Dance Movement Psychotherapy Service Evaluation 2005-2013

Report commissioned by:
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Acknowledgements

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Please note:
Percentages throughout this report may add up to +/- 100% due to rounding up/down.

EXECUTIVE SUMMARY

South West Yorkshire Partnership NHS Foundation Trust provides a variety of services to a diverse population across the localities and is committed to achieving its mission and values:

Mission:

- Enabling people to reach their potential and live well in their community

Values

- Honest open & transparent
- Person first and in the centre
- Relevant today, ready for tomorrow
- Respectful
- Improve & be outstanding
- Families and carers matter

The findings of **Phase 1** of this evaluation represent a longitudinal study over 4 years of the impact on people with dementia at the now closed Kershaw Grange Specialist Dementia Centre between 2005 and 2009. **Phase 2** is a less in-depth evaluation of the service at Higgins Close, Lower Edge and Hebden Vale Day Centres, plus on the ward at Beechdale (CRH).

Service aims are psychotherapeutic, helping the person feel connected to a sense of self (supporting 'Personhood'), to other people and the environment around them. This means remaining in contact with residual strengths and remaining capacities, in order to cope better with the mounting losses they experience as the condition worsens, and to remain living independently in the community for as long as possible. These are difficult outcomes to measure, however a methodology has been developed involving the use of six different categories applied to each participant by RC after each DMP session. They have been presented and analysed here, all of which relate to current best practice as recognised by NICE guidelines, the National Dementia Strategy (2009) and in Trust policies and procedures. Phase 1 results show significant outcomes as all service users at Kershaw Grange had a dementia diagnosis. The results will now be written up in a publishable format in the context of DMP, and offered for publication in the DMP/ dementia care field.

The main conclusions are that these results can be taken as significant indicators of the positive impact on service-users in each of the six categories analysed here; 'Wellbeing through Movement', 'Expresses Self Creatively', 'Communication with Others', 'Shows Pleasure & Enjoyment', 'Connection with Past Memory and Experience', 'Connection with Songs and Music'. The findings so far are relevant to improving skills and knowledge for the service and for the wider DMP field. Further analysis is needed however, perhaps data picked out as a case study with publication of results accordingly.

The main recommendations are that:

1) Further data analysis needed in relation to development of a case study taking the scores of one service-user (selected at random) and examining them, offering up new conclusions not presented or analysed here. Combined results then turned into a publishable article.
   Action: RC in liaison with CGST
2) Systems for electronic data gathering and analysis are antiquated and need to be much more robust and less time consuming, making it possible for electronic data input on a regular basis rather than after a period of years.
   Action: RC in liaison with CGST
3) A review of the DMP service be held in relation to all the changes currently taking place in OPS Calderdale, to ensure a good fit with stakeholder needs (Calderdale Council)
   Action: RC in liaison with CGST, Line Manager, Calderdale Council

1. Introduction

The Dance Movement Psychotherapy Service aims to make effective contributions to the psychological well-being of people affected by degenerative neurological conditions; as an accredited psychological therapy it also creates opportunities for verbal and non-verbal (embodied) communication: 'In the hands of a skilled arts therapist, the artistic medium can be safe, containing and enabling forms of communication where words are not enough' (Arts Therapies Professional Bodies 2009).

This report contains analysis of 2 phases of work. **Phase 1** represents a detailed longitudinal audit of the DMP service at Kershaw Grange Specialist Dementia Centre from January 2005 to when it closed in October 2009. All service users had a diagnosis of dementia, which is significant in relation to future publication of the results. **Phase 2** runs from October 2009 to Jan 2013 and is not as detailed an analysis as the Kershaw audit, in part because it is not possible to measure like with like, as possible at Kershaw, in part because evaluation and audit systems currently used are too time consuming; which is a recommendation in this report, to simplify and make them more robust and electronic as well

1.1 Background

Designed and run by Dr Richard Coaten (RC) a leading specialist in movement, dance and dementia, the service provides group and individual based sessions in Dance Movement Psychotherapy (DMP), including the provision of staff development and training. Delivered within a 'Person-Centred' & 'Relationship-Centred' paradigm activities involve a range of movement, music, dance, song and reminiscence all carried out in the context of either chair-based or ambulant participation (Coaten, 2010). The service since October 2009 is located in three Health and Social Care Partnership Day Centres in Calderdale (Higgins Close, Lower Edge and Hebden Vale) and on an Acute Assessment and Treatment Ward (Beechdale) at Calderdale Royal Hospital; involving a partnership with Calderdale Council.

Phase 1 of this evaluation represents a significant piece of work in plotting the effects of the service on service users with dementia over time, drawing conclusions from the data and making recommendations for the future. The data analysis phase was very time consuming and for that reason has not been undertaken in the other sites where the service now operates, although the data itself is available. An assumption has been made here, that a detailed and thorough analysis over a longer time period in one setting is likely to reveal accurate trends across service provision. SPSS analysis was carried out on the data supplied to Victoria Hitchman and Suzy Daly.

1.2 Aim

The DMP service provides a high-quality, bio-psychosocial model of care aiming to increase the range and quality of embodied psychologically oriented therapeutic activity currently within Trust Services in Calderdale. It does this within NICE and other guidelines, also contributing to the training and development of nursing, health and social care-staff in settings where the service operates. It aims to ensure all interventions take place within a multidisciplinary framework with links to RIO, Health/Social Services and other local teams (Care Home Liaison/Home Care Team/CMHT's) and also with Carers. It also helps to maintain direct links with other colleagues e.g. Occupational Therapists, Physiotherapists, Speech and Language Therapists, Psychologists and Psychiatrists.

RC is not permitted to train staff in DMP but instead in Therapeutic Dance effective in equipping staff to support the on-going development of non-verbal movement

based embodied practices. Evidence is found within the NICE guidelines for the use of arts-based therapies as a psychologically based treatment and care option for people with dementia especially within a ‘Person-Centred’ approach to care service provision.

1.3 Methodology

Data was collected on an ongoing basis after each DMP session from 21st February 2005 to 20th October 2009. Each participant was given a number, and a total of 122 individual participants were involved over the 4 year period.

All aspects of confidentiality were maintained throughout the project.

1.4 Staff involved

Dr Richard Coaten – Dance Movement Psychotherapist
Suzy Daly – Clinical Audit Facilitator, CGST
Victoria Hitchman – Information Management & Project Support Officer, CGST

2. Phase 1 Results

The number of sessions was recorded annually from 21st February 2005 until 20th October 2009. In total there were 314 sessions. Overall there were 122 participants over the four-year period.

The following results are shown both as a total for the evaluation period and for each year in the evaluation period.

2.1 Service user participants

Service users attended between 1 and 314 sessions over the period. The average number of times the service users attended over the period was 17. The average number of service users per session was 6.

Table 1 - Service user attendance

Number of sessions attended	Number of service users attending sessions				
	05 – 06	06 – 07	07 – 08	08 – 09	09 - 10
1 – 9	32	14	26	22	24
10 – 19	7	3	6	4	3
20 – 29	1	5	2	6	5
30 – 39	1	2	4	2	3
40 – 49	-	-	2	1	1
50 – 59	-	-	-	1	-
60 – 69	-	-	-	-	-
70 – 79	-	-	-	-	-
80 or more	-	-	-	-	-
Totals	***41***	***24***	***38***	***36***	***36***

Table 2 - Number of service users per session

Number of service users in session	Number of sessions	Total number of attendees from all the sessions
One	2	2
Two	1	2
Three	10	30
Four	51	204
Five	70	350
Six	92	552
Seven	41	287
Eight	30	240
Nine	12	108
Ten	4	40
Eleven	1	11

2.2 Staff and student participation

Staff and students were also invited to attend the sessions. One or more members of staff attended 261/314 (83%) sessions. In 52 sessions there was one student attending and at 1 session 2 students attended.

2.3 Scores

The 'Individual Record of Response to the Session', was used for each service-user post each session. The following 7 categories were used; 'Wellbeing through Movement', 'Expresses Self Creatively', 'Communication with Others', 'Shows Pleasure & Enjoyment', 'Connection with Immediate Memory & Experience', 'Connection with Past Memory and Experience', 'Connection with Songs and Music'. A Likert Scale was used to represent differing degrees of significance for the participant as identified by RC: 0 (No signs), 1 (Some signs) and 2 (Significant signs).

The maximum score was calculated by taking the total number of attendances from all the sessions (1826) and multiplying by 12 (top score of 2, times 6, the number of categories), giving an overall score of 21,912. The total of the scores recorded was 18,016 (82%). The following results show the maximum total scores and those achieved for the duration of the evaluation period and for each year of the evaluation period, for each of the seven assessment categories. Reliability is arguably stable for all the measures taken, in relation to the fact that RC is the only person carrying out these measures.

Conclusions are drawn from analysis of these scores and assumptions are also made, however a more complete picture can only really be gained, by adding qualitative data such as service user comments to the quantitative analysis represented in this report by the following categories.

2.3.1 Well-being through Movement

This category refers to the need to identify the impact of the session on observed 'well-being' for all participants as experienced through the embodied movement/dance domain. The basis for decision making by RC in this category is founded on his 'Person-Centred Care Training' his 'Dementia Care Mapping Training' (DCM 7th Edition) provided by the Bradford Dementia Group (2001) with update to DCM 8th edition (2006); combined with his training and experience in DMP. A Level 2 score would be given on the basis of significant indicators of observed 'well-being' through movement, witnessed by full participation and engagement with the movement and dance based aspects of the session; with full appreciation by RC of those less ambulant, either in wheelchairs or with 'Zimmer' frames or 'rolators'. Level 1 score would be for a person showing some signs of engagement, with Level 0 the person showing no signs of 'well-being' through movement, where engagement with the movement aspects of the session is non-existent. See table 3 on the following page for a breakdown of the scores.

Table 3 – Well-being through Movement scores

	Year					
	05 – 06	**06 – 07**	**07 – 08**	**08 – 09**	**09 – 10**	**05 – 10**
Number of '0' scores	35	9	27	39	34	144
Number of '1' scores	110	53	205	199	151	718
Number of '2' scores	125	293	198	181	167	964
Total score for time period	***360***	***639***	***601***	***561***	***485***	***2646***
Maximum score for time period	***540***	***710***	***860***	***838***	***704***	***3652***
Percentage achieved	***66%***	***90%***	***70%***	***67%***	***69%***	***72%***

Analysis of Table 3 reveals that for the period 06-07 and 07-08 there were more scores at Level 2 than in the previous or following years. The significance thus appears to increase generally for the person with a drop-off in year 08-09 with a corresponding increase in Level 1 scores that year and also an increase in Level 0 scores. This increase in Level 1 scores from 07-08 onwards may reflect deterioration in mental health on the part of those taking part on a regular basis. Significantly for the whole period the service achieved an overall percentage of 72% equating maximum scores for the time period with total time scores.

2.3.2 Expresses Self Creatively

This refers to the extent to which the person is able to express creatively in the session. For example, do they initiate a creative activity, do they participate fully in one (Level 2 score), or only partly (which would mean a Level 1 score) or not at all (a Level 0 score). Creative self-expression is linked to the ability of the person to initiate activity and it is known that neurological deterioration in Alzheimer's, for example, inhibits motivation and self-expression, as the frontal lobes are affected. Thus support for initiating creative activity helps both maintain this function and to build on residual strengths and capacities in the person. Table 4 below shows a full breakdown of the results.

Table 4 – Expresses Self Creatively

	Year					
	05 – 06	**06 – 07**	**07 – 08**	**08 – 09**	**09 - 10**	**05 – 10**
Number of '0' scores	19	4	21	21	27	92
Number of '1' scores	96	48	218	207	130	699
Number of '2' scores	155	303	191	191	195	1035
Total score for time period	***406***	***654***	***600***	***589***	***520***	***2769***
Maximum score for time period	***540***	***710***	***860***	***838***	***704***	***3652***
Percentage achieved	***75%***	***92%***	***70%***	***70%***	***74%***	***76%***

This reveals a similar trend of number '2' scores peaking in Year 2, also with the lowest number of Level 0 scores in that year. In years 07-08 and 08-09 the level of No.1 scores increases significantly which was also a feature of Table 3, as do the Level 0 scores, again repeating a theme of possible increased deterioration in mental-health, a feature that we would expect to see given the levels of frailty and dementing conditions present. Once again the overall percentage remains at a high 76%.

2.3.3 Communication with others

This refers to the extent to which service-users are actively communicating with each other and with the group as a whole, as a way of assessing the individual's social interaction and connection with those around them. The service-user who is witnessed actively communicating with others, verbally and non-verbally throughout the session, will thus be given a Level 2 score; some communication with others will illicit a Level 1 score; and no communication, or taking a very passive communicative stance in the session will illicit a Level 0 score. Table 5 below gives a full breakdown of the results.

Table 5 – Communication with Others

	Year					
	05 – 06	**06 – 07**	**07 – 08**	**08 – 09**	**09 - 10**	**05 – 10**
Number of '0' scores	13	15	60	58	49	195
Number of '1' scores	79	111	179	199	107	675
Number of '2' scores	178	229	191	162	196	956
Total score for time period	***435***	***569***	***561***	***523***	***499***	***2587***
Maximum score for time period	***540***	***710***	***860***	***838***	***704***	***3652***
Percentage achieved	***81%***	***80%***	***65%***	***62%***	***71%***	***71%***

Table 5 again shows a peak in Year 2 for scores at Level 2, which is a consistent finding across the tables reducing thereafter with increases in Level 0 and also in Level 1. Once again the overall percentage of maximum score for the time period set against the total score reveals a high score average at 71%, which is again of significance. This indicates strong evidence of communication with others taking place. There is also evidence here of a deterioration in communication ability as the Level 2 scores show a decreasing trend, with a relative increase in Levels 1 and 0 scores. N.B. the scores for 09-10 have to be taken only as part years, as they ceased in October 2009 rather than January 2010.

2.3.4 Shows Pleasure and Enjoyment

Pleasure and enjoyment relate to overall observed 'well-being', an important element in the delivery of 'Person-Centred Care'. A service-user exhibiting high degrees of pleasure and enjoyment would gain a Level 2 score, with Level 1 showing some signs and Level 0 showing no signs of this. Table 6 on the following page shows a full breakdown of the results.

Table 6 – Shows Pleasure & Enjoyment

	Year					
	05 – 06	**06 – 07**	**07 – 08**	**08 – 09**	**09 - 10**	**05 – 10**
Number of '0' scores	5	2	3	10	21	41
Number of '1' scores	72	29	128	141	79	449
Number of '2' scores	193	324	299	268	252	1336
Total score for time period	***458***	***677***	***726***	***677***	***583***	***3121***
Maximum score for time period	***540***	***710***	***860***	***838***	***704***	***3652***
Percentage achieved	***85%***	***95%***	***84%***	***81%***	***83%***	***85%***

Table 6 again shows a peak in Year 2, coupled with higher overall percentages than in any of the other categories, which is also significant. The overall 85% for all the years indicates that overall pleasure and enjoyment ('well-being') are consistently being achieved. This is evidence of significant outcomes of the service in this category. These results are consistent with contemporary researches in the DMP field, and are of added significance because it is well-known that people with a dementing condition have so many losses and difficulties to deal with; that to find activities which they can both participate in and also enjoy, is clinically, emotionally and psychologically of great importance.

2.3.4 Connection with Past Memory & Experience

This category attempts to capture evidence for connection with memories of life experience and the past, on the basis that as language skills deteriorate, being able to tap into individual memories of the past are important by way of support for self-identity and the on-going concept of 'Personhood'. Level 2 scores would be given for significant signs of past memories being present, Level 1 for some signs and Level 0 for no signs. Table 7 below shows the full results.

Table 7 – Connection with Past Memory & Experience

	Year					
	05 – 06	**06 – 07**	**07 – 08**	**08 – 09**	**09 - 10**	**05 – 10**
Number of '0' scores	34	52	221	281	199	787
Number of '1' scores	96	141	142	106	99	584
Number of '2' scores	140	162	67	32	54	455
Total score for time period	***376***	***465***	***276***	***170***	***207***	***1494***
Maximum score for time period	***540***	***710***	***860***	***838***	***704***	***3652***
Percentage achieved	***70%***	***66%***	***32%***	***20%***	***29%***	***41%***

Table 7 shows a significant drop in Level 2 scores after Year 2, also coupled with a significant rise in Levels 1 and 0 during subsequent years. This sudden drop could be due to any number of factors. A detailed case-study analysis may shed light on this phenomenon by looking at random individuals. The overall percentage achieved at 41% is significantly less than the average achieved in the other categories. Problems with memory, both long and short-term, are to be expected with all forms of neurological deterioration; it is interesting however that this aspect of the session and its analysis, point to collective and on-going group problems with memory.

2.3.5 Connection with Songs and Music

As with the other categories this was chosen to capture an important element of a DMP session. It is of increasing interest to DMPs in the field that music, movement, dance and song are all related to each other and much research work has been done in the field of music therapy and dementia care (reviewed by Aldridge, 2000). As 'emotional expression' seems less affected by a dementing condition, in the latest researches in the field (Milwain, 2010), music 'rhythm & pulse' have also been found to support communication ability and the recovery of language. Level 2 would be given for significant signs of connection/enjoyment of songs and music, Level 1 for some signs and level 0 for no signs. Table 8 on the following page shows the full results.

Table 8 – Connection with Songs and Music

	Year					
	05 – 06	**06 – 07**	**07 – 08**	**08 – 09**	**09 - 10**	**05 – 10**
Number of '0' scores	21	1	24	17	13	63
Number of '1' scores	87	47	101	112	60	347
Number of '2' scores	137	294	305	290	279	1026
Total score for time period	***361***	***635***	***711***	***692***	***618***	***2399***
Maximum score for time period	***540***	***710***	***860***	***838***	***704***	***2948***
Percentage achieved	***67%***	***89%***	***83%***	***83%***	***88%***	***81%***

Results in Table 8 show significantly high scores at Level 2, remaining of significance throughout the time period, with an overall 81% significance rate achieved. There is also evidence of increasing Level 1 scores, which may also correlate with increasing frailty and decreasing levels of ability as seen in the other tables analysed here in this evaluation. Results in this category are consistent with research in the field generally, that music and song are important elements in enabling service-users to remain in touch with previously acquired musical abilities, and in helping support and maintain observed 'well-being'.

3. Phase 2 - October 2009 to January 5th 2013

This began following the closure of Kershaw Grange and Savile Close and transfer of the DMP service to three Health & Social Care Partnership Day Centres, while work continued on Beechdale Ward at the Dales. This part of the audit is far less detailed than that in Phase 1, which in terms of time commitment alone would not be feasible to repeat in all settings. Furthermore the service-users at Kershaw were all diagnosed with dementia and this is certainly not the case in Phase 2 settings where there is a mixture of presentations.

Hebden Vale Day Centre, Calderdale

Start date: 12/11/09 End date: 11/12/12

Session Nos: 84 Participating service-users: 156

Higgins Close Day Centre, Calderdale

Start date: 11/11/09 End date: 08/01/13

Session Nos: 121 Participating service-users: 124

Lower Edge Day Centre, Calderdale

Start date: 10/11/09 End date: 10/01/13

Session Nos: 100 Participating service-users: 167

Beechdale Ward (CRH), Calderdale

Start date for purposes of this evaluation: 23/06/09 End date: 09/01/13

Group based session Nos: 63 Participating service-users: 142

Phase 2 Service-User total = 589

4. Summary of Phase 1 & Phase 2 Results

The Phase 1 data presented here are significant for the Trust and also for the DMP profession as they represent the first detailed audit run over a five-year period, using the evaluation methodology described here. Results have shown significantly high average percentages (over 71%) for the duration of the time period in; 'Wellbeing through Movement': 'Expresses self-creatively': 'Communication with others': 'Pleasure and Enjoyment', and in 'Connection with Songs and Music'. 'Connection with Past Memories' did not score as high (41%), which is arguably connected with deteriorating memory, to be expected with these service-users.

Reliability is maintained to the extent that RC is the only person filling in the session record sheets; that took place immediately following each session in order that RC's own memory of what took place is not impacted by delay in writing up. Overall, service-user attendance averaged six in a group and since the closure of Kershaw, the average service-user attendance has risen to about 10. Smaller group numbers mean more time to pay individual attention to each person. As session numbers grow, so it is less possible to maintain individual focus as meeting group needs becomes increasingly important. However, higher numbers also mean the service is reaching more service-users.

Results analysed here consistently show support for the use of **residual strengths and remaining capacities** by those participating service-users, totalling 122 in number over 314 sessions; arguably helping service-users maintain independent living in the community. Carers have been supported in relation to awareness raising activities by the service, concerning the vital importance of non-verbal 'body-based' communications and how to recognise and respond to them better. The service also provided an important respite for carers on a daily basis.

The service is innovative because it is at the leading edge of developing awareness and evidence concerning the importance of psychologically based embodied arts-therapies in the treatment of people with dementia. It is also innovative because movement, dance, music, reminiscence and song are at the core of the work and all these have been shown in research studies to benefit people who are cognitively impaired. Singing, Moving, Dancing, Reminiscing and listening to music are also very accessible to both carers and people with dementia in supporting their relationships (see 'Singing for the Brain' and 'A Company of Elders').

The service also enabled care-staff to be trained in both movement and dance-based approaches as well as in Person-Centred Care.

5. Conclusions and Recommendations

5.1 Conclusions

Conclusions are that Phase 1 results be taken as significant indicators of the impact on service-users in each of six categories analysed here, using a Likert Scale; 'Wellbeing through Movement', 'Expresses Self Creatively', 'Communication with Others', 'Shows Pleasure & Enjoyment', 'Connection with Past Memory and Experience', 'Connection with Songs and Music'. There is still much more information relating to service-users that could be reliably extracted from the data using a Case-Study approach. The significance of the findings so far, are relevant to improving knowledge in the DMP field and further case-study type analysis coupled with publication in a suitable journal would enable that to happen.

An assumption is made in this evaluation that given the detailed analysis at Kershaw in Phase 1, the outcomes are likely to be similar in the other settings where the DMP service was operating during Phase 2. A total of 589 service-users took part in DMP sessions in Phase 2 including individual work (Beechdale Ward) which is also significant.

Overall, the evaluation has highlighted that evaluation and data analysis systems are not in line with current needs for effective feedback loops to enable RC and others to know details of how the service is performing on a regular basis. Electronic input systems would help a great deal as recommended in discussions with SD & VH (30/4/13). The evaluation has also highlighted the need for a service review in the light of all the changes taking place in OPS service in Calderdale.

5.2 Recommendations

1) Further data analysis needed in relation to development of a case study taking the scores of one service-user (selected at random) and examining them, offering up new conclusions not presented or analysed here. Combined results then turned into a publishable article.
Action: RC in liaison with CGST

2) Systems for electronic data gathering and analysis are antiquated and need to be much more robust and less time consuming, making it possible for electronic data input on a regular basis rather than after a period of years.
Action: RC in liaison with CGST

3) A review of the DMP service be held in relation to all the changes currently taking place in OPS Calderdale, to ensure a good fit with stakeholder needs (Calderdale Council and work of other teams in the Trust)
Action: RC in liaison with CGST, Line Manager, Calderdale Council

5.3 References

Aldridge, J., (2000) Music Therapy in Dementia Care, London: Jessica Kingsley.

Burns, J., (2009) 'Remember, I'm Still Here', Joint Report between Scottish Care Commission and Mental Health Welfare Commission

Coaten, R., (2009) 'Building bridges of understanding: the use of embodied practices with older people with dementia and their carers as mediated by Dance Movement Psychotherapy' PhD Thesis, Roehampton University, Research Repository

Coaten, R., (2010) 'Working with Older People with Dementia' in 'Dance, Health and Wellbeing; pathway to practice for dance leaders working in health and care settings', Handbook published by Foundation for Community Dance: Chapter 5, 69-72.

Kitwood, T. (1997) Dementia Re-considered: the person comes first, Open University Press

Millwain, E., (2010) 'The brain and person-centred care No. 5: A deeper look at emotion in dementia care', Journal of Dementia Care, Vol.18, No.4, 20-23.

Verghese, J., et al., eds (2003) 'Leisure activities and the risk of dementia in the elderly', New England Journal of Medicine, 348, No.25, 2508-2516.

Appendix 1 Clinical Governance Support Team

The Clinical Governance Support Team (CGST) is a multi-disciplinary consultancy and project management team with a wealth and diversity of expertise, established to promote and facilitate clinical governance and practice effectiveness throughout the Trust.

The aim of the department is to facilitate the provision of high quality services in line with the principles of Clinical Governance and to support the Trust's mission, vision, values and goals.

The Clinical Governance Support Team works through partnerships with clinical and non-clinical staff, service users and carers, health and social care providers, universities and educational providers and voluntary agencies

Service	Description of services/resources
Practice Effectiveness	Promoting practice effectiveness through supporting staff to develop evidence based practice
Advice Surgeries	Providing advice, expertise and encouragement to staff wanting to undertake project work including service development, audit and service evaluation
Project Management	Delivery of localised and trust-wide commissioned projects within the clinical governance agenda, linking services or professions across any number of areas. Monitoring of project activity across the Trust and reporting of audit and evaluation priorities twice yearly to the CASE work stream of the Practice Effectiveness TAG
Links with Trust groups	Linking in and supporting the Trust Care groups and Trust Action Groups
Training and Development	Supporting and developing the skills of staff through clinical governance training, advice surgeries and action learning. Supporting the involvement of service users and carers in audit and evaluation through training, learning and development.
Risk Strategy	Support the organisation's risk strategy
Library	Loan service (books; Journals; CD.ROMS; etc…) access to Intranet, Internet, electronic databases, Inter-library loans; study facilities and electronic database training.
Health Promotion Resource & Information Centre	Loan service (DVDs; videos, resource packs, anatomical charts and models, AV equipment, display boards; etc…); health promotion leaflets and posters.
Clinical Governance	Support the monitoring of clinical governance through the annual report, action plan and the monitoring of the performance against the plan and through the membership of various trust groups.

The team currently covers the full geographical area of the Trust. Location and contact details of all members of the team are as follows:

Personnel	Role	Contact details
Gillian Marley	CGST Lead	CGST, Castleford, Normanton & District Hospital, Lumley Street, Castleford, WF10 5LT Tel: 01977 628065
Liam Redican	Project Manager – Patient Experience	
Marie Dawson	Information Management & Project Support Officer	
Victoria Hitchman	Information Management & Project Support Officer	
Hazel Baxter	CGST Lead	CGST, SWYT, 4th Floor, F Mill, Dean Clough, Halifax, HX3 5AX Tel: 01422 281343
Suzy Daly	Clinical Audit Facilitator	
Michael Morley	Library/Resource & Information Centre Manager	Library/Resource & Information Centre, Learning & Development Centre, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP. Tel: 01924 328608
Sarah Thompson	Librarian	

Appendix 2 Session Planning and Evaluation Sheets (x2)

Session Planning and Evaluation

Session number.................... Venue................... Group....................

Time....................

Staff **Participants**

What are your session aims?

What are you planning to do?

What actually happened?

Ideas for next session

Richard Coaten January2005

INDIVIDUAL RECORD OF RESPONSE TO SESSION

Names of group members →								
Willingness to join Group								
Unwilling								
Came along without prompting								
Prompting needed								
Well-being through Movement								
No signs 0								
Some signs 1								
Increased signs 2								
Areas of body tension / pain								
e.g. feet, legs, hips, back, head/ neck etc								
Expresses self creatively								
No signs 0								
Some signs 1								
Significant signs 2								
Communicates with others								
No signs 0								
Some signs 1								
Significant signs 2								
Shows pleasure / enjoyment								
No signs 0								
Some signs 1								
Significant signs 2								
Memory Connection with **immediate** memories & life experience during session								
No signs 0								
Some signs 1								
Significant signs 2								
Memory Connection with **past** memories & life experience during session								
No signs 0								
Some signs 1								
Significant signs 2								
Connection with songs & music								
No signs 0								
Some signs 1								
Significant signs 2								

Other comments;

Signed:

South West Yorkshire Partnership NHS
NHS Foundation Trust

Appendix 3 Action Plan

Recommendations and action plan for Dance Movement Psychotherapy Service Evaluation 2009-2013

Recommendations	Actions	Expected Outcome	Person(s) responsible	Deadline(s)
Preparation of case study	Prepare case study data	Publication of journal article	RC SD & VH	December 31st 2013
DMP service review	Review Service	Better DMP service fit with other services/service offer etc	RC Maria Palmer	December 31st 2013
Electronic design for data input and SPSS analysis	New systems designed	Improved delivery of data analysis and results of service	RC SD VH	December 31st 2013

Is a re-audit required after this audit?

If 'Yes' please indicate time period until start of re-audit (e.g. 6 months or 1 year)	1 year	
Signed on behalf of Business Unit		*(Please print name below)*
Date		**Contact number**