



How Meeting Centres continue to support people affected by dementia: report on UK COVID-19 impact

Journal:	<i>Working with Older People</i>
Manuscript ID	WWOP-12-2020-0060
Manuscript Type:	Research Paper
Keywords:	older people, well-being, social care, vulnerability, social inclusion, quality of life

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How Meeting Centres continue to support people affected by dementia: report on UK COVID-19 impact

Abstract

Purpose: Due to COVID-19 restrictions, Meeting Centres (MCs) for people affected by dementia in the UK, ceased to meet physically but continued to provide remote support. The aim was to understand the extent to which MCs were able to operate when physical meetings were not possible and how they achieved particularly in relation to the Adaptation and Coping Model and practical, emotional and social adjustment.

Design: Semi-structured interviews and focus groups were conducted with people affected by dementia, staff, volunteers, managers and trustees from MCs. Data were collected on the type and quantity of contact MCs had with people affected by dementia during lockdown. Data were coded and mapped against adaptation and coping strategies i.e. practical understanding and empowerment, optimising emotional well-being and opportunities for social engagement.

Findings: A range of remote approaches, both technological (eg. using online platforms) and non-technological (eg. newsletters and post) were implemented alongside limited face-to-face contact. Regular MC activities were adapted using the different approaches. It was possible to map all the Adaptation and Coping model support strategies to the activities delivered in this way. MCs were able to adapt rapidly to continue to support people to adjust to change.

Social implications: Moving forwards, combining approaches (usual MC and remote) means person-centred support could be optimised, addressing social isolation and reaching those who cannot attend MCs.

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3 **Originality:** This article offers new insight into the extent to which community-based
4 support for people with dementia can continue when face to face contact is not
5 possible due to COVID-19.
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12 **Keywords:** dementia; COVID-19; community-based support; Adaptation and Coping
13 Model; adjusting to change; social isolation
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19 **Running title:** Meeting Centres support during COVID-19
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23 **Introduction**

24
25
26 In usual times people with dementia are amongst the most vulnerable in our
27 communities. The pandemic has increased this vulnerability due to both the
28 morbidity and mortality from COVID-19 and the indirect effects of the pandemic on
29 the health and social care system on which they depend. People affected by
30 dementia become increasingly dependent on the health and social care systems
31 which are themselves stretched to their limits in dealing with the pandemic (Brown et
32 al., 2020; Canevelli et al., 2020; Giebel et al., 2020).
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44 A recent survey (Alzheimer's Society, 2020) showed that COVID-19 restrictions have
45 had particularly negative impacts on the health and well-being of people affected by
46 dementia in the UK. 46% of people reported that lockdown had a negative impact on
47 their mental health and in a wider group that included caregivers, 82% reported a
48 deterioration in the symptoms of people with dementia.
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3 Meeting Centres (MCs) are a community-based post-diagnostic intervention for
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5 people with mild to moderate dementia and family caregivers living at home. MCs
6
7 originated in the Netherlands (Dröes et al., 2004a; Dröes et al., 2004b; Dröes et al.,
8
9 2011). The MEETINGDEM research programme (www.meetingdem.eu)
10
11 implemented and evaluated the Dutch MC model in the UK, Italy and Poland and
12
13 assessed what adaptations were necessary. The research demonstrated good
14
15 evidence that MCs help people, their families and communities build resilience for
16
17 the longer term (Brooker et al., 2018; Evans et al., 2018; Mazurek et al., 2019;
18
19 Szcześniak et al., 2019).
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26
27 In usual times MCs are places where people with dementia and their family can
28
29 regularly and routinely socialise, take part in activities and get support. At the heart
30
31 of MCs is a small social club (15 people with dementia per day plus family
32
33 caregivers), based in an ordinary community building, close-by to where people live.
34
35 MCs operate up to three times per week, providing people with dementia and family
36
37 caregivers the chance to build friendships, engage in peer support, understand their
38
39 problems, get help and prepare for the future. They are facilitated by a small team of
40
41 paid staff alongside a group of volunteers. Evidence-based post diagnostic
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43 interventions are provided in a friendly manner, geared to the needs of people with
44
45 dementia and facilitated by a small team of staff and volunteers. A programme of
46
47 activities for both people with dementia and family caregivers, facilitated face to face,
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49 takes place based on the wishes of people with dementia and family caregivers and
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51 will include movement and co-ordination (for example seated exercise, tea dances,
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53 gardening and walks), talks by people with dementia or family caregivers or people
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55 from the community, visits to local attractions and heritage sites, quizzes,
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3 discussions and arts and crafts activities. Regular family caregiver meetings take
4 place and serve as an opportunity to engage in peer support and learn about
5 dementia. The use of technology is relatively limited.
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12 All the features of a MC are geared up to help people make the best emotional,
13 social and practical adjustments to living with dementia. Staff and volunteers are
14 trained in person-centred dementia care and the Adaptation-Coping model. This
15 model has its theoretical origins in the stress-appraisal coping model of Lazarus and
16 Folkman (1984). Dröes et al. (2010) developed this model as a framework for
17 understanding mood and behaviour difficulties in people with mild to moderate
18 dementia.
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31 In the UK MCs, Adaptation and Coping is also known as the Adjusting to Change
32 model. The domain names were re-named as practical, emotional and social
33 adjustment. This translation is illustrated in Figure 1 together with related support
34 strategies which will vary depending on each individual person and family (Brooker
35 et al., 2017).
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45 ---Insert Figure 1 here---

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49 **Fig 1 UK translation into the '*Adjusting to Change Model*'**

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51
52 Due to the pandemic all MCs had to close their doors on 23rd March 2020 and all
53 face to face support ceased. This provided an opportunity to gain an understanding
54 of the extent to which MCs are able to operate when physical meetings are not
55 possible.
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Methods

Study Design

The research focused on the four UK MC demonstrator sites. All these MCs were already enrolled into on-going data collection as part of a wider research project on UK MCs. A decision was made to change the focus of the research to gain insight into the impact of lockdown.

Data was collected for the period 23/03/20- 30/06/20, on the type and quantity of contact they had with people with dementia and family caregivers during lockdown.

Recruitment of participants for both the semi-structured interviews and the focus groups was facilitated by the relevant MC manager at each MC. Participants were invited and went through an ethically approved consent procedure.

The aim was to recruit up to six people with dementia and/or family caregivers, the manager, one member of staff or volunteer and one trustee from each MC. Semi-structured interviews were conducted via telephone and were recorded. People with dementia and family caregivers were asked about the type of support they receive in usual times, what support they had received since lockdown from the MC, what impact this had and what other support they were receiving from the community. Staff, volunteers, managers and trustees were asked specifically about how they were supporting people with dementia and family caregivers to adjust to change and whether they thought they had the skills to adapt to the current and changing situation and where there might be a need for training and development.

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3 In addition to the interviews, the aim was to conduct across MCs, via video
4 conferencing software, a focus group, of six people for each of the following groups:
5
6 - people with dementia and family caregivers, staff and volunteers and managers
7
8 and trustees. Zoom was chosen as the video conferencing software as all MC
9
10 managers were familiar with it. Interviews were designed to last up to one hour using
11
12 the relevant questions for those indicated above as a framework.
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19 **Data Analysis**

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21 Descriptive analysis was used to calculate the total numbers of different types of
22
23 contact across the period in question. Qualitative data were transcribed. The content
24
25 was coded against the 'Support Strategies' listed in The UK translation into the
26
27 Adjusting to Change Model (Figure 1).
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33 **Ethical Permissions**

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35 Ethics approval, including an appropriate process for involving people living with
36
37 dementia who were not able to provide informed consent was sought from and
38
39 granted by the University of Worcester Ethics Health, Life & Environmental Sciences
40
41 (CHLES REP) Research Ethics Panel Committee, 5th April 2020, REP CODE:
42
43 CHLES18190018-R amended 5th May 2020.
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49 **Results**

51 **Types of contact**

52
53 During the lockdown period, the four MCs reported supporting 76 people living with
54
55 dementia and 72 family caregivers through the type of contacts detailed in Table I
56
57 below. The data presented in Table I are based on the information reported and
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3 should be considered as an under-representation of the actual level of activity taking
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5 place.
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9 ---Insert Table I here---
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14 Most contact was via email. A significant amount of contact was carried out via
15 traditional modes of engaging i.e. via telephone, post and home garden visits.
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18 Zoom, WhatsApp and FaceTime were used to a lesser extent because (according to
19 MC Managers) a minority of people with dementia and family caregivers did not have
20 the relevant technology and/or skills to participate.
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27 ***Interviews and Focus Groups***

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29 We interviewed 28 stakeholders and conducted 6 focus groups as detailed in Table
30 II.
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37 ---Insert Table II here---
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41 Data are presented below to illustrate the support strategies set out under the
42 Adjusting to Change model as in Figure 1.
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48 ***Understanding and Empowerment***

49 *Cognitive stimulation*

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51 During lockdown it was easy for people with dementia and caregivers to become
52 quite isolated, especially if they had few family and friends to support them. Regular
53 contact with the MC staff, especially through the telephone calls and Zoom sessions,
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55 meant that they had a different person to talk to keep them cognitively stimulated
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3 and engaged. These forms of contact also provided new topics of conversation and
4
5 helped to give people a different focus away from their day-to-day lives. It was
6
7 noticed that even when people with dementia did not particularly engage with the
8
9 online sessions, they took some interest in helping caregivers to get items ready for
10
11 them, such as sorting out photographs that could be shared. This in turn stimulated
12
13 conversations between people with dementia and caregivers.
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19 Similarly, people were encouraged to do activities outside of sessions and/or take
20
21 photographs for a particular theme such as watching nature in the garden or baking
22
23 and share them during group sessions. Many group sessions also included short
24
25 quizzes or singing for people to join in with, much as would be done in a usual MC
26
27 face-to-face session.
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33 Newsletters were used by all the MCs on a regular basis, either weekly, fortnightly or
34
35 monthly, with one MC producing up to 40 pages a week over four different
36
37 newsletters. The newsletters had an important role to play in terms of keeping
38
39 people with dementia and family caregivers cognitively stimulated by including a
40
41 variety of mental activities such as word searches, quizzes, spot the difference, dot-
42
43 to-dot and colouring in. The photographs and short captions used within the
44
45 newsletters also helped to keep faces familiar and remind everyone of previous
46
47 events or trips, which in turn could stimulate reminiscence and discussions.
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53 *Physical Fitness*

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55 There was relatively limited reference to exercise and physical fitness in the
56
57 interviews and focus groups although these activities are a key aspect of regular MC
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3 activity. Two MCs produced short video clips of seated exercises, which were shared
4 with people with dementia and caregivers via Facebook. Three MCs also
5
6 incorporated seated exercise into their Zoom group sessions. Items were included in
7
8 newsletters, for example one MC advertised weekly Friday Keep Fit ('leotards not
9
10 compulsory'), alongside signposting the seated exercise videos. At another MC a
11
12 family member was a qualified seated exercise instructor and was involved in
13
14 supporting Zoom sessions.
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22 At the beginning of June, staff started visiting people with dementia and family
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24 caregivers in their gardens and/or going for walks. A member of staff commented
25
26 that some people with dementia found it difficult to concentrate on WhatsApp calls
27
28 and that going for a walk with a member of staff or volunteer was more beneficial. At
29
30 one MC people with dementia and family caregivers engaged in bespoke garden tea
31
32 dances delivered by the usual club facilitator.
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38 *Optimising choice and control*

39 People with dementia and caregivers were asked what they would like to see
40
41 included in the newsletters and for ideas for new topics and they also provided
42
43 content for some of the newsletters, giving them ownership and control over their
44
45 focus:
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51 *"The feedback that we get from the caregivers is that, oh, when that comes*
52 *through the door, that's [name's] or whoever it is, you know. That comes*
53 *through the door. That sits by his chair and then once he's had a look at it...and*
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3 *one of the women was saying, well, I just ask for permission to have a look at*
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5 *it because it's his."* (Staff member interview).
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10 With the Zoom sessions there was the flexibility to run them at times to suit people
11
12 with dementia and family caregivers as well as staff:
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17 *"We're making phone calls; we're doing Zoom calls in the evening because*
18 *some family members can't do them during the day. One of the members all*
19 *three of us Zoom together with them. But, you know, it's seven o'clock on a*
20 *Tuesday evening that we're doing that."* (Staff member interview).
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28 Offering different options works for different people in different ways:
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33 *"One is a husband and wife and that's WhatsApp, on a video call on a phone*
34 *so it's a small screen. And then I tend to either talk to one or the other and they*
35 *pass the phone between them. Whereas the Zoom call is with someone living*
36 *with dementia and their son who live together. And they sit side by side and it's*
37 *on a laptop and it's a three-way conversation rather than a more sort of*
38 *individual conversation I have."* (Staff member interview).
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49 *Information and signposting*

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51 Online sessions gave people something to look forward to, a bit of routine and
52
53 structure at a time when all the days blur into each other and it is easy to lose track
54
55 of time. One MC was running a Zoom session every day at 2 pm for an hour,
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57 advertised via the newsletter and email providing a regular point of contact.
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5 Staff were more available than usual MC for contact outside of sessions, so
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7
8 caregivers could get in touch often much sooner than usual if they had issues. This
9
10 regular contact via telephone calls can help to provide information and address
11
12 problems before they escalate and staff can spot at an early stage when people are
13
14 starting to struggle.
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19 Regular newsletters were used to keep people up-to-date with COVID
20
21 guidance/rules and plans for reopening, enabling clear, effective and timely
22
23 communication. The clarity of the information around reopening was particularly
24
25 appreciated by both carers and members. Referring to a form they had received, a
26
27 member was able to easily see when they were due to return to their MC once it
28
29 reopened.
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35 *"It's got [name's] day for the club', [manager] put this through my door.*

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37 *Tuesdays 10 to 12, Thursdays [...] club at one o'clock, [...] Friday 1 'til 3.*

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39
40 *That's my week". (Member interview).*
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45 ***Improving Emotional Well-being***

46 ***Relaxation and fun***

47
48 The newsletters and email contacts often contained ideas for different activities for
49
50 people to try at home, providing opportunities for people with dementia and family
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52 caregivers to do something different from their everyday lives and be engaging and
53
54 fun.
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3 The garden visits also provided a good distraction from 24/7 caring as they gave
4 caregivers a chance to come out of caring mode for a while. They could just relax
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6 and have a laugh with the visitor instead, which was “an enormous morale booster”.
7
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10 The carer Zoom sessions were also a chance to relax and have fun, as the
11
12 atmosphere was very relaxed with caregivers feeling comfortable enough to laugh
13
14 and joke with each other.
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19 People with dementia and family caregivers both had fun with the activities and
20
21 games during the Zoom group sessions, with card bingo being one example of a fun
22
23 game for all. While singing was not used by all MCs, it proved to be a particular draw
24
25 with some people with dementia, even encouraging them to remain as part of a
26
27 session for longer than intended:
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33 *“It started off as a couple of them wanted to go early but then when they know*
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35 *there’s singing coming up, they stay because they say, ‘oh yes, we’ll stay for*
36
37 *the singing.”* (Staff member interview).
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42 The fun aspects of the sessions extended beyond the time actually online, as
43
44 preparing for sessions together was also an enjoyable experience for some couples
45
46 as baking or searching for photos to share sometimes triggered conversations and
47
48 was something different that they could do together.
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51 52 53 *Building confidence*

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56 Some people with dementia and family caregivers felt quite isolated and worried
57
58 about leaving the house and MCs were able to provide some reassurance during
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3 telephone calls and garden visits to reduce anxiety. Use of Zoom also helped to
4
5 maintain continuity with familiar faces for when MCs would re-open.
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10 People affected by dementia embraced the Zoom sessions, more than staff had
11
12 expected:
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17 *“These are people in their eighties who have, you know, managed this*
18 *technology incredibly well. It’s very impressive. I think they’ve done better than*
19 *I have trying to negotiate Zoom and Teams and all the rest of it.”* (Staff member
20
21
22 interview).
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26 27 28 *Opportunities to talk to others who understand*

29
30 Three of the MCs ran regular online caregiver meetings which were found to be
31
32 highly supportive for family caregivers.
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38 Some caregivers were not getting a break from caring or support during lockdown
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40 and were missing the reassurance that they were not alone in their situation and that
41
42 they were not the only ones feeling guilty.
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47 *“You might laugh at this but after we come off of the iPhone, I felt*
48 *honestly as if I’ve been out. And I thought, well, I haven’t been*
49 *anywhere, why should I feel like that? But I suppose relaxation and*
50 *that sort of thing, just talking, listening to other people and that, you*
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56 *know.”* (Caregiver interview)
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3 Zoom contact was also useful for people with dementia as it gave them someone
4 else to talk to. For example one MC was running Zoom sessions with two members
5 of staff and one member. The carer was still there in the background but they were
6 able to get on with something else or just sit and relax a little.
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14 Staff and volunteers found improved relationships with people with dementia and
15 family caregivers as the online aspect enabled increased individual contact time.
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21 *“At the virtual Meeting Centres, I got to know her more than I would*
22 *have done if I was just seeing her occasionally at the Meeting Centre*
23 *because she would have been off doing other things. So at the Virtual*
24 *Meeting Centres you are there all the time.” (Volunteer interview)*
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31 32 33 **(Re-) building Social Opportunities**

34
35 Lack of social contact had affected people with dementia and family caregivers.
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37 There had been differing levels of contact with family, friends, neighbours, the local
38 community and professionals during lockdown, so that in some cases the contact
39 with MC managers and staff had been a significant part of their social circle. Some
40 people with dementia and family caregivers live in quite rural areas, therefore the
41 Zoom sessions kept people connected and helped address social isolation.
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51 *“And then loading the tablet and sending it out to them with the*
52 *instructions so that they can then use that to communicate. And for*
53 *people with dementia I’ve noticed it’s actually huge because speaking*
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3 *on the phone is something that they tend not to do so much anyway.”*

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5 (Trustee interview).
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10 *Opportunities to engage with others in a relaxed atmosphere*

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12 Many other community services had stopped altogether while others were limited to
13 telephone contact. Being able to visit people in their gardens was very useful, both in
14 terms of providing social interaction and being able to physically see the people with
15 dementia and caregivers and see what has changed with them and to better assess
16 support strategies.
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26 One MC ran hour-long Zoom sessions four days a week, rather than one session
27 weekly, and this helped some people with dementia to recognise each other and
28 stay in touch. Caregivers also enjoyed seeing everyone during the online sessions
29 and liked that they are different to a telephone call.
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38 *“We have a chat at the beginning and we have a bit of singing so it’s*
39 *fulfilling part of the function which is just seeing other peoples’ faces.”*

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41 (Carer interview).
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47 Some people with dementia and family caregivers were able to use the technology
48 provided by the MC and new digital skills to connect with family too:
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53 *“One of my ladies that we sent out the tablet to and she said, oh, my*
54 *goodness, he was just so amazed that his family, you know, his children*
55 *were there speaking to him and he could make more sense of it and far*
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3 *more engaged with it, so that's been a huge thing.*" (Staff member
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5 interview).
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10 *Supporting others going through similar experiences*

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12 Carer sessions were felt to be useful in terms tips and strategies for coping picked
13
14 up from others. One MC saw more engagement from caregivers than they would do
15
16 during face-to-face sessions.
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21 *"He's never been to the caregivers' meeting but he has said after the*
22
23 *Zoom meetings, he has got to know us and he says he's going to come*
24
25 *to the caregivers' group when he can - we have got a lot from him and*
26
27 *he's got a lot from us. It's terrific really."* (Staff member interview).
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33 Relationships have grown stronger during carer Zoom sessions and some would
34
35 have missed the support of the carer group if it had not been able to continue over
36
37 Zoom.
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41 *Effective help seeking*

42
43 Two of the MCs took on much more of a wider community role during lockdown
44
45 supporting other organisations working with people with other conditions. Caregivers
46
47 reported feeling able to contact someone at an MC if they needed help, as did the
48
49 person with dementia who took part in an interview.
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55 *"[Manager] said to me 'if you ever get any problems [name], give me a ring'.*
56
57 *I've got her phone number on the thing in front of me."* (Member interview).
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3 MCs were still receiving new referrals during lockdown and the remote support has
4 enabled new people with dementia and family caregivers to become part of the MC
5 even though they had not actually 'met' anyone or visited the physical premises.
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12 *"So I think absolutely the fact that we are able to stay in contact with*
13 *these carers and give them the support while these things are*
14 *happening. I think even though it's maybe not the same, kind of,*
15 *structured support we could possibly have given them if it was normal*
16 *times, I think the support we are offering absolutely is still key to them"*
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24 (Manager interview).
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28 **Discussion**

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30 The study has enabled an understanding of the extent to which MCs were able to
31 operate when physical meetings were not possible. The types of contact used and
32 the example activities were able, to varying degrees, to facilitate the delivery of all
33 the strategies set out in the Adjusting to Change model.
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42 Support in usual times is provided almost entirely on a face to face basis. MCs had
43 to find alternative ways to facilitate this support using remote approaches with
44 different types of contact to provide activities.
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51 The type of contacts used differed between MCs and was adjusted by the MC
52 Managers and staff to meet the needs and preferences of their people with dementia
53 and family caregivers. For example, some preferred telephone calls and visits to
54 online meetings or sessions, so more effort was put into these contacts where
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3 appropriate. The variety of types of contact used ensured that all people with
4 dementia and caregivers were regularly reached and supported in a way that suited
5 them throughout lockdown.
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12 The home garden visits enabled all of the strategies, except supporting others going
13 through similar experiences, to be applied. This shows how important face to face
14 contact is even though the approach only enabled staff or volunteer and one
15 member and family carer engagement.
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24 Group meetings and activities were only feasible by using Zoom but in using this
25 type of contact all the strategies could be met and to some extent could replicate
26 regular MC activity. There was an impact on the range of activities that could be
27 provided and/or the number of people that could engage in activities. Some of the
28 activities were quite similar in an online environment such as quizzes and card bingo
29 although groups were smaller than during regular activity with often no more than
30 eight participants. In the case of carer meetings these were enhanced in terms of
31 frequency, flexibility of timing and reach. Some family caregivers would previously
32 neither had the time nor the opportunity to meet with other caregivers as a group and
33 as a result there was increased peer support.
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49 The nature of the activity could also be affected, for example with the online choir
50 participants were not able to hear others singing resulting in a reduced social and
51 community experience. However, the alternative was that there was no choir
52 resulting in a decrease in opportunities for cognitive stimulation, relaxation and fun,
53 building of confidence and engagement with others in a relaxed atmosphere.
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5 A new approach that was enabled via Zoom was 2-2-1 support with two members of
6 staff and a person with dementia for chat and in some cases creative arts activities,
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8 with the family caregiver in the background. This facilitated a different type of
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10 relationship with this three-way interaction in terms of building confidence and
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12 relaxing and having fun as well as the opportunity for the family caregiver to have
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14 some personal time.
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21 There was a trade-off between flexibility frequency and duration of contact. Some
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23 people with dementia and family caregivers had been used to up to four days of
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25 contact per week and this was reduced for some to two or three Zoom sessions a
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27 week (if they had the access to the technology) and a weekly phone call, a
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29 newsletter and an email. For some family caregivers there was the opportunity for
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31 more contact and more opportunity for peer support but this was dependent on their
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33 access to and skills in using technology.
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40 Most people with dementia and family carers, and staff and volunteers had limited
41
42 knowledge of Zoom before lockdown and had not used it to support people with
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44 dementia. Staff and volunteers had to quickly learn how to use Zoom and use it to
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46 adapt usual club activities. There was little time for reflection and no time for training.
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51 However, a majority of those attending the MC, however, did not have the
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53 technology nor the digital skills to engage in Zoom sessions and were therefore
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55 excluded from the benefits. Managers were able to obtain technology and data but
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57 physical distancing meant that it was very difficult to support people with limited
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3 digital experience and skills to engage. Addressing barriers to engagement needed
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5 to be weighed up in terms of adding to the anxiety and stress of people with
6
7 dementia and family caregivers. Numbers of people with dementia who might benefit
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9 from technology may be relatively low, so there is a danger of putting too much
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11 energy into one area with the technology. All but one of the MCs involved were in
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13 rural areas and there continues to be connectivity issues for many.
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19 Recruitment of people with dementia and family caregivers to the study was lower
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21 than had been anticipated and low numbers of participants is a limitation of the work
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23 reported here. In particular this relates to hearing the voices of people with dementia.
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25 In usual times recruitment would be facilitated by the manager at the MC and the
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27 nature of the study and consent forms would be explained face to face. This may not
28
29 translate so well over the telephone or in an email. Additionally, data collection in
30
31 such times as lockdown and physical distancing is challenging. Research may not be
32
33 a priority in such circumstances as a pandemic for any of the stakeholders with the
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35 focus needing more than ever to be on practical everyday matters and a pressing
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37 need to address health and well-being with doubt as to the benefits to the
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39 participants (Bartlett et al., 2019).
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47 **Conclusions**

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49 Overall this study demonstrated that MCs could continue to support people affected
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51 by dementia to adjust to change during a period when no or limited face to face
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53 contact was possible.
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3 MCs were able to adapt much of what they do in usual circumstances by introducing
4 a remote support with continuity and consistency having been maintained to some
5 extent. However, key aspects such as group activities were only open to the minority
6 of attendees and as such the majority were digitally excluded. In some cases support
7 was enhanced in terms of availability and flexibility as were relationships, between
8 family caregivers and between people with dementia, family caregivers and staff but
9 this was again largely only to the benefit of the minority. Non-technological
10 approaches such as newsletters and garden visits were vital in terms of bridging that
11 gap. However, it is important to recognise that remote support can cost at least as
12 much as regular MC activity with impact on staffing (one MC had to recruit an
13 additional member of staff) and resources such as for producing printed newsletters.
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31 Moving forwards, a blended approach using remote and regular MC face to face
32 methods means person-centred support could be optimised, reaching those who
33 cannot attend MCs and could be used in rural areas to address social isolation. It
34 would enable flexibility and consistency should there be future lockdowns. The
35 implication is that MCs, once regular usual club and family carer sessions are
36 permitted, should direct attention to developing member, family carer and staff digital
37 skills. With health and social care systems stretched to their limits in dealing with the
38 pandemic and the increased implementation of digital clinical solutions such as
39 remote consultation and monitoring MCs could play a key role in supporting people
40 affected by dementia with digital inclusion to access such services. Digital upskilling
41 of MC people with dementia, family caregivers and staff and volunteers is essential
42 not only to mitigate against the impact of a similar lockdown situation in the future but
43 also to help address both social inclusion and digital exclusion in usual times.
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5 Future studies could focus on the effectiveness of remote and/or blended
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7 approaches to support. There is promise of the Adjusting to Change strategies
8
9 providing a framework for the approach and which could be built into activities.
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14 **Conflict of interest declaration:** The authors declare no conflict of interest. Neither
15
16 the funders nor the Meeting Centre managers had a role in the design of the study;
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18 in the collection, analyses, or interpretation of data; in the writing of the manuscript,
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20 or in the decision to publish the results.
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26 **Funding:** This report was funded by The National Lottery Community Fund (UK
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28 Project No.10333678).
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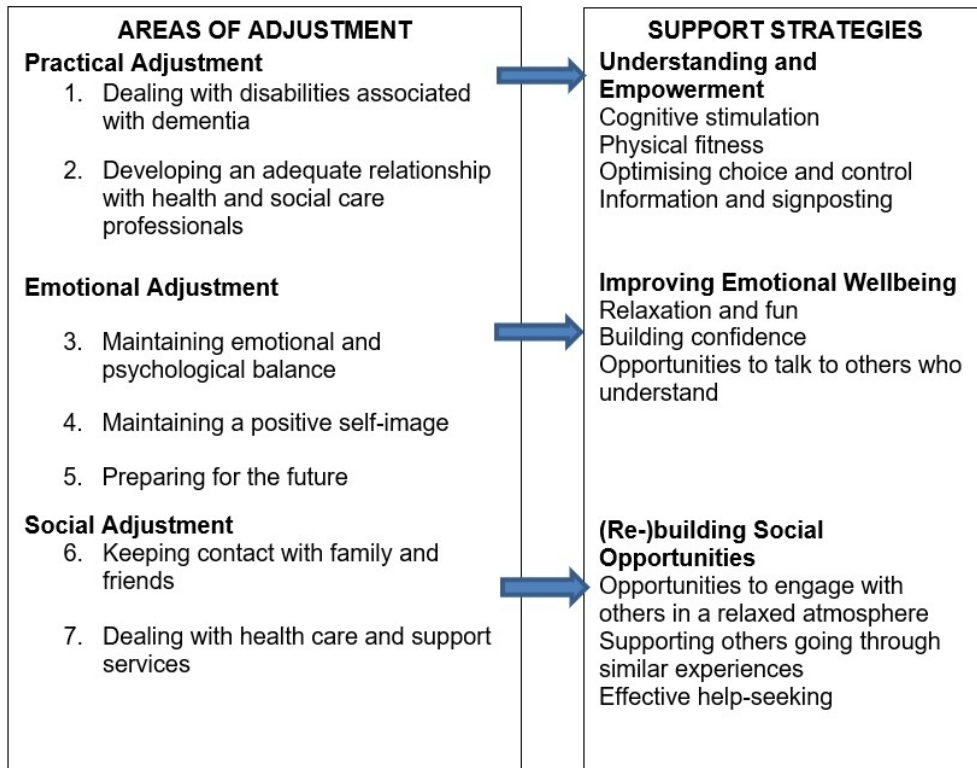
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14 15 16 17 **Figure/Table legends**

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19 Figure 1: UK translation into the '*Adjusting to Change Model*'

20 Table I: Type of contact and number of contacts summed across 4 MCs

21 Table II: Number of interviews and focus groups conducted across stakeholders
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UK translation into the 'Adjusting to Change Model'

219x172mm (96 x 96 DPI)

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Table I: Type of contact and number of contacts summed across 4 MCs

Type of contact	Number of contacts
Non-technological approaches (other than the telephone)	
Telephone call	717
Post	335
Home garden visits	191
Other contacts	Delivering shopping 43 Newsletters (most of the post contact included newsletters)
Technological approaches	
Other contacts	914 Emails 27 Facebook contacts
WhatsApp ¹ or FaceTime. ¹	163
Zoom ¹ for 1-1 meetings	38
Zoom for group meetings	101 involving people with dementia; 70 just for caregivers
Zoom for group activity sessions – in lieu of MC activity sessions	60
Total attendances by people with dementia at group activity sessions	222
Average attendance at group activity sessions	1-5 people with dementia and 1-6 caregivers per session

¹ WhatsApp and FaceTime were the only applications used for video telephony. Zoom was the only video conferencing software used. These terms are used throughout the remainder of this article when addressing the relevant modes of engagement.

Table II : Number of interviews and focus groups conducted across stakeholders

Role at MC	Number recruited and interviewed	Number of focus groups taking place (number of participants)
Member/Family Carer	12 (11 caregivers and 1 member)	2 (8)
Manager	4	N/A
Staff/volunteer	7	2 (7)
Trustee	5	2 (8)