Promoting participation and engagement for people with dementia through a cognitive stimulation therapy programme delivered by students: A descriptive qualitative study

Carolyn M Murray¹, Susan Gilbert-Hunt², Angela Berndt³ and Lenore de la Perrelle⁴

Abstract

Introduction: Dementia can affect participation and engagement due to deprivation of cognitive, social and sensory stimulation. To meet this need, educators and a service provider collaborated for occupational therapy students to provide cognitive stimulation therapy for people with dementia.

Method: We used a published, evidence-based cognitive stimulation therapy programme called ‘Making a Difference’. However, due to student availability, we adapted the programme to be conducted once weekly for 12 weeks by students in pairs. These services occurred in both community and residential settings. Following completion of the programme in 2012, perspectives of staff (n = 8), family carers (n = 5) and three people with dementia were sought about their involvement. Semi-structured interviews were recorded, transcribed and analysed using thematic analysis.

Findings: We found three themes of ‘something to talk about’, ‘it was a new relationship’ and ‘wanting to have a go’. Despite some initial concerns about people with dementia becoming stressed, the programme promoted social interactions, participation and engagement. The students adopted a relationship-centred approach with empathy and deliberate planning of sessions being important.

Conclusion: Through provision of the adapted Making a Difference programme, occupational therapy students were able to fulfil an unmet need while learning from their experience.

Keywords

Aged care, activity programmes, group work

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need for social interaction and adequate levels of stimulation (Hancock et al., 2006).

Symptoms of distress in dementia can be ameliorated in a cost effective, non-pharmacological manner by meeting needs of social engagement and providing appropriate stimulation (Cohen-Mansfield et al., 2015; Knapp et al., 2006). Unfortunately, boredom and lack of opportunity for active participation and engagement often occurs for PwD (Vikström et al., 2008). Lower performance on activities of daily living, social withdrawal, lack of engagement in activities and taking psychotropic medications have been associated with reduced quality of life for PwD in residential care (Ballard et al., 2011).

There is a need for flexible, quality and cost effective services (Knapp et al., 2006) to support PwD to fulfil a meaningful life (Roland and Chappell, 2015) and to provide opportunities for sensory, cognitive and social activities that are within their abilities, give opportunities for success and do not cause stress (Chung, 2004). Service providers in Australia are required to provide opportunities for social contact with others and for participation and engagement in activities (Australian Government, 2015). For efficiency, many such activities are generic and may not be meaningful for all individuals (such as bingo or singing). In response to the need for more individualised and meaningful activities and to address the need for sensory, cognitive and social stimulation, it was arranged for occupational therapy students to facilitate CST groups for PwD tailored for individual interest and ability.

Australian clinical practice guidelines for dementia were updated and adapted in 2015 from UK guidelines (National Institute for Health and Clinical Excellence, 2006; modified 2012). According to these guidelines, CST is situated within a cluster of ‘cognitive training and rehabilitation’ (Cognitive Decline Partnership Centre, 2015). CST consists of engagement in activities aimed at general enhancement of cognitive and social functioning (Clare and Woods, 2004). A Cochrane meta-analysis of 15 studies determined that CST had a beneficial effect on cognition, self-reported quality of life and well-being, as well as communication and social interaction (Woods et al., 2012). However, there was no significant effect on mood, activities of daily living, general behaviour, carer depression, anxiety or burden (Woods et al., 2012). Due to the beneficial effects found, occupational therapists Hoffmann and Liddle (2012) concluded that CST ‘is worth consideration as a therapeutic approach’ (Hoffmann and Liddle, 2012: 399).

The CST programme that has been employed in this research is called the ‘Making a Difference’ (MD) programme (Spector et al., 2003). This is an evidenced based group intervention designed for people with mild to moderate dementia to optimise cognitive functioning (Spector et al., 2006). It was developed by a group of psychologists in the UK, and consists of 14 sessions, with each session having a theme. Sessions are administered in small groups (four to six people) twice a week for 45 minutes (Spector et al., 2006). The MD programme was chosen for the occupational therapy students to use because it provided them with structure and was based on evidence.

The founders of the MD programme undertook a qualitative study to explore the perspectives of participants in their groups (18 PwD, carers (n = 14) and group facilitators (n = 7) using focus groups and interviews (Spector et al., 2011). Study outcomes included PwD feeling positive and confident throughout the day, having opportunities to listen, talk and express their opinions as well as finding it easier to communicate after sessions (Spector et al., 2011). There were also reported improvements in alertness, brightness and engagement in activities (Spector et al., 2011). For our research, we chose a study design that was similar to that of Spector et al. (2011). However, some adaptations were made to the MD programme because of the involvement of students.

**Involvement of occupational therapy students**

Masters of occupational therapy (graduate entry) students implemented the adapted MD programme during 2012. The 18 key principles of the MD programme are highly congruent with occupational therapy practice (Spector et al., 2006). Principles that align with occupational therapy include pitching activities appropriately, giving respect, promoting involvement and inclusion, providing choice and fun, maximising potential and building relationships (Spector et al., 2006). Although the programme includes session plans that follow a set format, the authors encourage flexibility and adaptation to suit the individuals in the group (Spector et al., 2006). Students were given indirect supervision, meaning they conducted detailed planning and adaptations of the MD programme (see Figure 1), which were discussed with university occupational therapists prior to implementing the group sessions. The students were also observed facilitating their groups at least four times by tutors who were occupational therapists from the university or employed by the service provider. As a result, students received direct feedback from occupational therapists as well as nursing and lifestyle staff who knew the PwD well.

**Aim and research questions**

The aim of the research was to gather perspectives from staff, family carers and PwD who participated in the groups about their experience with the adapted MD programme facilitated by occupational therapy students.

The research was guided by the following three questions:

1. What was the experience of being involved in the programme for PwD?
2. What changes did family carers and staff observe for the PwD while participating in the programme?
3. What observations did family carers and staff make about how the programme was conducted?
Method

Research design

A descriptive qualitative research design was used, which enabled evaluation of experience with minimal abstraction of data and without applying specific methodological approaches (such as grounded theory) (Stanley, 2015). In this way, interpretation conducted by the researchers was limited to making sense of and organisation of the data.

Recruitment and sampling

Ethical approval was obtained from the University Human Research Ethics Committee and endorsed by the Clinical Governance Committee of the service provider. In 2012, 16 students implemented the MD programme across nine residential and community settings. Purposive, convenience sampling (Patton, 2002) was used to identify potential participants after the students finished the programme. The manager of dementia services identified and invited staff, family carers and PwD to be interviewed. Participation was voluntary and anonymity assured.

The selection of MD programme participants

PwD who tended not to participate in larger generic groups and could benefit from involvement in a smaller group programme were identified by staff. Formal signed consent was obtained from family members of the PwD. This was in keeping with the processes of the service provider for PwD to participate in activities outside of their usual programme. However, PwD gave informal consent each time they were offered the opportunity to attend the group and their right to refuse was respected. Those people who were adverse to group involvement or unable to attend a group were given an option of individual contact with the students.

Student preparation

Prior to commencing the MD programmes, students received two days of intensive training run by university staff, the service provider and the local Dementia Training Study Centre. The training covered effective strategies for communicating with PwD, person-centred care (Benson, 2000) and the principles of the CST programme. In addition, during the two days students received instruction in occupational therapy specific practices associated with session planning, such as goal setting, modifying task demands according to client capacity and reflective practice.

The adaptation of the MD programme

The students facilitated the MD programme in pairs with between four and five older people. Due to limited student availability, the programme was conducted once weekly over 12 weeks (rather than 14 sessions twice weekly over seven weeks). Two sessions from the original MD programme were removed: ‘current affairs’ because the theme was highly discussion based and ‘word games’ because of similarities with ‘word association’ (see Figure 1). To establish an occupational profile of their group members, the students used the Pool Activity Level instrument (Pool, 2008), which is used with PwD and has adequate validity and reliability (Wenborn et al., 2008). Depending on individual need, ability and interest, students were encouraged to modify or expand on the suggested activities in the MD programme (Spector et al., 2006) while monitoring participants for any signs of frustration or stress if activities were
beyond their abilities (Perrin et al., 2008). Using the MD programme as a guide, the students usually planned activities that were simple and sensory-motor in nature (Baker et al., 2003) using visual cues and objects as prompts. Structure and routine (such as having a group song) facilitated participation and ownership of the group.

Planning for the MD programme

Planning took place during weekly tutorials at university, which provided opportunity for debrief, reflection and supervision (see Figure 1). Long-term goals for the group and for individuals within the group were established, so that the programme was both individualised and goal directed. Student observations against the indicators of wellbeing in the Bradford well-being profile (14 indicators) (University of Bradford, 2008) gave a focus for establishment of goals, targeting different areas of occupational performance and for monitoring signs of stress in participants.

Every week, the students completed the monitoring progress chart provided in the MD programme (Spector et al., 2006) manual to rate from 1 to 5 the participants’ levels of enjoyment, interest, communication and mood. They also employed the person, environment, occupation (PEO) transactional framework to understand the interdependence between the PEO for the group participants (Law et al., 1996). The PEO approach enabled a cycle of reflection and implementation of changes for the next session. Students considered each person in relation to their interests, cultural background and functional capacity as well as their potential response to distractions, stress and failure.

Data collection

Semi-structured interviews were completed by an independent research assistant up to two months after the completion of the MD programmes. The research assistant was an experienced project officer. She visited the staff at work and PwD and family carers at home. One interview with a family carer was conducted over the telephone. The interviews lasted from 30 minutes to an hour. The interview schedule is outlined in Table 1 and followed a semi-structured process. The questions were designed to gather views about what the participants had experienced or witnessed during the MD programme.

Data analysis

Interviews were digitally recorded and transcribed verbatim. A thematic analysis process was followed (Patton, 2002). Interviews from the three participant groups were analysed together to give a combined response to the research questions. Interview transcripts were read in full by two researchers (CMM and SGH) to gain an initial understanding of interview content. The two authors then discussed their understanding of the interview content and any differing perspectives they had. Transcripts were then coded by CMM using line-by-line open coding. Codes were clustered together into categories before arriving at descriptive themes that represented the views of those who were interviewed. Peer review of findings was carried out by SGH through each stage of data analysis.

Rigour

Transferability of the research to other contexts is enhanced by the detail provided about the implementation of the adapted MD programme (Liamputtong, 2013). This includes the level of support that the students were given and the tools provided to support their thinking. Because we were invested in the development and implementation of the adapted MD programme and were involved in supervision of the students, we were sensitive to perceived changes that the participants in the research may have experienced. Therefore, the use of an independent researcher to conduct the interviews supports the confirmability of the research findings (Liamputtong, 2013). The use of quotes from participants, the reporting of contrasting opinions and the use of two people to analyse and review the data support the credibility of the research (Liamputtong, 2013).

Findings

Participants

There were 16 participants consisting of eight staff, three PwD and their family carers (six participants), and two

<table>
<thead>
<tr>
<th>Table 1. Interview questions.</th>
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<tbody>
<tr>
<td><strong>For service provider staff</strong></td>
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<tr>
<td>Have you noticed any changes in the person you care for? (socially/willingness to do things/emotionally/cognitively)</td>
</tr>
<tr>
<td>Was there anything that surprised you about the client’s involvement in the group programme?</td>
</tr>
<tr>
<td>What do you feel went well about the student-led groups?</td>
</tr>
<tr>
<td>Would you recommend that CST groups occur with other residents and families?</td>
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</tbody>
</table>

CST: cognitive stimulation therapy.
other family carers (see Table 2). Some participants were community based and some were based in residential care. All of the PwD were men and the severity of their dementia was unknown. One PwD participated in the MD programme individually while the others had participated in a group. Carers consisted of five wives and one son. Three of the staff were men.

Themes

Three themes were developed including ‘something to talk about’, ‘it was a new relationship’ and ‘opportunities to have a go’. Quotations are provided to support the interpretation of the findings and the source of the quotation is indicated as the PwD, family carer of PwD (FC), staff member (SM), and an ID number.

**Theme 1: ‘Something to talk about’ (SM 2)**

Involvement in the MD programme promoted participation and engagement because it gave the PwD ‘something to talk about’ with family and care staff. There were common threads in the data related to social connectedness and interaction including the opportunity for the PwD to talk and reminisce. SMs and FCs noticed that conversation skills of participants were heightened both during the sessions and for some time afterwards. Involvement in the programme gave SMs and FCs something to ask them about and the PwD something to think about and comment on.

So they could talk about, for example, the cooking that they were doing or the gardening… or the music. Or I could talk to them about what they had been doing. So it created conversation. (SM 2)

When he came home from the days out he felt more stimulated…and probably more alert but happy to talk about it and tell us what he’d actually done for the day. Sort of brought him out I think. (FC 2 for PwD 2)

The approach taken by the students promoted participation and engagement. SMs noticed that the students were willing and patient listeners who would allow time for participants to respond during discussion and were genuinely interested in their responses. SM 2 observed that the students designed the activities to foster interaction. She found the level of planning meant they could ‘adapt depending on the moods and interests of the clients’. As a result of the individualised planning, SM 4 noticed that the students would find it harder when unexpected people turned up to participate.

When involved with the students, SMs and FCs observed PwD to smile and laugh, which were signs of wellbeing (University of Bradford, 2008). Being happy and stimulated during the sessions was a recurrent theme in the data with humour, fun and laughter being components that kept clients engaged, interacting and wanting to come back again.

He was very upbeat and very stimulated and very awake. (FC 1 for PwD 1)

Every time he’s been home after going there – immediately after he doesn’t stop talking…he had such fun and laughed and they were really good and he brings things home…and they gave him a photo. (FC 3 for PwD 3)

As well as ‘enjoying what they’re doing at the time’ (SM 3), FCs and SMs noticed a sense of enjoyment that was sometimes sustained after the sessions had finished. For example, PwD 1 was interviewed six weeks after the programme had finished and still had this to say:

They seemed to be happy when they arrived you know, and I looked at them, and gee you’re happy too. Lovely girls they were. (PwD 1)

**Theme 2: ‘It was a new relationship’ (SM 7)**

The PwD in the CST programme developed relationships with each other and also with the student facilitators. These relationships seemed to promote positive feelings for the people involved.

It was a new relationship with the girls [students]…and they spoke about their lives as well, so it was bonding. (SM 7)

Actually the two [students] were absolutely marvellous and they join in any fun we have. They crack jokes with us, backwards and forwards and that sort of thing. Oh no, it was good and all those things set [for] us to do, well that really tried [tested] us out. But we all realise it was for a good cause. But those [students] just fitted in…I miss them actually; I’d like them to be there every week. (PwD 2)

There were reports of authentic interest from the students in the stories and feelings of the PwD because the students

<table>
<thead>
<tr>
<th>Participants</th>
<th>Residential</th>
<th>Community</th>
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<tbody>
<tr>
<td>Male staff member</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Female staff member</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Male PwD with female family carer</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Female family carer (spouses)</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Male PwD with male family carer</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Male family carer (son)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Female family carer (spouses)</td>
<td>2*</td>
<td>0</td>
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<td>Total</td>
<td>7</td>
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*Female family members lived in the community and their spouses lived in residential care.

<table>
<thead>
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<th>Overview of participants and where they lived or worked.</th>
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<tbody>
<tr>
<td>Participants</td>
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<tr>
<td>Male staff member</td>
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<tr>
<td>Female staff member</td>
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<tr>
<td>Male PwD with female family carer</td>
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<td>Total</td>
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*Female family members lived in the community and their spouses lived in residential care.
had the time to listen. After a routine was established, the PwD started to look forward to them coming. SMs and FCs made comments about the level of respect demonstrated by the students and how they took the time and did not mind going slowly to ease the PwD into what they were doing that week.

I’m sort of sweeping through because I’m doing a…round and I don’t have a lot of time to be involved in the actual programme but I could sort of see or hear what’s going on. I just think that the dedication of the girls…the’ve got time to present it…And because these people have got time to spend with the people…they get a good response. And I think that’s really been a big benefit of having them here. (SM 8)

He’s still talking about it, so it’s had definitely a long lasting effect on him. And particularly anyone that comes he shows everybody the picture of the boys up there and explains again, to his capability, of what they did and how happy the time was. So all in all I feel it was very successful. Very successful. (FC 2 for PwD 2)

The OT students treated them with quite a level of respect for what they could do as well as what they couldn’t do. (SM 1)

Another element to this theme was the PwD forming friendships with each other and this was enhanced by getting to know each other in a consistent, small group.

My key observation was that the group – they bonded as a group. And I see them together more after, now as a group; they sort of hang out together, which is kind of cool. So I guess it’s the new friendships. That’s the main thing I’ve seen. (SM 6)

**Theme 3: ‘Wanting to have a go’**

The opportunity to participate in the groups promoted PwD to ‘have a go’ and SMs observing them learned new ways for enhancing participation and engagement. They learned different ways of communicating with and empowering the PwD to engage in doing things that may have been former interests but now sat outside of their normal activities (i.e. cooking, gardening, painting, drawing and having conversations). For example, SM 3 observed a woman that she cared for doing drawing:

She used to draw a lot at home, and a couple of activities were to do with drawing, and she did very well…she’s disconnected from that now, she’s not interested in doing it, but when she did do it…she just had a natural flair for it. (SM 3)

SM 2 was also surprised at the level of engagement demonstrated by a PwD when participating in a cooking activity. This assisted the SM to view her from a new perspective:

Seeing one particular lady cooking was very interesting because I’ve never seen her do anything of that before. And she certainly knew what she had to do, whereas during the day…she’s really not given any of the activities to participate in…she could follow what was going on and she certainly does have severe dementia and she doesn’t normally get involved in anything. So I was surprised that she was making a cheesecake. (SM 2)

Sport was used consistently as an activity in sessions, which enabled participants to draw on procedural memory and bond over shared sporting interests and stories. SMs saw the PwD doing things with the students that they did not expect and began to appreciate that they had potential to be doing more.

Even the guys who have…real mobility issues, but no he’ll get up and he’ll play golf with the rest of us without a problem, because he wants to participate and have a go. (SM 1)

Not only did the presence and effort of the students promote new perspectives for the SMs but also for the PwD with whom they were working. PwD 2 noticed that he had become:

perhaps more interested in certain aspects, like I suppose sport and I’ve been doing a little bit of extra reading. Only a little bit…since those days, got a bit more interested in life I suppose. (PwD 2)

There were concerns about the PwD becoming stressed or agitated as a result of the demands of ‘having a go’ in the MD programme. SM 5 was concerned about the participants being embarrassed by having their capacities challenged. However, he found that the way the activities were planned and presented to suit the abilities of the PwD put his concerns at ease.

I did observe when the puzzles and things were coming out that was a little bit of concern to me. There was a little bit of stress. You could see a little bit of stress on the clients’ faces because they couldn’t recover that information, and that was the thing – I mean it worked out okay…but both [the students] were quite happy to assist and help them through that. (SM 5)

FC 5 saw no change in her husband that she could attribute to the programme but she was pleased that he was given the opportunity to ‘have a go’ and she was curious about the programme being based on evidence.

I was sort of interested; it seemed to work so successfully in 2006…And I felt that [husband’s name]…had nothing to lose even if he didn’t gain anything. I did ask
the staff right at the beginning, if he got agitated to please take him away. They said, “we’d automatically do that” . . . I don’t know what I was expecting . . . to me personally, I haven’t seen any change in [husband’s name]. (FC 5)

Discussion

Through presentation of the three themes of ‘something to talk about’, ‘it was a new relationship’ and ‘having a go’, we found that the key ‘ingredients’ for promoting participation and engagement in activities for PwD were the students’ therapeutic use of self (Taylor, 2007), their empathy and their considered and deliberate processes of planning. The findings of this research will be discussed in the context of existing literature about provision of activities for PwD and the recommendation for a relationship-centred approach. The process of student involvement in the facilitation of the adapted MD programme and the tools they used for planning and implementation will also be discussed for translation into practice.

Activity programming for persons with dementia

Activity programmes promote participation and engagement for PwD (Brooker and Duce, 2000) and can be viewed as protective factors against the negative effects of living with dementia. When exploring perspectives of PwD about what motivates them to participate and engage in occupations, Raber et al. (2010) found that having positive and appropriate social experiences were influential. Our research found the MD programme gave opportunities for social interactions and the development of relationships. Adams and Gardiner (2005) proposed that a relationship-centred care approach supported PwD to make choices about their care. This approach focuses on rapport building so the opinions and preferences of PwD are heard. Based on the findings, the students effectively used their own selves as a therapeutic medium, which enabled strong relationship building and is consistent with the notion of the therapeutic use of self (Taylor, 2007).

The principles of CST and the MD programme (Spector et al., 2006) are consistent with being relationship centred. The students promoted choice and inclusion by planning and designing activities that included the participants’ interests, abilities and preferences. This approach has growing evidence for improving engagement and pleasure for PwD; an example being ‘tailored activity’ programming developed by Gitlin et al. (2009). When engaged in discussion, the students made allowance for people with vision and hearing loss, who had English as their second language or had difficulties with speaking. In keeping with the MD programme principles, they used opinion-focused questions such ‘what do you think is happening in this picture?’, which meant there were no ‘right’ or ‘wrong’ responses and every contribution was perceived as successful.

There is growing evidence that focusing on the ‘process’ of doing can support active engagement, such as occurs with Montessori activities (Jarrot et al., 2008). During implementation of the programme, the students focused on the process of ‘doing’ (such as gardening) and minimised dependence on discussion. To support cognitive stimulation, the students used objects, pictures and sensory triggers as part of the MD programme. This may have contributed to changes in communication because of the enriched environments they created.

When providing activities to counteract boredom and passivity, there is potential for over-arousal and induction of anxiety and stress for PwD. In the ‘wanting to have a go’ theme, SMs and FMs expressed concerns about the PwD becoming upset. To avoid this problem, students matched the demands of what people were doing with their abilities. To do this they developed their skills in observation, used the Pool Activity Level instrument (Pool, 2008) to decide the level at which to pitch activities and monitored them during the group, giving intervening support if needed (Gitlin et al., 2009, Raber et al., 2010). Perrin et al. (2008) emphasised the need for creating a balance between giving PwD opportunities for trying different things while not tipping them into a state of stress. There also needs to be a balance between providing structure and routine and providing sessions that are not too predictable. Doing so will continue to gently challenge and extend the PwD both cognitively and socially.

The process and tools used by the students

The planning processes (as seen in Figure 1) were essential learning tools for the students. The reflective cycle enabled the students to learn about session planning, grading of activities and the importance of knowing the PwD well. In addition, using tools such as the Pool Activity Level (Pool, 2008) and the Bradford well-being profile (University of Bradford, 2008) complemented the professional reasoning of the students and the structure provided by the MD programme. These tools enabled the students to plan their sessions so that the PwD could ‘have a go’ and have their wellbeing needs addressed. The use of occupational profiling meant the students were sensitive to the interests and history for the PwD, but with this information they could also avoid provoking stress and frustration. Consistent with occupational therapy theory, the students endeavoured to work out what activities brought the PwD comfort and happiness in their current stage of life and did not assume that these were the same as they have enjoyed in their past (Perrin et al., 2008).

Recommendations for students implementing adapted MD programme

Arising from this research is a number of recommendations for occupational therapy students implementing an adapted MD programme. Students are not a proxy workforce and require support and supervision. They need support to link their theory with practice and to develop their
professional reasoning abilities. For these students, this support was provided through discussion and feedback about the documentation of their session plans and feedback following observations of their performance during group facilitation. Having two students working together was a necessary part of the process as they were able to give each other feedback and provide mutual support.

Limitations and recommendations for future research

The severity of dementia that PwD was experiencing was unknown and a measure of this would have increased the utility of the research. Qualitative research using interviews requires the ability of the interviewee to find language, recall and process information to express personal views, which may be difficult for PwD. It is therefore recommended to complement future research with other methods of data collection, such as observation. Our research would have been enhanced by the inclusion of the students’ perspectives in the data and future research is warranted about the student learning and pedagogical implications of their involvement in implementing the MD programme. A longitudinal study, particularly in relation to tracking any attitudinal changes for staff would be worthwhile.

Conclusion

The gathering of perspectives about involvement in the student-led adapted MD programme contributes to the growing literature about activity programming for PwD. These findings demonstrate that while some FCs and SMs were initially concerned about the PwD becoming overwhelmed and stressed, they were reassured by the relationship-centred approach taken by the students and their considered and deliberate planning. Their tools and planning processes enabled them to be adaptable to changing needs and promote participation and engagement. Using the structured MD programme, occupational therapy students were able to provide a CST intervention and fulfil an unmet need while learning from their experience.

Key findings

- The programme promoted social interactions, participation and engagement and changes in communication for PwD.
- The success of the programme relied on relationships development, empathy and deliberate processes of planning.

What the study has added

This study provides qualitative evidence about CST as an intervention for PwD and illustrates an innovative educational approach for occupational therapy students.

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Research ethics

Ethical approval was obtained from the University of South Australia Human Ethics Committee (protocol no. 0000023881), and the ACH Group Clinical Governance Committee approved this study in May 2011.

Declaration of conflicting interests

The authors confirm that there is no conflict of interest.

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