementia charity Alzheimer's Australia, in a role supporting the staff of care homes across the state of Queensland, from the city of Brisbane to the rural and regional areas beyond. In 2015, I moved to London, UK, with a plan to take on locum work with the National Health Service (NHS). I stumbled upon a locum contract in a small, newly-commissioned care home team for an NHS Trust in South West London, which soon after became a permanent role; four years later, I am proud to be Clinical Lead of the team. Our multidisciplinary service provides support to the staff of care homes in working effectively with residents of any age with a diagnosis of dementia, or those over 75 years who have a mental health condition. Here, I lead the team in utilising an innovative and psychologically-driven approach to care, one that actively challenges a more traditional, medical model view of mental health and ageing.

The approach I use in my work with care home residents with dementia is the Newcastle model (James and Stephenson, 2007). This systemic, formulation-based approach aims to understand distressed behaviour displayed by an individual with dementia as an expression of their unmet needs. The model advocates for a compassionate and person-centred response to meeting those needs. I have found that many of the major challenges of implementing this model in the

Australian aged care sector are also present in the British one, particularly in regards to care home staff working within highly risk-averse and institutionalised workplace cultures, which prioritise the completion of daily care tasks over providing an enriching and enabling environment for their residents. Further, the degree of training, remuneration, and organisational support for staff is often inadequate given the complex and challenging nature of their work.

In this context, I have learnt that enabling care staff to compassionately understand and approach distressed behaviour displayed by their residents with dementia is often a matter of education. Our team endeavours to train and empower staff to understand the ways that dementia affects a person's brain, and the subsequent psychological, sensory and behavioural changes that result. I work with staff so that they can understand an individual resident's life history, and can tailor their approach, communication and daily activities to the person's unique preferences and interests. The process involves a lot of 'detective work': speaking to a patient's family, friends and networks to piece together their individual personality and life experiences. Once empowered by this knowledge and understanding, carers regularly adopt a skilled and compassionate approach to their work with older people, and overcome challenges within the often rigid and inflexible care home environment.

Relocating to London has brought the opportunity to work with older people who have lived within an incredible diversity of cultures and historical circumstances quite different to the historical and cultural context in Australia. Amongst the older people I work with are those who were the first within their family to migrate to London and made the capital their home. Understanding diverse cultural and spiritual needs, through consultation with the resident and their family, forms a key part of the Newcastle approach. Meeting the vast diversity of spiritual and cultural needs of Londoners within the care home system presents a myriad of challenges, including overcoming language barriers, adapting care tasks and routines, and meeting dietary requirements and preferences. It is necessary to openly enquire about, and explore, a person's individual cultural and spiritual needs, and utilize a collaborative and creative approach to problem-solve barriers to meeting these with staff and the resident's family.

Many of the care home residents with whom I work have lived through historical circumstances that have included war and social unrest, with some having experienced repeated and complex trauma. For example, a number of the Jewish people who sought safety in the UK as a result of the Holocaust in World War Two are now residing in London's aged care facilities. Some have also developed dementia. These survivors are deeply affected by their wartime experiences, and I have found that past traumas can interact with dementia in complex ways. Those who experience dementia lose their more recent memories, and traumatic memories may surface in a way that makes the person feel as if their safety is currently under threat. Medical and institutional environments similar to those in aged care facilities can also trigger memories of trauma, as does the loss of independence, privacy and control often associated with moving to an aged care home. Understanding how a patient's traumatic past surfaces in their present behaviour is vital in providing individual care, particularly in regards to potentially invasive tasks such as washing and dressing.

The success of the care home service in which I work would not be possible without highly collaborative and effective working relationships, both amongst our multidisciplinary colleagues

within the team, and with the care home staff and external professionals with whom we work. Operating within care homes and an NHS team, I often find myself in highly-pressured, time-poor and, at times, chaotic environments in which a reliable and supportive team approach is essential in managing busy workloads whilst remaining patient-focused. More broadly, taking the time to connect with and nurture relationships with other professionals in the aged care field, both at home in Australia and abroad, has provided me with invaluable support and motivation in my work. Doing so allows me to appreciate the key issues and challenges in the field of ageing from an international perspective, and enables me to aspire for best practice within our service.

Jackman, L., & Beatty, A. (2015). Using the Newcastle Model to understand people whose behaviour challenges in dementia care. *Nursing older people*, *27*(2).

James, I.A. & Stephenson, M. (2007). Behaviour that challenges us: The Newcastle support model. *Journal of Dementia Care, 15* (5), 19-22.

Dexter-Smith, Sarah. (2010). Integrating psychological formulation into older people's services - three years on (Part 1). *PSIGE Newsletter. 112* (1), 8-15.

http://www.dwmh.nhs.uk/wp-content/uploads/2015/03/P22d-Caroline-OA-Understanding-and-Treating-Behaviour.pdf