Mental Health and Older People

A Guide for Primary Care Practitioners

Carolyn A. Chew-Graham
Mo Ray
Editors

Springer

Mental Health and Older People

Carolyn A. Chew-Graham • Mo Ray
Editors

Mental Health and Older People

A Guide for Primary Care Practitioners

Springer

Editors
Carolyn A. Chew-Graham
Keele University
Newcastle Under Lyme
Staffordshire
UK

Mo Ray
Keele University
Newcastle Under Lyme
Staffordshire
UK

ISBN 978-3-319-29490-2 ISBN 978-3-319-29492-6 (eBook)
DOI 10.1007/978-3-319-29492-6

Library of Congress Control Number: 2016937415

Printed on acid-free paper

This Springer imprint is published by Springer Nature
The registered company is Springer International Publishing AG Switzerland

Foreword

It is a pleasure to have been asked to provide a foreword for this excellent book edited by Carolyn A. Chew-Graham and Mo Ray.

Mental health in older people is an important part of everyone's life. With an increasing age of the population and an increased number of older people (a great success story) come the challenges to maintain health and wellbeing as we age. Mental health is arguably the most important component of that. The explosion of interest recently in dementia is welcome, and Carolyn and Mo's contribution is a timely reminder that the important issues are not just around those organic dementias but the whole range of mental health difficulties which can affect older people.

This book attempts a lot but succeeds. It covers the full range of mental health difficulties in older people, it provides up-to-date evidence to support clinical decision-making, it offers specific guidance on clinical issues and, if that was not enough, it succeeds in emphasising the importance of integrating health and social care. In older people this is a priority. The eclectic nature of the choice of the authors strengthens the book considerably, and the range is impressive spanning details of the scale of the challenge, through detailed analyses of depression and anxiety to psychotic disorders and delirium and dementia. The range from early diagnosis to end of life care is covered admirably. With the increasing importance of care of older people and their mental wellbeing, this contribution is a landmark publication, and Carolyn and Mo are to be congratulated at bringing it together.

Alistair Burns
Professor of Old Age Psychiatry, University of Manchester
National Clinical Director for Dementia, NHS England
Consultant Old Age Psychiatrist, Manchester Mental Health and Social Care Trust, Manchester, UK

Preface

We hope that this book will be a useful resource for anyone who works with, or is interested in, the mental health of older people.

We have attempted to adopt a broad approach, recognising the complexity of older people's lives, the interplay between the physical, psychological and social, and the need for integration between primary and specialist health care, specialist health care and social care and the voluntary ('third') sector.

Our aim is that this book will appeal to students in health and social care professions, general practitioners and primary care nurses, social workers, clinicians in specialist care and practitioners in the voluntary sector.

We, and our contributors, have drawn from their professional experiences in writing the chapters. We have used 'cases' to illustrate the concepts and topics, which reflect contributors' work and expertise. We have also included suggestions for personal reflection and audit, in order to challenge the reader into thinking how what they have read will impact on their practice.

We hope that this text will contribute to increased recognition of mental health problems in older people and an improvement in their care.

Keele, Staffordshire, UK

Carolyn A. Chew-Graham, MD, FRCGP
Mo Ray, PhD

Contents

Contributors

Teresa Atkinson, BSc Psy, MSc C.Neuropsychiatry Association for Dementia Studies, University of Worcester, Worcester, UK

Bernadette Bartlam, MA, PhD Research Institute for Primary Care and Health Sciences, Keele University, Keele, Staffordshire, UK

Sophie Behrman, BA, BMBCh, MRCPsych Department of Psychiatry, Warneford Hospital, Oxford, Oxfordshire, UK

Jennifer Bray, BSc French and Mathematics Association for Dementia Studies, University of Worcester, Worcester, UK

Heather Burroughs, BSocSci, MPhil, PhD Research Institute for Primary Care and Health Sciences, Keele University, Keele, Staffordshire, UK

Suzanne Cahill, B.Soc.Science, M.Soc.Science, PhD The Dementia Services Information and Development Centre, St. James's Hospital and Trinity College Dublin, Dublin, Ireland

Richard Cheston, MA, PhD, Dip C Psychol Department of Health and Social Sciences, University of the West of England, Bristol, UK

Carolyn A. Chew-Graham, MD, FRCGP Research Institute, Primary Care and Health Sciences, Keele University, Keele, Staffordshire, UK

Christopher Dowrick, BA, MSc, MD Department of Psychological Sciences, University of Liverpool, Liverpool, UK

Chris Fox, MB, BS, Mmedsci, MRCPsych MD Department of Clinical Psychology, Norwich Medical School, Norwich, Norfolk, UK

Simon Gilbody Mental Health and Addictions Research Group, Department of Health Science, University of York, York, UK

Jon Glasby, PhD, MA/DipSW, PG Cert (HE), BA Health Services Management Centre, University of Birmingham, Birmingham, West Midlands, UK

Kimberley Harrison, MBBS, BSc, MRCPsych Royal Bolton Mental Health Unit, Old Age Psychiatry, Hazelwood Ward, Royal Bolton Hospital, Bolton, Lancashire, UK

Andrea Hilton, BPharm (Hons), MSc, PhD Faculty of Health and Social Care, University of Hull, Hull, UK

Steve Iliffe, MBBS, FRCGP Research Department of Primary Care and Population Health, University College London, London, UK

Jacqueline Jones Stoke-on-Trent, Staffordshire, UK

Salman Karim, MBBS, MSc, MD, FCPS Central Lancashire Memory Assessment Service, Lancashire Care NHS Trust, Preston, Lancashire, UK

Valentinos Kounnis, MD, MSc, PhD Department of Oncology, Oxford University Hospitals NHS Foundation Trust, University of Oxford, Oxford, Oxfordshire, UK

Ken Laidlaw, MA (Hons), MPhil., PhD, C.Psychol. Department of Clinical Psychology, Faculty of Medicine and Health Sciences, Norwich Medical School, University of East Anglia, Norwich, UK

Rosemary Littlechild, Msoc Sci, Bsoc Sci, CQSW Institute of Applied Social Studies, University of Birmingham, Birmingham, West Midlands, UK

Linda Machin, MA, PhD Research Institute for Social Sciences, Keele University, Keele, Staffordshire, UK

Ian Maidment, PhD School of Life and Health Sciences, Aston University, Birmingham, UK

Jill Manthorpe, MA Social Care Workforce Research Unit, Kings College London, London, UK

Susan Martin, BA, MSc, PhD Netherton Feelgood Factory, Liverpool, UK

John McBeth, MA, PhD Centre for Musculoskeletal Research, Arthritis Research UK Centre for Epidemiology, The University of Manchester, Manchester, UK

Louise McCabe, MA, MPhil, PhD School of Social Sciences, University of Stirling, Stirling, UK

Alisoun Milne, BA, CQSW/Diploma ASS, MA, PhD Sociology and Social Research, School of Social Policy, University of Kent, Chatham Maritime, Kent, UK

Rashi Negi, MBBS, MD, MRCPsych, MSc Med Department of Old Age Psychiatry, South Staffordshire and Shropshire Foundation Trust, Lichfield, Staffordshire, UK

Lynne Phair, MA, BSc (Hons), Nursing RMN, RGN Lynne Phair Consulting Ltd, Heathfield, East Sussex, UK

Mo Ray, PhD Gerontological Social Work and Programme, School of Social Science and Public Policy, Keele University, Keele, Staffordshire, UK

Jane C. Richardson, BA (Hons.), MSc, PhD Research Institute for Primary Care and Health Science, Keele University, Keele, Staffordshire, UK

Louise Robinson, MBBS, MRCGP, MD Newcastle University Institute for Ageing and Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK

George M. Savva, PhD School of Health Sciences, University of East Anglia, Norwich, UK

David G. Smithard, BSc, MBBS, MD, FRCP Department of Clinical Gerontology, King's College Hospital NHS Foundation Trust, Princess Royal University Hospital, Farnborough, Kent, UK

Eugene Yee Hing Tang, MBChB, BSc, MRCSEd, MSc, PGDip. Newcastle University Institute for Ageing and Institute of Health and Society, Newcastle University, Newcastle upon Tyne, UK

Denise Tanner, PhD, MSocSc, BSc, CQSW Institute of Applied Social Studies, University of Birmingham, Birmingham, West Midlands, UK

Alan Thomas, MRCPsych, PhD Institute of Neuroscience, Newcastle University, Newcastle upon Tyne, UK

Jochen René Thyrian, PhD, Dipl-Psych Site Rostock/Greifswald, German Center for Neurodegenerative Diseases (DZNE), Greifswald, Germany

Perla Werner, PhD Department of Community Health, University of Haifa, Haifa, Israel

Ross Wilkie, BSC, PhD Research Institute for Primary Care and Health Sciences, Keele University, Keele, Staffordshire, UK

Philip Wilkinson, BM, BS, FRCPsych Department of Psychiatry, Warneford Hospital, Oxford, Oxfordshire, UK

Part I

Introduction

Setting the Context

1

Carolyn A. Chew-Graham and Mo Ray

1.1 What Is Older Age?

'Older age', although lacking a clear definition, represents an important period of life in which health and social care needs rise substantially and in which multiple mental and physical health problems are common and interacting, often compounded by social isolation.

'Older age' generally encompasses two broad transitions [1]:

- The predominantly social transition from working life to retirement – not only capturing a constellation of potential life changes, e.g. in a person's perceived role, daily routine, income level and social environment, but also reflecting a time when patterns and lifestyles are set up which may have important longer-term implications, e.g. financial planning, patterns of family and social relationships and choice of housing.
- The potential transitions of later 'old age', which include the accumulation of health conditions and increasing physical frailty, the consequent or threatened loss of independence, social isolation potentially accompanying loss of independence, compounded by bereavements and movement to institutional or other supported accommodations.

C.A. Chew-Graham, MD, FRCGP (✉)
Research Institute, Primary Care and Health Sciences,
Keele University, Keele, Staffordshire ST5 5BG, UK
e-mail: c.a.chew-graham@keele.ac.uk

M. Ray, PhD
Gerontological Social Work and Programme, School of Social Science and Public Policy,
Keele University, Keele, Staffordshire, UK
e-mail: m.g.ray@keele.ac.uk

C.A. Chew-Graham, M. Ray (eds.), *Mental Health and Older People: A Guide for Primary Care Practitioners*, DOI 10.1007/978-3-319-29492-6_1

1.2 The Ageing Population

According to demographic statistics, the population of the United Kingdom is becoming increasingly older [Office for National Statistics (ONS), 2010]. At the turn of the twentieth century, only 5 % of the UK population, then totalling 32.5 million people, were aged 65 years or more. In contrast, the equivalent data for the turn of the twenty-first century estimated that 16 % of a population, which by then accounted for 52 million, was over 65 years of age (Census, 2001). Current projections for the year 2050 suggest that 25 % of the UK population, which by then is estimated to be in excess of 75 million, will be aged 65 years or more [2]. Moreover, the life expectancy at birth for the UK population is now around 82 years of age for females and 78 for males; over a century ago, life expectancies for women and for men were below 50 years of age. The population trend in the United Kingdom is also occurring on an international scale in developing and developed countries.

When the National Health Service was founded in 1948, 48 % of the population died before the age of 65; that figure has now fallen to 14 %. Life expectancy at 65 is now 21 years for women and 19 years for men, and the number of people over 85 has doubled in the past three decades [3, 4]. By 2030, one in five people in England will be over 65 [5].

This success story for society, and for modern medicine, has transformed our health and social care needs. Many people stay healthy, happy and independent well into old age, and there is mounting evidence that tomorrow's older people will be more active and independent than today's [6]. However, as people age, they are progressively more likely to live with complex co-morbidities, disability and frailty. People aged over 65 years account for 51 % of gross local authority spending on adult social care, and two-thirds of the primary care prescribing budget, while 70 % of health and social care spend is on people with long-term conditions. There is evidence that mental health services for older people are underfunded. Achieving parity in service provision for adults aged 55–74 with those aged 35–54 would require a 24 % increase in NHS mental health spending [7].

1.3 Health and Social Care

In the United Kingdom, primary care services are an integral part of the National Health Service (NHS) in which general practitioners (GPs) work as independent contractors. People are required to register as patients with a general practice; currently a practice determines its boundaries and only accepts patients who reside within this area. The GP is a generalist and provides personal, primary and continuing care to individuals, families and a practice population, irrespective of age, gender, ethnicity and problem.

GPs increasingly work with a range of healthcare professionals in a multidisciplinary primary healthcare team. The team includes a practice manager and

administrative staff, practice nurses and nurse practitioners or specialist nurses. Community nurses, such as district nurses, active case managers and McMillan nurses, and health visitors may be co-located or linked with a group of practices. Increasingly social workers are also linked with a group of practices. Multidisciplinary team working is essential in order to manage the complex demands placed on general practice, which are partly due to caring for an increasingly ageing population with chronic and multiple health problems. The greater emphasis on preventative care, the transfer of clinical responsibility for some chronic diseases from secondary to primary care and the shift in service provision in order to deliver care closer to patients' homes have contributed to these demands [8].

The implementation of a new General Medical Services (GMS) Contract in 2004, which is updated each year, [9] fundamentally changed the way in which general practitioners work in the United Kingdom. The Contract defines essential primary care services and optional enhanced services that are additionally remunerated. The Contract links achievements in clinical and non-clinical care quality to financial rewards, through a Quality and Outcomes Framework derived from evidence-based care, and encourages the delivery of optimum care in clinical domains, with emphasis on chronic disease management [10]. The recently published Primary Care Workforce Commission [11] recommends that practices should develop a stronger population focus and an expanded workforce. Many existing healthcare professionals will develop new roles, and patients will be seen more often by new types of healthcare professional such as physician associates, practice nurses with special interests and pharmacists. It is suggested that such roles would specifically support the management of older people and those with complex problems. Integrating third sector services within the broader primary care teams suggested by the Commission document would provide innovative, accessible services, again, particularly relevant to older people.

Social care covers a range of services and support to help people maintain their health and independence in the community. Such services may include home care (personal care, meals, laundry, shopping), day services and respite care. The current direction of social care policy suggests that funded residential or nursing home care should only be available for those people with the most complex needs who cannot receive adequate care at home or in alternative forms of housing, such as extra care housing [5]. In England, the Care Act (2014) highlights the expectation that care is integrated and personalised [12]. Initiatives include a continued emphasis on developing integrated care and identifying good practice examples, coordinating care and support effectively and providing clear information about health and care needs. The role of personal budgets in personalised care, whereby people who require social care can opt to receive payments directly and purchase services themselves, continues to have a central role in care policy. Positive outcomes such as promoting independence and choice, in the use of personal budgets, have been reported for younger adults with physical or learning disabilities [13], but evidence relating to positive outcomes for older people is less clear. The national evaluation of pilot sites highlighted a negative impact on psychological well-being and little evidence of heightened levels of control amongst older people in receipt of personal budgets

[14]. The ability of direct payment arrangements to be responsive to fluctuating and uncertain conditions also remains an issue. Social work and social care services have a key safeguarding role with older people, and this is likely to be especially relevant when those people lack decision-making capacity.

1.4 Inequity of Access to Care

Health and care services have failed to keep up with the dramatic demographic shift.

The NHS has designed hospital medical specialties around single organ diseases. Primary care consultations and payment systems do not lend themselves to treating patients with multiple and complex conditions [15, 16]. Common conditions of older age receive less investment, fewer system incentives and lower-quality care than general medical conditions prevalent in midlife [17]. Local governments have experienced significant funding cuts over the past 4 years which has impacted on adult social care with an estimated funding gap of 4.3 billion by the end of the decade [18].

There is substantial evidence of ageism and age discrimination in health and care services, ranging from perceived patronising attitudes and behaviours to poorer access to treatment [19–21]. Older people may have access to primary care, but their mental health problems may not be recognised or addressed [22, 23].

1.5 Recent Policies to Address Inequity of Access

The strategy '*No Health Without Mental Health'*, published in 2011 (HM Government 2011) [24], perfectly captures the ambitious aim to mainstream mental health in England, with a clear statement that there should be so-called parity of esteem between mental and physical health services. The document emphasises the importance of addressing mental health problems in older people, particularly when there are co-morbid physical health problems, and the importance of social inclusion in this population.

Similarly, the publication '*No decision about me, without me'* [25] stressed the governing principle that people who use services should be at the centre of everything that is done in the health services and that care should be personalised to reflect the person's needs, not those of the professional or the system. The need for people to have access to information and support to make informed choices about both provider of care and treatment or management is central to this policy document. In addition, the aim was to empower local organisations and practitioners to have the freedom to innovate and to drive improvements in services that deliver support of the highest quality for people of all ages and all backgrounds and cultures.

The Health and Social Care Act 2012 [26] profoundly altered the structure and management of the National Health Service in England, putting patients 'at the centre of the NHS' and changing the emphasis of measurement to clinical outcomes and empowering health professionals, in particular GPs who would play a key role

Table 1.1 Parity of esteem

Parity of esteem means that, when compared with physical healthcare, mental health care is characterised by:
Equal access to the most effective and safest care and treatment
Equal efforts to improve the quality of care
The allocation of time, effort and resources on a basis commensurate with need
Equal status within healthcare education and practice
Equally high aspirations for service users
Equal status in the measurement of health outcomes

in commissioning local services for local populations. One main stated aim of this Act is to facilitate health and social care services to work more closely together, with responsibility for health promotion activities, and commissioning, given to health and well-being boards.

The Health and Social Care Act also secured explicit recognition of the Secretary of State for Health's duty towards both physical and mental health. In conjunction with a clear legislative requirement to reduce inequalities in benefits from the health service, these place an obligation on the Secretary of State to address the current disparity between physical and mental health.

The Department of Health therefore asked the Royal College of Psychiatrists to establish an expert working group to consider the issues in detail, to develop a definition and vision for 'parity of esteem' and to produce recommendations for how to achieve parity of esteem between mental and physical health in practice.

The published report [27] makes key recommendations for how parity for mental health might be achieved in practice and includes a set of commitments to actions they will be taking to help achieve parity of esteem. In essence, 'parity of esteem' is best described as 'Valuing mental health equally with physical health' (Table 1.1).

So, it is against this background that older people with symptoms which may suggest mental health problems negotiate the health and social care systems in order to access care.

References

1. Public mental health priorities: investing in the evidence. Annual Report of the Chief Medical Officer 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf. Accessed 14th Nov 2014.
2. Sunak R, Rajeswaran S. A portrait of modern Britain. Policy Exchange. 2014.
3. Office for National Statistics. 2011 census – population and household estimates for England and Wales, March 2011. London: Office for National Statistics; 2012.
4. Office for National Statistics. What does the 2011 Census tell us about the 'oldest old living in England & Wales? London; 6 Dec 2013. www.ons.gov.uk/ons/dcp171776_342117.pdf.
5. House of Lords. Ready for ageing? HL Paper 140. London: House of Lords Select Committee on Public Service and Demographic Change. Report of Session 2012–13. 2013.
6. Spijker J, MacInnes J. Population ageing: the timebomb that isn't? BMJ. 2013;347:f6598. doi:10.1136/bmj.f6598.

7. Beecham J, Knapp M, Fernández J-L, Huxley P, Mangalore R, McCrone P, Snell T, Winter B, Wittenberg R. Age discrimination in mental health services. PSSRU Discussion Paper 2536. May 2008. http://kar.kent.ac.uk/13344/1/dp2536.pdf.
8. Department of Health. Our health, our care, our say: a new direction for community services. London: Department of Health; 2006.
9. Department of Health. General Medical Contract. Available at: www.nhsemployers.org/GMS2014-15. Accessed 10 Jan 2015.
10. Lester H, et al. The quality outcomes framework of the GMS Contract. Br J Gen Pract. 2006;56:245–6.
11. Primary Care Workforce Commission. The future of primary care: creating teams for tomorrow. London: Higher Education England; 2015. [Online] Available from: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/07/The-future-of-primary-care.pdf. Accessed 15th Aug 2015.
12. Department of Health. Care Act 2014: statutory guidance for implementation. London: Department of Health; 2014. https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation.
13. Leece D, Leece J. Direct payments: creating a two-tiered system in social care? Br J Soc Work. 2006;36(8):1379–93.
14. Netten A, Jones K, Knapp M, Fernandez J, Chalis D, Glendinning C, Jacobs S, Manthorpe J, Moran N, Stevens M, Wilberforce M. 'Personalisation through individual budgets: does it work and for whom? Br J Soc Work. 2012;42:1556–73.
15. Beales D, Tulloch A. Community care of vulnerable older people: cause for concern. Br J Gen Pract. 2013;63:615. pp 549–50.
16. Roland M. Better management of patients with multimorbidity. Br Med J. 2013;346:f2510.
17. Steel N, Bachmann M, Maisey S, Shekelle P, Breeze E, Marmot M, Melzer D. Self reported receipt of care consistent with 32 quality indicators: national population survey of adults aged 50 or more in England. Br Med J. 2008;337:a957.
18. Local Government Association. State of the Nation Report: 2014. London: Local Government Association; 2014. http://www.local.gov.uk/documents/10180/5854661/Adult+social+care+funding+2014+state+of+the+nation+report/e32866fa-d512-4e77-9961-8861d2d93238.
19. Centre for Policy on Ageing. Ageism and age discrimination in mental health care in the United Kingdom: a review from the literature. London: Centre for Policy on Ageing; 2009.
20. Centre for Policy on Ageing. Ageism and age discrimination in primary and community health care in the United Kingdom: a review from the literature. London: Centre for Policy on Ageing; 2009.
21. Centre for Policy on Ageing. Ageism and age discrimination in secondary health care in the United Kingdom: a review from the literature. London: Centre for Policy on Ageing; 2009.
22. Chew-Graham C, Kovandžić M, Gask L, Burroughs H, Clarke P, Sanderson H, Dowrick C. Why may older people with depression not present to primary care? Messages from secondary analysis of qualitative data. Health Soc Care Community. 2011;20(1):52–60.
23. Gask L, Bower P, Lamb J, Burroughs H, Chew-Graham C, Edwards S, Hibbert D, Kovandžić M, Lovell K, Rogers A, Waheed W, Dowrick C, and the AMP group. Improving access to psychosocial interventions for common mental health problems in the United Kingdom: review and development of a conceptual model. BMC Health Serv Res. 2012;12:249. doi:10.1186/1472-6963-12-249.
24. Department of Health. No health without mental health: a cross-government mental health outcomes strategy for people of all ages. London; 2011.
25. Department of Health. Liberating the NHS: no decision about me, without me. 2012. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_11735.
26. Department of Health. Health and Social Care Act. 2012. https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets.
27. Royal College of Psychiatrists. Whole person-care: from rhetoric to reality. Achieving parity between mental and physical health. Occasional Paper OP88. http://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx. 2014.

Resilience and Well-Being

2

Jane C. Richardson and Carolyn A. Chew-Graham

The world breaks everyone, and afterward, some are strong at the broken places.

(Ernest Hemingway, A Farewell to Arms, 1929)

2.1 Introduction

The need to improve the treatment and management of long-term conditions is one of the most important challenges facing the NHS [1]. The idea of 'resilience' represents a paradigm shift to a treatment model that promotes positive adaptation, using an asset-based model of resilience, in the context of long-term health issues [2].

2.2 What Is Resilience?

In 2002, Ganong and Coleman suggested that we have entered the 'age of resilience' [3]. Indeed the term appears to have proliferated over the last 10–15 years: a quick Internet search reveals, for example, psychological resilience, ecosystem resilience and resilience in relation to peak oil, to the ability of a city to resist a terrorist attack and to a number of organizations dedicated to promoting resilience of individuals, cities and systems. A search for well-being produces similar, although perhaps not as prolific, results. Resnick et al. draw attention to the value of resilience as espoused through traditional adages and mythology [4], and, we would add, through now ubiquitous phrases that have entered popular culture (e.g. 'Keep calm and carry on'), that also espouse resilience.

Resnick et al. suggest that the popularity of the concept is due to the prospect that resilience can be fostered. (In fact, they go one step further and suggest that fostering of resilience can be used for primary prevention of chronic illness in at-risk

J.C. Richardson, BA (Hons.), MSc, PhD (✉) • C.A. Chew-Graham, MD, FRCGP
Research Institute for Primary Care and Health Sciences, Keele University,
Keele, Staffordshire, UK
e-mail: j.c.richardson@keele.ac.uk; c.a.chew-graham@keele.ac.uk

C.A. Chew-Graham, M. Ray (eds.), *Mental Health and Older People: A Guide for Primary Care Practitioners*, DOI 10.1007/978-3-319-29492-6_2

populations.) [4] It is also likely that the proliferation of interest in resilience and well-being, at least in the developed world, is linked to demographics: larger numbers of people living longer, with greater expectations of their health, coupled with a decrease in public services, makes an emphasis on resilience and well-being very timely. A critical approach to resilience and well-being, however, means that there must be caution about blaming victims if they do not exhibit resilience and resisting the romanticization of resilience:

> How can we celebrate an individual's accomplishments and well-being in adverse situations without either blaming those whose lives show less cause for celebration, or dropping the critique of the contextual structures that promote the adversity. [5]

Given this background, the remainder of this chapter aims to provide a brief overview of resilience and well-being in the context of older people in primary care.

2.3 The 'Disability Paradox'

Many older people with chronic conditions describe themselves as healthy. General Household Surveys in the UK, for example, have found that although 60 % of those aged over 65 report some form of chronic illness or disability, less than a quarter rate their health as poor [6], sometimes referred to as the 'disability paradox' [7]. At the same time, doctors are generally working within a pathogenic paradigm, which emphasizes burden, disease and decline [8]. This tension has the potential to adversely influence consultations between doctors and older patients [9].

A salutogenic approach enables these paradoxes to be explored [10]. In the salutogenic approach, wellness (absence of morbidity) and illness (presence of morbidity) are seen as a continuum rather than a dichotomy; the focus is on factors that support health rather than factors that cause disease, and questions such as why some people manage better than others can be explored. Research adopting this perspective sometimes uses the idea of people 'beating the odds' or 'punching above their weight' (metaphors also used for resilience) [11–13]. Previous studies exploring why some people do better than others have compared, for example, healthy and unhealthy 'agers' in deprived areas (where no differences were found in terms of life histories and current circumstances) [14] or people whose self-reported health status differed from that predicted by a model derived from questionnaire responses [15]. The salutogenic approach thus has great potential for exploring health in later life [6].

An assumption is often made that resilience contributes to well-being; however, 'The Wellbeing and Resilience Paradox' report [16] suggests that this relationship is not always straightforward. The authors make a useful distinction between well-being as a complex concept that captures a 'psychological state at a point in time' and resilience, while no less complex, as being more dynamic and incorporating aspects of the past and future. Well-being is strongly related to resilience, and there is overlap in the factors that influence both, but there are also individuals and

communities for whom well-being is high but resilience is low. Communities with high well-being but low resilience tend to have larger numbers of older people. The authors suggest that the individuals and communities who exhibit this paradox are particularly vulnerable but perhaps not so easily identifiable as other groups, which has implications for health care for older people.

2.4 Definitions and Dimensions of Resilience and Well-Being

The 'salutogenic umbrella' incorporates a number of resilience-related psychological and sociological concepts, including resilience and well-being, for example, hardiness, assets, inner strength and coping [17]. The concept of resilience is increasingly used in the field of gerontology but lacks consistency in definition and use [18]. It has had numerous meanings in the literature, but generally refers to a pattern of functioning indicative of positive adaptation in the context of significant risk or adversity [19]. But beyond that common understanding, there are different views on (a) whether resilience is a personality trait or a process, (b) the dimensions of resilience, (c) the validity of resilience as a concept and its consistency over time and (d) the relationships of resilience with adaptation and whether it adds something new in developmental and life course theories [20]. Research into resilience was originally developed in the domain of developmental psychology, dealing with childhood and adolescence, and has only recently been extended to other periods of the lifespan, including old age.

Looking in more detail at the construct of resilience, two dimensions have been proposed – exposure to adversity and showing signs of positive adaptation to this adversity [20, 21]. According to this definition, identifying resilience requires two judgements: is there now or has there been a significant risk of adversity to be overcome and is the person 'doing okay'? In many studies, 'doing okay' is measured by assessing mood, well-being or quality of life before and after being exposed to adversity [22–24]. Maintained or increased psychosocial well-being and quality of life are indicative that the person is doing okay and is therefore resilient.

Those with resilient outcomes to adverse situations have been reported to draw on a broader range of social and individual resources than those with vulnerable outcomes. As a consequence, these people were better able to maintain continuity of their previous lives and were more in control and, therefore, more able to transform an adverse event into a benign one [25]. Drawing on previous experiences of loss and coping to create a sense of oneself as resilient has been found to help women deal with challenges from current ill-health [26].

Kuh makes a case for studying not only physiological but also social and psychological resilience alongside frailty in older people, raising the prospect of being able to be physically frail but psychologically and socially resilient [27]. This suggests that resilience may offer an appropriate framework for understanding wellness and well-being in the context of older age and/or chronic conditions. This also comes

across in Windle's proposed definition of resilience, developed from a review and concept analysis:

> Resilience is the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and 'bouncing back' in the face of adversity. Across the life course, the experience of resilience will vary. [28]

In this definition, 'bouncing back' and adaptation are both seen as part of resilience, which, I would suggest, make it more appropriate to older people. Adaptation also distinguishes resilience from stoicism, which, although often lauded as a positive response, has no elements of flexibility, which are key to resilience [29].

However, the notion of bouncing back, at least in the context of older people with chronic conditions, could also be seen as flawed. Chronic conditions, by definition, persist and might get worse rather than better, and resilience here may mean that a person 'keeps going' despite the adversity, rather than returning to a pre-adversity state. Some research uses comparison of measures such as well-being and quality of life before and after adversity to determine resilience, with the focus on bouncing back rather than keeping going. It is difficult to measure adversity 'objectively', and people may experience the same adversity differently. This demonstrates the importance of looking at older people's own definitions of adversity, well-being and resilience [18]. These are important because they will shape the actions they take, and have taken, over their lifetime. It is important for healthcare professionals to consider older people's own definitions of resilience (or perhaps rather 'keeping going') as part of a patient-centred approach.

2.5 Measuring Resilience

The measurement of resilience is problematic: a recent review of resilience scales found no current 'gold standard' amongst 15 measures of resilience [30]. This review reported that a number of scales are in the early stages of development, but all require further validation work. The authors identify the lack of attention paid to family and community resources as a major weakness of existing attempts to create a valid measure of the concept. A further problem, particularly for those wanting to adopt a salutogenic approach, is that measures for older people often focus on deficits, such as challenges of living with chronic illness, pain, loss and loneliness [31]. The growing literature on optimal ageing [32] yields more positive measures, for example, Wagnild and Young developed a resilience scale measuring positive attributes (including equanimity, perseverance, self-reliance, existential aloneness and spirituality/meaningfulness) through interviews with 'resilient' individuals [33].

Other examples of measuring resilience include Martens et al., who used 'mastery' as a proxy measure, or marker, of resilience [34] and measured it using the 'Personal Mastery Scale' [35]. They suggest that having a high level of mastery helps older people to cope with and adapt to living with a chronic condition. They also suggest that further longitudinal research is necessary to unravel the long-term

effects of mastery, income and social support on 'relatively successful functioning' in chronically ill patients. Lamond et al. suggest that the CD-RISC is an internally consistent scale for assessing resilience amongst older women and that greater resilience as assessed by the CD-RISC related positively to key components of successful ageing [36]. The strongest predictors of CD-RISC scores in this study were higher emotional well-being, optimism, self-rated successful ageing, social engagement and fewer cognitive complaints. Janssen et al. conducted a qualitative study and suggest that the main sources of strength ('to improve resilience') identified amongst older people were constituted on three domains of analysis; the individual, interactional and contextual domain and thus proactive interactions need to help older people build on the positive aspects of their lives [37].

This resonates with Wild et al.'s [18] model (Fig. 2.1) of the different levels of resilience, including individual, family and community [18].

2.6 Alternatives to Resilience

The salutogenic umbrella can also be referred to as an 'asset-based approach' – identifying the protective factors that create health and well-being and in contrast with the deficit-based approach described earlier. Resilience can be seen as an asset. Clearly in health care, a deficit model is necessary to identify need, priorities and so on, but an asset-based approach would seem more acceptable as a complement to this deficit-based approach. However, as with resilience, the focus of much research in this area has been personal factors and cognitive resources, and there is a need to

Fig. 2.1 Levels of resilience (From: Wild et al. [18] with permission)

extend this further. The scales of resilience (individual, household, family, neighbourhood, community, societal), seen in Fig. 2.1, can also be applied to an asset-based approach, as can the different domains of resilience, shown in the second model above, for example, financial, environment, physical, social, psychological, mobility and so on.

2.7 The Importance of Resilience in Context

Wild et al. acknowledge the potential for applying the concept of resilience to older people, acknowledging as they do that it can incorporate and balance vulnerability alongside strength across a wide range of contexts [18]. Locating resilience within these broader contexts removes the focus from individual characteristics and the associated blame for those who do not 'achieve resilience' [18]. The model also acknowledges that people may be resilient in one area but not in others (Fig. 2.2).

Older people, particularly those with chronic conditions, might not consider themselves to have a medical condition but simply to be getting older; nevertheless, they have to face up to changes in their physical abilities and their perception of themselves. Being 'resilient' (in the sense suggested by Wild et al. [18] and Windle [28] above) means being able to accommodate and adapt to physical changes and fluctuations in health and well-being in order to sustain what is important in life and for a valued sense of self.

Windle draws attention to the 'normal, everyday' nature of resilience, echoing Masten's evocative phrase 'ordinary magic' and suggesting that 'the opportunity for positive adaptation should be an option for everyone' [28]. Perfect physical health

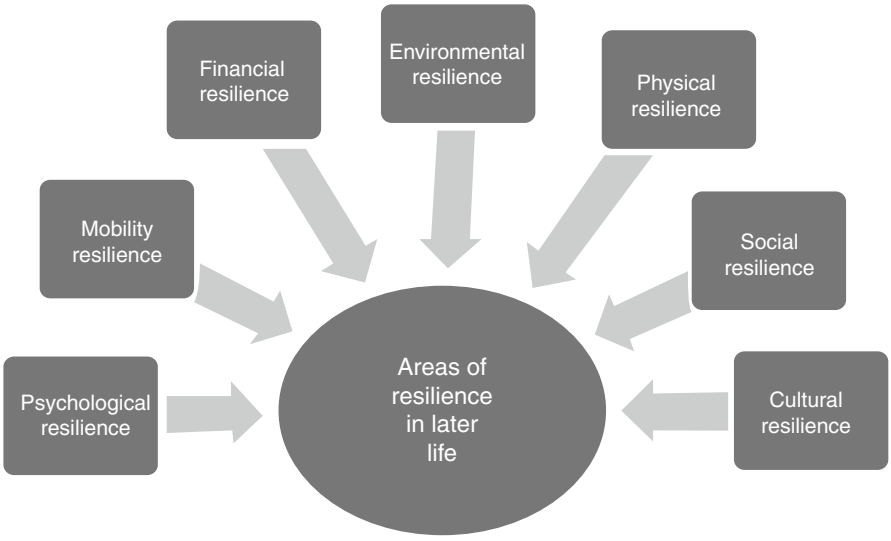

Fig. 2.2 Areas of resilience (From: Wild et al. [18] with permission)

is neither necessary nor sufficient for successful ageing as defined by the older adults themselves. Their holistic self-appraisal involves strong emphasis on psychological factors such as resilience, optimism and well-being, along with an absence of depression.

2.8 Implications of Taking Account of Resilience

Most of the public discourse on population ageing involves dire predictions and negative stereotypes. This negative view of old age has been contrasted by empirical research on older adults who continue to function well and are ageing 'successfully'.

Health and welfare services may be part of the environment of many older people, particularly those with chronic conditions, but those who provide care need to appreciate that a frail body is not indicative that the cared-for person lacks a resilient sense of self or is not able to draw on other domains or levels to achieve resilience.

Clinicians can help reduce societal ageism through their optimistic approach to the care of seniors. Treating the frail body should not come at the expense of undermining an older person's sense of self. In order to balance professional perceptions of an individual's 'frailty' with an individual's embodied and lived experience, we suggest that health and social care providers take an individual's own approach to managing their condition as the starting point for any support.

Further research on how older adults develop and maintain positive self-appraisals in the presence of biological decline may also inform similar adaptations across the lifespan.

2.9 Suggested Activity

Think about a particular patient using a salutogenic approach and using the models shown above. Is it possible to identify different levels of resilience that the patient can draw on/could be helped to draw on, outside of his/herself? Are there other domains in which the patient is resilient that can be used to support an area of difficulty? Does the patient have valued activities? How can they be supported to continue with these? How could any treatment given to a patient be used to support rather than undermine a positive sense of self? Are there opportunities for fostering resilience in older people with current high levels of well-being?

References

1. Coulter A, Roberts S, Dixon A. Delivering better services for people with long-term conditions. London: The King's Fund; 2013.
2. Jeste DV, Palmer BW. A call for a new positive psychiatry of ageing. Br J Psychiatry. 2013;202:81–3.