

Older People and Mental Health Nursing: A Handbook of Care

Edited by

**Rebecca Neno,
Barry Aveyard
and
Hazel Heath**



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Contents

<i>Contributors</i>	xi
<i>Foreword</i>	xiii
<i>Introduction</i>	xv
Part 1: CONTEXT	1
1 Background and Influences	3
<i>Rebecca Neno, Barry Aveyard, Hazel Heath and Heide Baldwin</i>	
Introduction	3
Psychological perspectives on mental health	4
Older people's mental health	5
The development of mental health services for older people	6
The contribution of nursing	8
References	11
Part 2: HELPING OLDER INDIVIDUALS	13
2 Older Individuals and Mental Health	15
<i>Sue Davies and Tony Ryan</i>	
Introduction	15
The mental health of older people	15
Experiences of ageing and mental illness	16
Discrimination	17
Participation in meaningful activity and mental health	18
Relationships and mental health	19
Physical health	20
Poverty	21
Transitions and the threat to mental health	21
The significance of continuity	23
Experiences of services	23
Community support: A model for the future	24
Conclusion	26
References	27
3 Normal Physiological Ageing	31
<i>Roger Watson</i>	
Introduction	31

	The process of ageing	32
	The ageing brain	32
	Latent potential	36
	Cognitive function	37
	Conclusion	38
	References	39
4	Values Underpinning Help, Support and Care	40
	<i>Jan Dewing</i>	
	Introduction	40
	Values and beliefs	40
	Values are everywhere	41
	Personal and professional values	42
	Clarifying your values	44
	Ageism	45
	What does a values clarification exercise look like?	46
	Values and evidence base	46
	Having values and working with them	47
	From values to action	48
	Values enabling person-centredness	49
	Conclusions	50
	Resources	50
	References	51
5	Approaches to Help, Support and Care	53
	<i>Elizabeth Collier</i>	
	Introduction	53
	Mrs Jane Gordon	54
	Mr Raj Josephs	56
	Mrs Rose Smith	60
	Josie Lomax	62
	Patrick O'Sullivan	64
	Conclusion	65
	Acknowledgements	65
	Resources	65
	References	66
6	Legal and Ethical Frameworks for Mental Health Nursing	67
	<i>Michael Tullett</i>	
	Introduction	67
	Contexts and circumstances	68
	Groups at risk – complexities	69
	The need for an ethical framework	69
	Codes of conduct as ethical components	70
	The politics of society vs. the individual	71
	How do services enable clients?	71
	The argument of best interest	72

Current ethical frameworks	73
Whose right and whose duty?	75
The use of advocacy	76
Moral or civil rights?	76
Advanced directives	77
The Mental Capacity Act, 2005	78
Consent	78
Conclusion	79
References	80
7 Dilemmas in Mental Health Nursing	81
<i>Tina Naldrett</i>	
Introduction	81
Rights, risks and responsibilities related to restraint	82
Avoiding the use of restraint, assessing the risks	82
Our responsibility in relation to restraint	83
Older people's rights	84
Dilemmas in caring for and supporting older people with mental needs	84
Some therapeutic approaches	85
Safeguarding adults	90
Conclusions	92
References	93
8 Assessing Older People with Mental Health Issues	95
<i>Henry Minardi</i>	
Introduction	95
Assessment revisited	96
The Single Assessment Process	97
Therapeutic relationship development	99
Structure of mental health assessments	103
What will be assessed?	104
How will it be assessed?	106
What will be done with the assessment?	108
Conclusion	108
References	109
Part 3: NEGLECTED ASPECTS	113
9 Culture, Religion and Spirituality	115
<i>Peter Draper and Wilfred McSherry</i>	
Introduction	115
Spirituality	115
The importance of culture	117
Religion, spirituality and older people	119
Skills focus: Assessing for culturally sensitive care	120
Conclusion	121
References	121

10	Intimacy, Sex and Sexuality	124
	<i>Denise Forte, Diane Wells and Angela Cotter</i>	
	Introduction	124
	The backdrop to understanding relationships, intimacy and sexuality	125
	What do we mean by intimacy and sexuality?	125
	Effects of age changes on sexuality	128
	Intimacy and sexuality – issues for older people with mental health needs	128
	Problems associated with sexuality in people with a mental health illness	129
	Skills and strategies for supporting intimacy and sexuality in older people with mental health problems	130
	Staff support and awareness	132
	Conclusion	133
	Resources	133
	References	134
11	Nutrition	135
	<i>Christine Eberhardie</i>	
	Introduction	135
	Nutrients and the brain	135
	Assessment of nutrition and eating skills	136
	Mental health status	139
	Nutritional issues in the clinical management of dementia	139
	Nutritional issues in the clinical management of depression	140
	Reflection	140
	Conclusion	141
	References	141
12	Palliative and End-of-Life Care	143
	<i>Lynne Phair</i>	
	Introduction	143
	Death and dying in today's society	144
	The challenges for mental health nurses working with people at the end of their lives	144
	Assessing the needs of older people with mental health needs at the end of their lives	145
	Meeting the challenges and offering appropriate care at the end of a person's life	146
	Conclusion	149
	References	150
	Part 4: MENTAL HEALTH ISSUES FOR OLDER PEOPLE	151
13	Acute Mental Health Issues	153
	<i>Sarah McGeorge</i>	
	Introduction	153
	How common is challenging behaviour in older people?	154

Why is it important to learn about challenging behaviour?	155
Understanding behavioural approaches and assessing behaviour	155
Causes of challenging behaviour	158
Example of a model in action	159
Interventions for older people with challenging behaviour	161
Caring for people who resist essential care	163
Caring for under-active or passive people	163
Caring for older people who may be aggressive	164
Caring for people with hallucinations	164
Caring for people with delusions	164
Caring for older people who 'wander' or 'pace'	165
Conclusion	165
References	166
14 Delirium	168
<i>Irene Schofield</i>	
Introduction	168
Risk factors for developing delirium	170
The experience of delirium	171
Identifying delirium	174
Prevention and care	175
Conclusion	179
References	180
15 Enduring Mental Health Issues	182
<i>Barry Aveyard</i>	
Introduction	182
Schizophrenia	183
Homelessness	186
Bipolar disorder	187
Substance misuse	189
Conclusion	192
References	193
16 Depression in Later Life	195
<i>Jill Manthorpe and Steve Iliffe</i>	
Introduction	195
What is depression?	196
Depression and dementia	200
Depression and risk	202
Treatment of depression	204
Medical treatments	205
Conclusion	207
References	208
17 Dementia in Later Life	211
<i>Trevor Adams and Gary Blatch</i>	
Introduction	211

Exploring dementia	212
Alzheimer's disease	212
Vascular dementia	213
The development of dementia care nursing	213
Dementia care nursing skills	216
Conclusion	221
References	221
Part 5: FUTURE DIRECTIONS	223
18 Mental Health and Well-Being for Older People in the Future:	
The Nursing Contribution	225
<i>Henry Minardi, Hazel Heath and Rebecca Neno</i>	
Introduction	225
Future populations of older people and nurses	225
The mental health and well-being of older people in the future	227
Developments in treatment and care	229
Developing services for the future	229
Nursing in the future	231
Conclusion	233
References	234
Index	236

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Foreword

This is an important text in bringing together the complex and diverse challenges for nurses working with older people with mental health needs. Across adult care, in acute hospitals, communities and care homes, older people will present with either pre-existing health conditions or demonstrate signs of deterioration of mental well-being.

Nursing in 21st-century health care requires practitioners to have a wide and comprehensive knowledge of a breadth of issues which both enable them to deliver better care. This will be achieved through effective assessment, complex care management and ensuring that fundamental care principles such as nutrition are received. Also, nurses will need to have an understanding of the legislative, and socio-political, cultural, sexual and end-of-life issues which are important underpinning themes of nursing today.

Nurses are key in delivering care and promoting well-being for older people with mental health needs. It is therefore essential that they develop the clinical skills and competencies to deliver effective care. In addition, as clinical leaders, nurses can be effective role models by demonstrating positive attitudes to promote well-being and management of mental illness.

This text brings together a range of nursing and other experts who have articulated the essence of knowledge and clinical competence which will equip readers with the requisite skills and knowledge to be the best and give the best.

Globally, contemporary health care is changing at a rapid pace, and this book will enable nurses, as the largest component of the workforce, to prepare, understand and rise to the challenge of working in partnership across the health- and social-care spectrum to make a real difference to older people and their families.

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Introduction

Mental health in later life is influenced by a complex set of biological, psychological and social interactions. As such, nurses need to be aware of how each of these influences may affect the older person with mental health needs. In addition to these influences, older people may also have to cope with societal assumptions that ageing automatically brings mental decline, and that no treatments are available. Nurses need to be able to challenge such views and assumptions, and to do this they must have adequate knowledge relating to the natural ageing process and skills in communication to be able to get their message across. These are seen as fundamental principles of mental health care for older adults and, of course, will be explored further within this book.

The underpinning concepts and approaches in this book value individual persons within the context of their lives, experiences and relationships. Mental health is seen as an integral aspect of overall health and as a continuum between wellness and illness. Traditional views of mental ill-health as disease can lead to people who experience this being labelled as 'different', with all the stigma this can attract. Rather, as Crump (1998, pp. 172–173) argues, we acknowledge that

'we all have both wellness and illness . . . mental health and mental distress are a continuum on which we all move back and forth, attempting to strike the right balance . . . People who have moved along the continuum away from health are still the same people but are now distressed and in need of support and understanding. The difference is not merely political correctness: it is crucial to how we perceive mental health nursing and, more importantly how we perceive those who find themselves requiring mental health support.'

This book focuses on the knowledge and key skills which practitioners require or must have, to work effectively with older people who have, or are at risk of developing, mental health needs. The text is aimed primarily at nurses working in all settings and all types of roles, but, acknowledging the intrinsically interdisciplinary nature of older people's services, much of the content is relevant to all disciplines. The content relevant to older people's mental health and care is broadly applicable, and the social policy, legislation and details of specific services are relevant to the UK.

It is intended that this book will enable practitioners to develop their knowledge and skills through the completion of the practice examples found within most chapters. These examples are meant to be thought-provoking, allowing readers to link theoretical concepts with their practice and ultimately improve the delivery of care.

The book is divided into five sections, to assist the reader in navigating the text.

Part 1 sets the context for the book; it explores the background, historical perspectives and influences of mental health care in later life. This section is designed to provide the foundation of the book; understanding the history and origins of elements of care and practice should assist practitioners in the mission of moving forward and developing practice further.

Part 2 focuses on helping older individuals, and includes chapters relating to:

- older individuals and mental health;
- normal age changes that influence mental health;
- values underpinning support and care;
- legal and ethical frameworks within which mental health care takes place;
- the practical implications of the legal and ethical frameworks by exploring some dilemmas in mental health nursing;
- assessing older people with mental health needs, including the importance of developing therapeutic relationships.

Part 3 focuses on some aspects which have traditionally been neglected in mental health care, including:

- culture, religion and spirituality;
- intimacy, sex and sexuality;
- nutrition;
- palliative and end-of-life care.

Part 4 details specific mental health issues for older people; these include:

- acute mental health issues;
- delirium;
- enduring mental health issues;
- depression in later life;
- dementia.

The final section explores future trends in older people's mental health and offers ideas as to how nursing may develop, and is developing, to address these.

The contributing authors of this book have considerable expertise in the care of older people and/or mental health care. We would like to extend our thanks to all authors who have contributed to this book and have worked hard to ensure their chapters are robust and contemporary. As such, we hope that this book will ultimately make a contribution to enhanced care and support for older people with mental health needs.

Rebecca Neno, Hazel Heath, Barry Aveyard

Reference

- Crump, A. (1998) Disease or distress. In: *Caring for Older People: Developing Specialist Practice* (J. Marr and B. Kershaw, eds). London, Arnold, pp. 165–189.

Part 1

CONTEXT

Chapter 1

Background and Influences

*Rebecca Neno, Barry Aveyard, Hazel Heath and
Heide Baldwin*

Introduction

There is one thing in life that is inevitable – ageing; and with ageing come biological, psychological and sociological changes and adjustments. As advances in knowledge, technology and health care continue, both life expectancy and lifespan are increasing. Lifespan is the maximum time a person can live, currently 122 years, whereas life expectancy is the average time a person can expect to live, currently 76 years for males and 81 years for females, within the UK (Official National Statistics, 2006). The increase in both lifespan and life expectancy has brought about considerable demographic changes for developed countries such as the UK. By 2030, the UK will have seen radical changes in its population structure. It has been predicted that the number of people over the age of 85 will double, resulting in a disproportionate cohort of old old age. Consequently, the average life expectancy is now nearing maximum lifespan.

As a result, health and social policy has heightened the awareness of public health and government initiatives often focus on the promotion of health and well-being. In England, the National Service Framework for Older People (Department of Health, 2001) has a standard dedicated to health and exercise in later life (standard 8). The Welsh Strategy for Older People (Welsh Assembly Government, 2003) aims to develop an evidence-based action programme of health promotion for older people and through community health and well-being planning, ensure local government takes a strategic approach to older people issues and responds to an ageing society. In 2006, the Scottish Executive consulted on a strategy for an ageing population; once again the consultation included the maintenance of health and well-being in later life (Scottish Executive, 2006). Similarly, policies within Northern Ireland also focus upon the promotion of health and activity in later life (Older People Improving Health, 2006). This change in policy focus is reflective of the move away from a curative approach of ill-health, to one of wellbeing and the management of long-term illness conditions.

Traditionally, most health and wellness strategies have been aimed at physical health, and in comparison few have focused on mental health and well-being. While it is important to stress that most older people, as at any age, do not

develop a mental health need, their mental health and well-being should be given equal emphasis to physical health needs. This will become increasingly important in the future as the numbers of older people increase. Age Concern and the Mental Health Foundation (2006) claim that, unless mental health and well-being in later life are promoted, as many as three million older people may develop mental health needs by 2031.

Psychological perspectives on mental health

Despite ageing being inevitable, the development of mental health needs at any stage in the lifespan is not. However, myths remain that as a person ages, cognitive changes occur which negatively affect intelligence, creativity and memory. While it cannot be argued that some changes take place within the brain as a person ages (see Chapter 3), it is wrong to assume that all older people will become forgetful and develop a dementia-related condition. Although there is some agreement on the biological changes occurring in ageing, there is little research-based agreement on the psychological dimensions (Daly, 1999), despite numerous research attempts. The difficulty with research studies is that, while attempting to provide a generalisable snapshot of the reality of mental health in later life, they cannot always reflect or provide answers to meeting individual needs (Daly, 1999). Adopting a person-centred and biographical approach to care can be crucial to planning services and meeting individual care needs. The major areas of psychological investigation and research include the decline of learning abilities, memory, personality changes and intelligence. All are considered to impact upon abilities in later life (see Chapter 3).

The first distinct contribution of psychology to the study of ageing is credited to Sir Francis Galton (1822–1911) who, among his other works, launched the first large-scale collection of empirical data across the lifespan. At this time, research into intelligence quotients (IQ) compared younger people with older people in laboratory conditions, and unsurprisingly these studies demonstrated a significant decline in ability in later life. This theory proposed that from birth, the individual learns and grows until adulthood, after which there is a long stage of consolidation, followed by a stage of decline, culminating in death. We now know that laboratory tests involving quick responses actually test motor function, rather than IQ, and such work has declined in importance since the emergence of developmental psychology.

Jung (1875–1961) was one of the first psychologists to define later life as having a purpose of its own. He described the first half of life as orientated to biological and social issues and the second half of life characterised by inner discovery. Jung identified this as a developmental process by which the person becomes more unique and better able to use inner resources to pursue personal aims. Overall, within current gerontological theory, it is accepted that, as a person ages, personality does not change. Similarly, changes to both short-term and long-term memory are thought to occur with the natural ageing process

(see Chapter 3), but it is thought that these changes do not necessarily impact upon the person's life, and often those complaining of poor memory in later life also report poor memory ability in earlier years.

Older people's mental health

There exists a broad assumption that older people's mental health is all about dementia. This is untrue. According to Age Concern and the Mental Health Foundation (2006), depression is the most common mental health condition in later life, and there are currently 2.4 million older people in the UK with depression severe enough to impair their quality of life (see Chapter 16). Aside from depression, older people are also prone to other mental health conditions: 5% of the population aged over 65 have dementia (Department of Health, 2001); 20% of older adults in an acute hospital environment will develop delirium (British Geriatrics Society, 2005) (see Chapter 14), and 1% of the older population within the UK have schizophrenia (Rodriguez-Ferra and Vassilas, 1998) (see Chapter 15).

While wishing to avoid 'labelling' or to focus merely on diagnosis, it is important to recognise that older people experience a broad range of mental health issues, and these may also include:

- dementia of varying types (Chapter 17);
- schizophrenia and paranoid states (Chapter 15);
- bipolar disorders (Chapter 15);
- anxiety states;
- stress-related disorders, post-traumatic stress;
- the effects of alcohol or drug misuse.

Apart from dementia, many areas of older people's mental health have been particularly neglected, and this may be attributed to prejudicial perceptions of old age. Dyson (2006) claims that alcohol misuse among older people is a neglected issue within mental health care. While it could be argued that the incidence of alcohol misuse is underestimated in all age groups, older people are notably absent in policy priorities (Galpin, 2004). For example, the Alcohol Harm Reduction Strategy for England (Strategy Unit, 2004) focuses on young binge drinkers and alcohol-dependent people of working age. Mental health and alcohol misuse are closely related and can interact through a cycle whereby stressors or mental health needs can increase alcohol consumption which, in turn, can affect mental health. Mixing alcohol with some prescribed drugs can be particularly dangerous for older people. Specialist services are limited, and the number of older people accessing these is low (Alcohol Concern, 2002 calculate that only 7% of specialist alcohol service users are over 60 years of age), but older people who do access treatment are able to alter their drinking patterns (Ward, 2003).

Another neglected area includes post-traumatic stress disorder (PTSD), labelled as 'shell shock', 'battle fatigue' or even 'weak willed', which was

common during and after the two World Wars. It was first identified by the psychiatrist WH Rivers working at Craiglockhart hospital in Edinburgh during the First World War. Working with soldiers suffering from psychological trauma, he developed the phrase war neurosis (Rivers, 1918). However, it was not until the latter part of the 20th century when research documented the extreme psychological reactions to major disasters that the underlying psychological processes developed. Now conceptualised as a catastrophic stressor outside the range of usual human experience (Farnsworth, 2002), PTSD is now more widely recognised among older people, and a range of psychotherapeutic and pharmacological treatments are available (Mason, 2005). There is perhaps a view in society that ideas around stress and psychological trauma are alien to older people, and that the 'older generation' just 'get on with it'. However, this is a likely stereotype with no real supporting evidence.

There are also groups of older people whose mental health needs are commonly under-recognised. These include older people who are homeless and those in prison. These are discussed further in Chapter 18.

The development of mental health services for older people

The history of mental health care is long and complex, but it is important to understand the legacy that current services have inherited as some influences from this remain today. Some of the earliest documentation refers to the founding of the Bethlehem Hospital in London in 1327 for the mentally distracted (McMillan, 1996). One of the first attempts to legislate in the field of mental health care was the 1774 Madhouses Act; this act introduced the concept of inspection of madhouses by commissioners (Wright, 1999).

The development of the lunatic asylum can be attributed to the 1845 Lunacy Act. This legislation led to the compulsory founding of asylums in every county borough in the UK. While with hindsight we tend to see the old asylums as very unpleasant places, in 1845 the idea of care for 'lunatics' was seen as very progressive and innovative. In 1957, the Percy Report claimed that there needed to be a much more therapeutic approach to mental health and monitoring of asylums. This report led to the 1959 Mental Health Act, which is often regarded as setting the foundations for modern mental health care (Nolan, 1992).

The development of neuroleptic drugs in the 1950s also played a revolutionary role in the development of mental health care. While there are without doubt many issues around the use of neuroleptic drugs, and clear evidence exists that they have at times been misused, there remains little doubt that they did revolutionise care. They brought about the demise of regular use of straitjackets and locked wards in 'mental hospitals'. They also slowly led to the development of community mental health care. It took nearly 50 years for the old psychiatric hospitals to close their doors, but it is now unlikely that people entering mental health care now will spend the rest of their lives in institutional settings.

Kitwood (1997) highlighted that the historical approach to older people in institutions was to 'warehouse' them (and this is discussed further in

Chapter 17). The suggestion was that they were cared for in places of safety where their basic human needs were provided for, but little else. Even today, institutional care can persist in any environment where staff do not focus upon the needs of the individual or do not question rituals. As the move towards community care developed in the 1970s, community services developed in an unstructured and disorganised way, and health and social services saw the needs of those with mental health conditions very differently (Phair, 1999). Despite the fact that there were some areas of excellent development, there were nonetheless a number of tragedies involving those with mental health needs, the most well known being the death of Jonathan Zito, who was murdered by Christopher Clunis on an underground station for no apparent reason. The enquiry into Jonathan Zito's death concluded that poor communication between health and social services and a lack of effective care coordination were contributing factors. As a result, an emphasis upon joint local services for people with mental health needs became a government priority, and thus the Care Programme Approach came to fruition. The Care Programme Approach should ensure that all older people with mental health needs, living in the community:

- have a key worker;
- have regular reviews of the care package undertaken by the multiagency team;
- have all care assessed and that care is reviewed in a systematic way.

A further requirement of the Care Programme Approach was to make the person's perspective central to any plan of treatment or care. This has been affirmed as a central component in the Review of the Care Programme Approach 2006 (Department of Health, 2006). The notion of person-centred care has become well established within both health and social care professional frameworks and is an idea associated with the groundbreaking work of Tom Kitwood (1997). Person-centred care aims to break the traditional approach to care, which often involved ritualised approaches. It aims to ensure that each person is cared for in an individualised manner. It is a concept that is now well established in care provision and underpins many government documents produced by the four countries of the UK (Department of Health, 2001; Welsh National Assembly, 2003).

At the start of the millennium, there was a shift in the focus of person-centred care. The Institute for Health Care Improvement (2001) broadened the remit to 'care that is truly person-centred considers the persons cultural traditions, their preferences and values and their family situation and lifestyle'. This shift has been accepted as progression, involving a radical movement from a highly individualised therapeutic approach to a social and political strategy.

It would be hard to disagree that person-centred care is an important way of looking to develop standards of care for older people. The challenge is to actually ensure that it is a reality and not rhetoric. Some researchers (Aveyard and Davies, 2006; Nolan et al., 2006) among others have begun to explore the notion of Relationship-Centred Care; this approach suggests that to achieve

person-centred care for older people, there needs to be a consideration of the needs of relatives and care staff as well as those of the person themselves. It is suggested that if there is a sense of well-being for all involved in care, then the outcome for the person being cared for will be much more person-centred in nature. The rationale for this change is based on increased recognition of the need to develop a systematic approach towards care (Adams, 2005). The foundation for change is that interaction in health and social care frequently requires the involvement of three or more people. It is less common to be dealing with only one individual in care. Where this triangle of care exists, various authors have commented on the risk of alienating the least able person where the focus is upon just one person (Biggs, 1993; Twigg and Atkin, 1994; Adams, 2005).

Relationship-centred care needs to consider the whole picture. There are risks associated with this, specifically where the person receiving care is unable to communicate their wishes and needs. The risk of losing the person in the development of relationship-centered care is recognised by Nolan et al. (2003, 2004). He is explicit in identifying that the inner subjectivity of the individual remains core, but in addition to these, others must be considered. Nolan et al. (2003) argues that there are prerequisites for good relationships, and he terms them as the 'senses framework'. The six senses are security, continuity, belonging, purpose, fulfillment and significance. The need for security includes feeling safe in both the receiving of and delivery of competent and sensitive care. The sense of continuity is both that of personhood, of having a history in life with positive past experiences that are recognised and valued. The sense of belonging is reciprocal, with opportunities to form meaningful relationships or feel part of a team, whereas a sense of purpose is found in the agreement of clear goals that are inspirational to the practitioner, the client and their carer or family. The achievement of meaningful and valued goals brings satisfaction or the sense of fulfillment, without which the relationship is empty; and in recognising the person, be that client, carer or professional, there is a feeling of significance in the role (Adams, 2005).

The contribution of nursing

Effective health care for older people requires the input of specialist professionals from a range of disciplines including medicine, physiotherapy, occupational therapy, speech and language therapy, nutrition, pharmacy, podiatry, as well as nurses who make their own distinct contribution.

Heath's (2006a) research highlights that good nurses bring to their work, among other inputs, an understanding of:

- health and disease processes – physical, emotional, social, spiritual – and how these interact;
- a broad range of treatment options including the effects and side-effects of medicines and also a variety of therapeutic interventions.