NOW YOU SEE THEM, NOW YOU DON'T: MENTAL HEALTH PROBLEMS IN OLD AGE IN THE GENERAL HOSPITAL SETTING

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ABSTRACT

This thesis details research undertaken in two general hospitals in the South of England. The study examines perceptions of mental health problems in old age from the standpoint of those within the setting. I consider various social influences and ask whether different models of mental health service provision impact on how mental health problems are perceived and addressed.

Fifty-two qualitative interviews were conducted with older people, relatives and staff members. All of the older people were hospital patients, with some having diagnosed mental health problems. Similarly some of the relatives had seen a mental health professional. None of the research participants had contact with mental health services prior to their current hospital experience. None of the staff members had specific mental health qualifications.

Examination of the data highlights vying and powerful phenomena, associated with organisational and professional traditions. These intertwine and serve to influence how mental health problems in old age in this setting are both constructed and sustained.

The key findings uncover a paradox of visibility and invisibility. Mental health problems, particularly dementia, are noted in the presence of overt problematic behaviour that is perceived to interfere with the smooth running of the setting or the organisation. Many mental health problems, as defined by psychiatry, are not perceived. They remain invisible and unaddressed. Particularly the phenomenon of depression is not seen as a mental illness, but rather as an artefact of normal ageing, especially in the presence of ill health.

People with mental illness are not seen as the proper business of a general hospital ward. There is an expectation that external mental health experts should respond to the needs of this patient group. While there is evidence that the presence of a consultation / liaison mental health service can improve staff knowledge and skills, conclusions suggest that current models of service perpetuate the stigmatised position of older people with mental health problems in general hospitals.
ACKNOWLEDGEMENTS

This thesis is dedicated to my Dad, who managed to see it through to the end, despite hiccoughs.

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Chapter 1

An Introduction

1.1 Introduction to the Research Problem

I am a mental health nurse of more than twenty years experience, the majority of that time spent working with older people. Since the late 1990s my work has involved working as a mental health liaison nurse specialist providing a mental health service for older people with mental health problems in a general hospital setting.

In the course of my work, I have become aware that older people with mental health problems in the general hospital setting often do not have their needs recognised or met. I began to wonder why this was and to notice that my colleagues in the general hospital did not seem to have the same view of the world of mental health and illness as I had. For example to me an older person with depression was readily recognisable by observing and examining their thoughts, speech and actions; yet this was not so for my colleagues, of various professions. I began to consider that the perception of mental health problems in old age by people in the general hospital setting may differ from that of those who, like me, work within the mental health specialty. If this were the case it may explain why there is a difference of focus and recognition.

In the field of psychiatry, mental health problems are predominantly viewed from the position of biological medicine; that is, a belief that an illness is caused by biological and/or genetic deficiencies which can be remedied. In the case of mental illness, symptomology may be exhibited in reported experience and unusual behaviour rather than purely through bodily signs. Conversely the popular lay view of mental health problems is that they are characterised by the presence of behaviour that is out of place within the normal bounds of the dominant culture (Pilgrim and Rogers 1999). In this research I am interested in the perceptions of mental health problems in old age within a
cultural setting that potentially sits in between the lay world and the specialist world of psychiatry.

In conducting this work I noted a considerable literature on the sociology of health and illness, mental health and on later life. There is rather less on mental health in later life. However, there is even less written on the issues that arise when these occur in combination in one setting.

My main interest then lies in establishing what constitutes mental health problems in old age, from the perspective of those within the general hospital setting. However, I also want to consider whether the ways in which mental health service expertise is accessed and provided in the general hospital affect how people formulate their views on mental health and illness. When I started the research there were two dominant potential models of mental health service in general hospitals. The traditional model is a method of intervention through which a psychiatrist makes a single response to a referral from a medical colleague who is seeking diagnostic or treatment advice. The consultation/liaison model describes a means of intervention whereby mental health expertise is provided following either formal or informal referral. There is emphasis on increased presence in the setting and the provision of education as integral to the role. I explore the role and service differences, between the two models, more thoroughly in Chapter 4.

In order to make the comparison between service models and their possible impact on constructions of mental health problems in old age, the research is conducted in two hospital sites in the South of England. I use fictional names for the hospitals, calling them Glimster General and Chapley Hospital. In Glimster a traditional mental health service is in place and Chapley uses a consultation/liaison model. I interviewed older people, relatives and staff members in each hospital, in order to explore any differing perceptions within each group of social actors represented in the setting.
As I move through the research process, and explore the resultant data, it becomes increasingly clear that the ways in which mental health problems in old age are constructed reflect varying societal views on the subject, but also the particular power dynamics that are in play, and in conflict, within the settings. I specifically explore issues of power in the next chapter.

The focus of this research is on perspectives of mental health problems in old age in two general hospitals in south England. Although I make some references to a more international picture, I concentrate both my review of the literature and the analysis and theory development towards the issues as they pertain to England. Similarly, as the research was carried out in a largely uni-ethnic part of England, I do not focus specifically on issues of race and ethnicity as they impact on the experiences of ageing and mental health.

Throughout the examination I emphasise the changing societal and political constructions of mental health problems, and particularly how candidacy for service has developed, arguably to the exclusion of older people with mental health problems, particularly depression.

In this introductory chapter I provide a backdrop against which the context of being an older person with a mental health problem in a general hospital can be considered. First I provide a brief history of mental health service provision, particularly for those with a combination of physical and mental health problems. I explore some of the relevant social policy culminating in detail of how current service has historically developed to shape the services available today. I go on to consider some perspectives on old age and ageing, noting that older people are not readily afforded the same rights and voice as younger society members. I draw particularly on the theory of the “structured dependency” of ageing (Townsend 1981) whereby older people in hospital have been moulded into an anticipated role of quiet compliance. I touch upon issues of ageism and the stigma associated with mental illness before I start to explore issues of mental health and illness.
Later in this chapter I provide an introduction to my choice in methodology by detailing my epistemological position in using an interpretive, constructionalist approach to this research. The final sections provide an overview of the research sites, the research questions and finally a chapter by chapter outline of the thesis.

1.2.1 History

There has long been recognition that mental and physical health problems are not mutually exclusive and that attention should be given to addressing all needs. However, particularly in Europe, the recognition has largely been unmatched by service change. Before focussing specifically on services for people in general hospitals, I briefly detail the history of events since the advent of the asylum.

It was the Lunatics Act of 1845 that required every county area in England to establish asylums. This was fuelled by a belief that people who were mentally unwell required specialist help. Specialists could, it was thought, reform their anti-social behaviour within the protected and peaceful environs of an asylum, where tranquillity, purposeful activity and religiosity could aid their recovery (Foucault 1967, Showalter 1985). With the establishment of large, out of town, institutions there followed a period in which “the Victorians became gripped with a kind of custodial fever ... and detained people other than curable lunatics within their confines” (Murphy 1991 p36). The asylum population was predominantly female, with women who were perceived to be morally insane, rather than having evidently lost their reason, being housed in this establishment that sought to “domesticate madness” (Showalter 1985 p29). Whatever the good intentions of providing asylum for those in need, Scull (1979) describes the development of these institutions into forms of social control for the mad, as has developed and persisted, in line with the views of those in power at the time, along a convoluting path to this day.

Any patient in a general hospital perceived to be mentally ill was, with the building of these institutions, either discharged or sent to the asylum. If a person with a mental
health problem required general hospitalisation, for example for an operation, they received treatment and were promptly returned to the institution. In most instances, in the United Kingdom, this method of service organisation remained in place until the asylum closures in the late twentieth century.

The development of out of town institutions for people with mental health problems arguably facilitated the geographical and intellectual isolation between medicine and psychiatry (Lloyd 1996). Access to the asylum was confined to those perceived, at the time, as being severely mentally ill. It has been suggested that the differentiation between physical and mental illness followed the work of Charcot, a French neurologist, who sought to define hysteria from malingering (Busfield 2000). He, and others such as the philosopher Descartes, began to differentiate bodily ills from ailments that changed behaviour and function in the absence of an organic cause, the latter becoming the business of the asylums. Such definition of difference served to embed the social role of psychiatry as controllers of deviance (Lloyd 1996, Pilgrim and Rogers 1999, Busfield 2000), albeit through medical intervention. This focus on social protection continues to this day with recent increasing focus on those aspects of deviance that are perceived to carry risk for the general population (Barker et al 1999).

Throughout the history of mental health service provision, definition, describing what constitutes candidacy for specialist intervention, has fluctuated. For example people with epilepsy were once regular inhabitants of mental hospitals; this was until specialists from the field of neurology defined what they perceived as a pure bio-medical definition of the disease and took control of this agenda. Interestingly people with dementia were also inhabitants of the large mental hospitals prior to their closure, but have not been similarly embraced as within the scope of general medicine. I will go on to explore this further and also consider how candidacy for mental health services have changed, over the years, particularly for people with depression.

Depression has emerged as a mental health problem relatively recently against the more overtly visible conditions that are now defined in psychiatry as severe mental illnesses,
that is, schizophrenia and bi-polar affective disorder (formally manic/depression).
Depression only became noted as a condition during the First World War when shell shock was noted and researched. Prior to this hysteria and melancholia were seen, and largely tolerated, as female conditions. The work of Sigmund Freud also served to challenge the view of an inevitable and hopeless female condition (Busfield 1996). With the recognition of shell shock, and arguably the strength of such recognition in a male population, the conditions of hysteria and melancholia were redefined as anxiety and depression. The word depression has now lost its place as a lay description of sadness and has become a medical condition. As the specialty of psychiatric medicine expanded, in the mid twentieth century, it sought to embrace the lesser mental illness of depression. In Chapter 4 I continue the exploration into the position of depression within psychiatry today, concluding that it has moved out of the field of speciality, into the realm of general practice. I will develop discussion on where this leaves people with depression, particularly older people in hospital with depression, throughout the thesis.

The history, as I have described this far, demonstrates a will for distinction between those who qualify for medical and those who qualify for psychiatric services. I now go on to examine the history as it relates to the provision of mental health care in the general hospital setting.

1.2.2 Mental Health Care in the General Hospital

In the early years of the twentieth century the recognition of the phenomenon of “shell shock”, as a psychological reaction to the trauma of war, not only redefined hysteria and melancholia as anxiety and depression. It also promoted a feeling that mental health problems could arise due to life and social events and could exhibit, on occasion, through physical symptoms. This recognition built on theories of Sigmund Freud suggesting that there might not be a clear distinction between normal and abnormal behaviour (Pilgrim and Rogers 1999). In 1926, the MacMillan Report concluded that mental health was a public health issue warranting a preventative community service. It acknowledged clear
links between mental and physical health problems, recommending interactive and complementary services.

"It has become increasingly evident that there is no clear line of demarcation between mental and physical illness. The distinction as commonly drawn is based on a difference of symptoms. In ordinary parlance a disease is described as mental if its symptoms manifest themselves predominantly in derangement of conduct and as physical if the symptoms manifest themselves predominantly in derangement of bodily function. A mental illness may have physical concomitants: probably it always has; though they may be difficult of detection. A physical illness on the other hand, may have, and probably always has, mental concomitants. And there are many cases in which it is a question whether the physical or mental symptoms predominate"

(MacMillan Report 1926, cited by Jones 1993 p131)

The report, however, did not lead to service reconfiguration in the UK. Since 1915, and the development of the Maudsley Hospital in London (Jones 1993), there have been many calls for, and experiments with, the introduction of specialist mental health units within general hospitals. There has, however, been no widespread uptake of this model, and such units remain a rarity to this day. Service development for people in general hospitals with mental health problems has more readily occurred in the United States where the number of psychiatric wards and psychiatric liaison services in general hospitals have increased (Lipowski 1983a).

In 1953 the World Health Organisation (WHO) promoted a need for psychiatric bed reduction alongside a focus on community care. The plans were enhanced in the 1960s by the anti-psychiatry movement which claimed that the potential for recovery for people with mental illness were hindered rather than aided by the intervention of psychiatry (Szasz 1966). Also influential in the drive for asylum closure was the work of Goffmann (1961), who defined such institutions as serving those who work within them, and not the patients, who were disempowered and abused (Jones 1993, Pilgrim and Rogers 1999, Lloyd 1996, Goodwin 1997). In England and Wales the agenda was further driven through legislation. The Mental Health Act of 1959 placed the drive towards community care within a legal framework (Speller 1964). Similar moves in Scotland and Northern Ireland followed.
The forthcoming abolition of mental hospitals was announced in the UK in 1961. As recommended in the MacMillan report, Enoch Powell, the Health Minister, envisioned that future service provision would occur within general hospital sites with the closure of mental hospitals (Mayou 1989, Jones 1993). This radical plan was watered down in publication to allow a continuing role for mental hospitals. The subsequent Hospital Plan (Ministry of Health 1962) proposed the establishment of District General Hospitals incorporating adjoining acute psychiatric facilities. However, these too were not realised as general medicine failed to embrace the realms of psychiatry into its midst (Jones 1993).

Further delays meant that it was not until 1975 that “Better Services for the Mentally Ill” was published (Department of Health and Social Security, DHSS, 1975). There are many cited reasons for the closure of asylums becoming politically viable at this time (Jones 1993, Pilgrim and Rogers 1999, Busfield 2000). Some argue that enhanced public awareness of the condition of those in mental institutions, through the wider publication of Goffman’s work (1961), provided social pressure to act. Others allude to the ongoing cost of maintaining and staffing large ailing buildings. The increased power of the pharmaceutical industry was another potential driver with the development of tranquillising medicines, such as chlorpromazine, meaning that symptoms could be dampened thus necessitating less need for 24 hour supervision.

“Better Services for the Mentally Ill” put forward plans to close the asylums and to develop community care over the next 25 years. The paper envisaged improvements in primary care and, again, the incorporation of beds for the acutely mentally unwell within district general hospitals. Such philosophy, particularly about community care, gained further emphasis in the 1990 NHS and Community Care Act (Department of Health, DOH, 1990). Although psychiatric bed numbers dropped dramatically, from 133,000 to 50,000 in the UK between 1959 and 1992 (Pilgrim and Rogers 1999), community provision did not rise to an equivalent extent and psychiatry has failed to integrate with general medicine, as was envisaged. It has been suggested that the failure to integrate, and thus provide a broader community focus, is inhibited by the ongoing medical rather
than sociological ontological position (Prior 1993). I explore this argument further as the research progresses. Similarly I will further explore the possibility that mental illness has not become integrated into community, primary and secondary (hospital) health care due to the unchanging ontological divisions between medicine and psychiatry.

As the large psychiatric institutions closed, and the number of people with mental health problems in general hospitals increased, the traditional model of psychiatric consultation, described above (p2), was used. In this way a general hospital physician referred to an external expert psychiatrist when a psychiatric opinion was required.

In the late 1980s the WHO in Europe (WHO 1988, Huyse 1991) expressed concern about the future quantity and quality of psychiatric and psychological service delivery in the general hospital setting, especially in the light of asylum closures. They were specifically concerned with the increase in the population of older people and the consequent rise of late life psychiatric disorders alongside chronic physical illness. The WHO noted that older people with mental health problems now entered general hospital wards rather than psychiatric units. These older people often “fall between two stools; too mentally unwell for medicine and not unwell enough for psychiatry” (Holmes et al 2002). The WHO also considered issues related to AIDS and risk taking behaviour in young adults. Whilst the European Consultation Liaison Workgroup has received funding to research AIDS and risk behaviour in the young, no monies were made available for the study of older people (Huyse 1991, Huyse et al 1996).

A group of UK physicians and psychiatrists subsequently produced a joint report (Royal College of Physicians and Royal College of Psychiatrists 1995) which again emphasised the prevalence of mental health problems in older hospitalised patients and the need for service improvement. Arguably these assertions of need have not brought about wide scale change in the recognition and acceptance of older people with mental health problems in the general hospital setting. However, it is notable that in the years since I started this work, in 2001, mental health liaison services for older people have proliferated.
During the twentieth century, as well as service development being hampered by divisions between psychiatry and general medicine, a further potential rift occurred within service provision for older people. Prior to the World Wars and the advent of the NHS, there existed a two tier hospital system, that of voluntary and corporation hospitals. Voluntary hospitals could be choosy about who gained admission, with corporation hospitals having to accept anyone. This two tier hospital system meant that people presenting with interesting medical symptoms were chosen to go to the voluntary hospitals, whilst others, and generally those over 60, went to the corporation hospital or, if their behaviour was unacceptable, to the asylum. During and after the war years, when hospitals were merged through necessity, doctors from the voluntary hospitals were exposed to older people more readily and some perceived a new option of specialty for their "clinical gaze" (Foucault 1976). The geriatric specialty thus emerged in the 1930s, when Marjory Warren identified a need for a geriatric specialism (British Geriatric Society 2006). John Vincent (1999) argues that the growth of the geriatric specialty, from the 1960s, was further facilitated by the ongoing will from other doctors to keep older people out of their beds.

The split between psychiatry for younger and older adults, with the development of the psychogeriatric specialty, occurred later, in the 1970s. Arguably this development was linked with the growing knowledge about dementia, which I explore further in Chapter 4, as well as following the lead of their general medical colleagues. Such developments of speciality provided expert focus and research attention, yet arguably division has also served to create social and service division between younger and older people. Much of the focus of this thesis is to explore the effect of such divisions on perceptions of mental health problems in old age, particularly when they exist outside what may be construed as their natural setting, that is a mental health service setting.

I have now provided a brief history of general hospital provision and move on to consider the current situation with regard to mental health service provision in this setting.
1.2.3 The Present

The service divisions, between young and old, medicine and psychiatry described above, are arguably now further emphasised by increasing specialism within general hospitals. The general hospital ward is now, in line with Turner’s vision (1995), subdivided into cardiology, endocrinology, urology and so on. Arguably there is a risk that workers in any such specialist areas may, as Turner feared, seek to ensure their exclusivity. Patients who do not fit in to the right category may be at risk of having some of their health needs unnoticed and unattended, whether those needs be related to another branch of general medicine or to mental health.

The historical and current divisions between general and mental health expertise and service provision embed a clear delineation between the specialties. Neither government policy nor professional education serve to encourage integration or an acceptance that caring for people with mental health problems is anything but the business of psychiatric services. Nurses do not perceive it as within their core role to have the expertise necessary to assess and care for those people with cognitive impairment (Wills and Dewing 2001) and such necessity is not delivered as part of their core education. Despite advice from the Nursing Council (UKCC 2000), highlighting the challenges in providing care for older people with mental health problems in acute medical settings, people are still defined as belonging under the umbrella of mental health services. They are seen as difficult rather than in need of therapeutic intervention (Wills and Dewing 2001, Norman 2003).

The current high prevalence of mental health problems in old age within general hospitals is a new, and potentially increasing, phenomenon. As longevity increases with greater emphasis on care and treatment at home, older people in hospital are now more likely to have multiple problems including those related to their mental health (Care Services Improvement Partnership, CSIP, 2005, Royal College of Psychiatry, RCP, 2005).
As discussed above, traditionally, historically and culturally, such problems have existed elsewhere, in mental institutions, or existed less, due to demographic changes or differing recognition and treatment criteria. There is therefore little history or established culture within the general hospital setting for people with mental health problems. Arguably mental health problems, where they exist concurrent to another “problem” have become homeless. In the past, whatever the concurrent problem, the person would be admitted to the large institution. Now people find themselves in services that are potentially not culturally adapted to their presence and in the care of staff not educated to meet their needs.

The speciality of liaison psychiatry has developed to address this need, as I go on to explore in Chapter 4. Some have warned of the dangers of creating a new psychiatric specialism in liaison psychiatry in that it produces further divisions (Lipowski 1983a, Katz 1996). Many argue that the speciality lies clearly under the umbrella of psychiatry (Lipowski 1983b, Lloyd 1991, Katz 1996, Holmes et al 2002), yet if mental illnesses are founded in biological change potentially it could lie within medicine.

The division between the young and the old, in terms of mental health service provision in England and Wales, has recently been emphasised within the definitions used in the National Service Framework for Mental Health (DoH 1999). The focus of this guidance, defined as being to address the mental health needs of adults of working age, is characteristic of the current and re-emerging direction of mental health services as being for people with defined severe and enduring mental health problems: schizophrenia, psychosis and bi-polar disorders. Less serious problems, notably anxiety and depression receive attention from mainstream services. The position of dementia is unclear. Arguably this leaves many people without the necessary mental health care and treatment.

I explore details of policies as they relate directly to the care of older people in Chapter 4, here noting that the principles of integration between general and mental health care,
extolled by MacMillan in 1926 (Jones 1993), and most recently reiterated in “Everybody’s Business” (CSIP 2005), remain an illusive dream.

I have now examined the historical and current divisions between general and mental health services and between services for younger and older adults and highlighted some of the risks of exclusion that such divisions bring. I now move on to further explore one of those sources of potential social exclusion more closely. Here I look at perspectives on age and ageing, as they inform the work of this research.

1.3.1 Perspectives on Later Life

This research focuses on mental health problems in old age and the services provided for those with such problems. I continue to explore the concepts of mental health problems, mental health problems in old age and service provision extensively as the work progresses. Here I feel it important to make reference to theories of ageing as a background to the more specific investigation. I am interested particularly in the way in which society embraces, and indeed defines, the phenomenon of ageing, scientifically and socially. These constructions have significant influence on the power relationships that emerge as being particularly pertinent within this research, as older people are not afforded the same social credibility and valued position in the world as their younger counterparts.

There are said to be more than 200 reported theories of biological ageing (Redfern and Ross 2005) with a common conclusion that most living organisms show functional decline with advancing time, and that such changes are universal, progressive, intrinsic and degenerative (Bond et al 1993). The theories support a belief that evolutionary necessity, ensuring procreation of the species, drives the need for a set life span with a bodily deterioration until death. More recently the focus of biological science has been on genetics suggesting that, with specific intervention aimed at changing genetic disposition,
life can be prolonged. This focus of belief serves to create old age both as a medical phenomenon and as an undesirable state (Vincent 2003).

The criticism of pure biological studies on ageing is that they tend to occur in the laboratory rather than in the context of the whole person existing in the world which itself culturally and socially influences the effects of time on the body. However, John Vincent (2003) suggests that biological theories are attractive to people as they provide potential for escape from the inevitable decline. “Treatment”, for example, of declining hearing acuity, helps us to avoid ageing by tagging it as remediable.

Successful ageing is now more frequently seen as the absence of disease than as the outcome of a successful life. Explanations and control have “passed from the pastor and priest to the doctor and geriatrician” (Vincent 2003 p138) promoting the clinician in a position of power able to organise and categorise, make things better, or even decide on the time to die. When an older person is hospitalised s/he is seen as ready to be discharged when deemed medically fit, without redress to other circumstances that may make leaving hospital unachievable. Anyone who remains in hospital when they are not “unwell” is defined as a problematic “bed blocker”. Medicine has become the dominant mode of solution to problems in old age and in being so deters attention from social factors such as housing, employment and pensions. In these areas older people are viewed as problematic rather than unwell. I will go on to explore where mental health problems fit in with this as the thesis develops.

Possibly the best known theory of ageing among health care professionals, until recent years, is Cumming and Henrys’ Disengagement Theory (1961). It suggests that, in advancing age, people and society withdraw from each other in order to prepare for death. Although this theory has been much critisised as over-simplistic (Putman 2002) and unrepresentative (e.g.Vincent 1995, Phillipson 1998) it continues to feature highly in literature and is arguably influential in the lay and medical perception of old age as a time of natural withdrawal from the social world.
As a background to this work, I draw particular attention to Townsend’s (1981) theory of “Structured Dependency” as it describes the dependence of older people as a product of the state, manufactured through political and economic restraint. Townsend suggests that the autonomy of older people has been curtailed and that reliance on the state is made inevitable. Physiological and biological changes are construed to render the older person childlike and without autonomy, as is reflected within the social setting of a general hospital. Patients are expected to conform and accept their care and treatment without question. The processes of retirement, minimum pensions, residential care and community services have arguably created a social dependence which is artificial, and which has suited industry, professionals and the economy. The practice of social exclusion due to age dates back to the late nineteenth century when the old were bracketed with the infirm and the feeble minded and perceived as “useless, worn out and unemployable” (Phillipson 1998 p110).

The recent trend in sociological research towards a “culture of personal identity” (Gilleard and Higgs 2000) encourages those who study ageing to move away from ageist assumptions of homogeneity and powerlessness to consider the experience of ageing from a personal perspective. Such research has created a great variety of studies, which I do not replicate within this thesis, covering a wide variety of experiences ranging from the experience of widowhood to late life employment, with attention to issues of gender race and ethnicity (see e.g. Blakemore and Boneham 1994, Arber et al 2003, Davidson et al 2003, Davidson et al 2005, Walker 2005). As this research takes place within a predominant white British population, I have not focused particularly on the literature concerned with issues of non-white ethnicity in old age. I draw on some of the literature about gender, particularly in looking at the phenomenon of depression but note that the literature on depression in old age is very limited. There is a large literature on dementia, as I explore in Chapter 4.

Current research attention, from a non-biological perspective, includes attention to pension provision, driven by economic concerns; action against discrimination, driven by the agenda of social equality and fairness and improved health promotion; and
management of health problems in old age. Chris Gilleard and Paul Higgs (2000) suggest that these agenda are driven by the presence of a growing number of older, more affluent and socially assertive people, products of the cohort that developed the “youth culture” in the 1960s. This population carries considerable polling potential and, as such, is of political interest. Such an argument may explain the propensity of research towards younger healthy older people rather than the unwell, older old who are the focus of this work.

Other psychological and social research on ageing has been precipitated by the much criticised (e.g. Fries 1980, Vincent 1995) view of the potential catastrophic effects of prolonged longevity alongside lowering birth rates creating a demographic time-bomb. As evidenced in the Census figures in 2001 the proportion of the UK population who are over 65 is 12%, as against 7% in 1971. The projected increase in the U.K of those over 65 is 14%, and those over 75 is 29% by 2021 (Government Actuary’s Department 2000). Clearly the escalation in the population of older people, against a decreasing proportionate workforce and increasing health care costs, is an issue of economic concern. As such it is being addressed through focus on pension provision and radical health service reform (DoH 2000, DoH 2005b, DoH 2006) aimed at minimising the need for hospital care and concentrating on the care of people with long term conditions at home. Those who argue against worries of the forthcoming catastrophe of the ageing population highlight the social benefits that the “grey economy” (Vincent 1995) bring in terms of essential non-paid activities such as grand-parenting, informal care, and other voluntary and charity work.

Peter Laslett (1989), following Fries (1980), focussed on the opportunities now available to healthy older retired people. This suggested optimism about older people being healthier, but also cautioned that the “fourth age” would bring a period of “compressed morbidity” (p17), during which people experience a combination of social and health problems culminating in death. It is particularly this older old population who currently find themselves in general hospitals and who are likely to have both mental and physical
health problems. It is on this population that the current review of health services concentrates. I now explore the limited literature available on the older old.

1.3.2 The Fourth Age

Within the literature there is a differentiation between the young old and the older old, sometimes termed, as the third and fourth agers (Laslett 1989). As I explore further in later chapters, such differentiation appears to be an issue in the conceptualisation of mental health problems in old age in the general hospital setting. I highlight here two theories of ageing that separate the younger from the older old, the stage theories of Eric Erikson and his widow Joan Erikson, and James Fries aforementioned work on the compression of morbidity.

Figure 2. The Increasingly Rectangular Survival Curve.
About 80 per cent (stippled area) of the difference between the 1900 curve and the ideal curve (stippled area plus hatched area) had been eliminated by 1980. Trauma is now the dominant cause of death in early life.

Figure 1.1 The Survival Curve Fries (2002)

Eric Erikson, one of very few psychodynamic theorists who took an interest in later life (Bond et al 1993), defined eight stages of life achieved through the personal fulfillment
of life tasks. Each life stage is characterised by positive and negative achievements of the
task, for example in early adulthood one achieves “intimacy” as opposed to “isolation”.
In old age, the eighth stage, Erikson suggested that one's task is to achieve “ego integrity”,
that is meaning and order in one's world, against the opposite “despair and disgust” at not
having achieved one's life goals. In examining this work Bond et al (1993) suggest that
Erikson's stage theory is sometimes taken, and therefore discarded, too literally, with
failure to achieve at one life stage seeming to prevent development within the next. They
suggest that this work should enable us to focus on the whole person who has
experienced triumphs and defeats during life, and who is the product of that history,
making people more and more unique as they age. Arguably this is the view that Tom
Kitwood drew upon in formulating his person centred approach to dementia care
(Kitwood and Bredin 1991) as I discuss in Chapter 4. This person centred care approach
is at the core of current policy direction within health and social services with consumer
focus on the individual, choice and preference. Interestingly after her husband's death, in
her late life experience at the age of 91, Joan Erikson talked of a ninth, and maybe a
ten, life stage termed as “beyond integrity” (Coleman and O'Hanlon 2004) alluding to
“gerotranscendence” as a move towards death. She thus recognised that, having achieved
her “ego integrity”, she prepared readily for the inevitability of death.

identified the theory of a “Compression of Morbidity”. Fries noted that, due to advances
in medical treatment and disease prevention, people were living longer and longer and
that therefore the major cause of death now occurred from non-communicable disease in
extreme old age. Thus the age of first disability and major infirmity occurs within a
compressed period at the end of life, during the last 18 months of life, often after the age
of eighty. As illustrated in Figure 1.1, Fries talked of a move from a triangular survival
curve, whereby the likelihood of death increased with advancing age, to a rectangular
position whereby most people become unhealthy and die in late old age. Trauma has
now become the main cause of earlier death. This theory underpins the current policy
direction described above (p16) whereby considerable health policy focus is being
addressed towards lengthening the period of healthy ageing and on the management of
long term conditions; that is, those that occur within the period of the compression of morbidity (Fries 2002).

Notably, like non-communicable physical illnesses, the prevalence of mental health problems, particularly dementia, increases with advancing age. However, the likelihood of co-morbidity, that is the presence of both physical and mental ill health, is not prominent within Fries' work. This appears to be an example of the divisions between general and psychiatric medicine which is a feature throughout this thesis.

As I have noted on the previous page, political rhetoric has moved towards the agenda of social empowerment, consumerism and the provision of choice encouraging social and health improvement for older people, under the heavy guidance of the state but not in the custody of it (Gilleard and Higgs 2000). Such progress, aimed at promoting social inclusion and health, is laudable but arguably inaccessible to the older old, particularly those who are in ill health. Recommendations, for example those on social inclusion (Office of the Deputy Prime Minister 2005), focus on how to maximize the health potential of older people and enhance quality of life through exercise, engagement and better service, yet in doing so, exclude those who do not escape the ultimate social exclusion through being hospitalised and institutionalised.

Arguably the differentials occurring between the young old, and the older old, render the unwell old more and more excluded with the potential for increased stigma being attributed due to their inability to meet social demands of healthy ageing and their inability to not be financially burdensome on the state (Gilleard and Higgs 2000, Bender and Wainwright 2004, Tester et al 2004). The differentiation between these arbitrary groups cannot be correlated with chronological age but is differentiated by disability and burden. Those in the fourth age are segregated from the world into the special settings, of elderly care wards or care homes, and excluded by virtue of their spoiled identity and societal invisibility (Goffman 1961). Peter Coleman and Ann O'Hanlon (2004) note that older people over 85, in awareness of functional loss and physical frailty, do define themselves as being in “old age”, whereas younger older people do not.
The few studies, focusing on long term care homes rather than hospitalisation, suggest that withdrawal from the bothersome relationships in life is seen as advantageous in one’s frailty. People have described contentedly living one day at a time, defined as social aloneness, as opposed to the derogatory term of loneliness. Peter Coleman and Ann O’Hanlon (2004 p 164) cite Brandstädter and Greve (1994) and their theory of assimilative and accommodative modes of ageing. In assimilation the older person strives to adapt to change through optimising and compromising. The person strives to maintain themselves in their lifestyle by fighting against the adversity of increasing age, functional and health changes. However, there comes a time when, in older old age, one achieves acceptance of how one has aged and changes are accommodated rather than striven against. It is, of course, questionable whether the described changes in feelings about ageing are attributable to an ageing process, personal life history (Kitwood and Bredin 1991), or that they are a reflection of society’s view that, once one has reached decrepitude, one is of no further social purpose. The correlations between spirituality and contentment in old age are an ongoing focus of research in ageing, though also often with focus on younger, more able, cohorts (Coleman and O’Hanlon 2004).

Such theory, implying that disengagement can be adaptive, fly in the face of criticism of disengagement theory. Disengagement may then be desirable for some of the institutionalised old who may not want to engage and be empowered in line with current rhetoric. I explore this difference in terms of depression in old age in the later chapters.

I have now examined the background to this research in terms of the historical and current nature of mental health service provision, particularly in the general hospital, and also by examining concepts of age and ageing. I now move into the core subject of the thesis, that of mental health problems.
1.4 Mental Health Problems and Mental Health Problems in Old Age

As I have already emphasised, the core concepts under scrutiny in this research are those around mental health problems in old age. From the literature, as I go on to explore in future chapters, there are three core evident ontological positions: the lay/popular view, that of bio-medicine, and sociological models.

The public perceive mental illness in terms of deviant behaviour, out of line with social normality. Those attributed with a mental illness are often seen as bad rather than mad (Pilgrim and Rogers 1999). Fear, stigma and social exclusion are emphasised and potentially perpetuated by the ways in which mental health problems are depicted in the media (Philo 2001). The medical and psychological ontological positions focus on remediable biological or behavioural aspects of the disease.

More recently, within mental health services, a broader, sociologically based perspective on mental health and illness is being advocated. Using this approach the person with mental health problems is seen as having a social disability. Recovery approaches (Anthony 1993, Barker 1999, DoH 1999, 2006b) focus on enabling people to live with their disability and encourage social inclusion, the development of coping skills and working with social networks. In terms of mental health problems in old age, this agenda is reflected within current approaches in dementia care as I examine in Chapter 4.

As I move through the literature and examine the data gathered in this research I will continue to explore perceptions of mental health and illness against these three core positions, the lay position, the bio-medical and the psychosocial.

The focus of my attention is also drawn to the potential differences in perception about adults of working age as opposed to mental health problems in older people. I have already mentioned the historical Cartesian division between general and psychiatric medicine and the age related separation that occurs in geriatric and psychogeriatric services. There is evidence within the political agenda that mental health problems in old age are not viewed in the same way, or with the same clarity of focus on the severity of the condition, as those for younger people.
The National Service Framework for Mental Health (DoH 1999) clearly defines that those adults of working age who meet the requirement for the attention of mental health services are people with severe mental illnesses, such as schizophrenia and bipolar mood disorders. Retired people are not included in these criteria and the dominant mental health problems of old age, dementia, delirium and depression; do not achieve specification as severe.

Within the policy context, the needs and service requirements for older people with mental health problems are addressed under the generic agenda for older people. For example, the National Service Framework for Older People (DoH 2001a) contains a specific chapter, Standard 7, on mental health issues. The recently published “Everybody’s Business” (CSIP 2005) emphasises that recognition and attention to the mental health needs of older people is within the remit of mainstream services. There is less clarity about what constitutes a condition severe enough to fall within the scope of specialist services and thus about who qualifies as a “proper” mental health service patient. Referral to mental health service is encouraged in the presence of suspected Alzheimer's disease or severe depression. However, if, as I suspect, people outside mental health circles do not readily use biomedical classification, attention to the problems will not occur.

I continue my exploration of the literature around mental health problems in Chapters 3 and 4. My intention here has been to highlight the evident lack of consensus about what constitutes a mental health problem in old age with a potential resultant confusion about service provision. This research aims to contribute in filling this gap.

I now turn to provide some background into the theoretical framework I chose as a basis for this research. I go on to briefly examine the research settings and the scope of the data.
1.5.1 An Epistemological Position

Prior to moving into the literature review and the body of the thesis, I explore here my sociological approach to the phenomenon of mental health problems in old age in the general hospital setting.

As I have explained, my original rationale in conducting this research was founded in a suspicion that mental health problems in old age may be conceptualised differently by different societal groups, notably staff from psychiatry and staff in general hospitals, and that such differences potentially affect the nature of both recognition and attention to such problems.

There has long been philosophical debate about what constitutes "reality" and "knowledge" with a wide variety of opinion and definition emerging. Here I begin by looking at the dominant ontological position within medicine and psychiatry before considering the alternative interpretive, constructionist approach that I go on to explain further in Chapter 5.

1.5.2 Scientific Positivism

A positivist view of the world can be said to be one in which there exist facts and truths about reality that are fixed and proven scientifically. Such facts are the results of human conceptual judgements and categorised for convenient usage (Porter 1998); in terms of medicine they are categorised into diagnoses.

Despite varying perspectives on mental health and illness, which I discuss further in Chapter 3, the orientation of practice in psychiatric services is based within a positivist approach of theory development. Practitioners and service organisers perceive those in their care to be "ill" using identified diagnostic terms that characterise certain presentations and expectations (Pilgrim and Rogers 1999). Such definitions are allocated following medical systematic experimental research, using methodology developed to deduce diagnostic reality by testing hypothetical theory against data. Models of care and
treatment serve to emphasise and further define constituents of the diagnoses (Prior 1993).

Using this illness framework, older people using psychiatric services are defined by diagnosis as being psychotic, having dementia and so on, and afforded treatment, often pharmacologically, accordingly. Such an approach can be said to mirror that of generic medicine, whereby doctors seek to define diagnosis, prognosis, aetiology and treatment, using the same epidemiological position founded in scientific reality. However, there exists concern that mental illnesses are less clearly shown to be biological in explanation and therefore the perception of "truth" is more readily challenged.

1.5.3 A Constructionist Position

The sociological theories, upon which I draw, suggest that knowledge is constructed from what is seen and heard within the lived environment (Porter 1998). As humans we learn through our social experience and adapt our learning with changing circumstance. In this way the diseases, described in the field of psychiatry, may not be universally perceived as such.

I work on the premise that everyday theories about the world are built inductively from data, rather than deduced by testing against hypotheses. I draw particularly upon the approach of Norman Denzin (1989) and Peter Berger and Thomas Luckmann (1991) in Interpretive Interactionism and Social Constructionism, respectively. The former is concerned with how perceptions reflect the innate qualities that people attribute to a phenomenon in forming interpretations thereof. Such an approach is relevant to the exploration of mental health problems in old age given the potential for the influence of the stigma associated with both age and mental illness.

Berger and Luckmann (1991), describing Social Constructionism, talk of the fluidity with which the social world is perceived. Knowledge, they assert, is not static, nor necessarily the same for different people in the same cultural setting. As I am exploring a
phenomenon, mental health problems in old age, arguably outside its anticipated setting, such an approach is the vehicle of choice.

I consider the theoretical framework in more detail, and as it is operationalised for this research, in Chapter 5.

1.6 The Research Settings and the Scope of Data

As I am seeking to explore how mental health problems in old age are socially constructed in the general hospital setting, I need to achieve data from the people who feature within that social setting. Although my original source of enquiry arose out of a potential difference in staff perceptions, between general and psychiatric services, I want to examine the perceptions of all involved parties in order to view the whole and to observe differences and make comparison.

The presence of mental health problems in general hospital settings impacts upon many people and groups: the older people themselves, other hospital patients, relatives and friends, as well as on health and social care workers and service managers. The social actors all have thoughts, feelings, behaviours, beliefs, communication methods and memories associated with, and influenced by, their experience (Williams and May 1996). As well as the personal and experiential influences carried by each person, further influence occurs due to the setting itself, an institution carrying history, administrative structures and mechanisms. I explore these further in the next chapter and in Chapter 6.

Data for the research was gathered in “elderly care” wards in two general hospitals in the South of England. I call the hospitals Glimster General and Chapley Hospital in order to anonymise them. I conducted qualitative interviews with older people, relatives and staff members. In Glimster General the traditional consultative model of mental health service provision is in place. In Chapley Hospital I provided mental health consultation and liaison interventions. Of course there were methodological complications in conducting research in a site in which I also worked clinically as I explore in Chapter 5. However, at
the time the research started there were no other accessible sites using a consultation/liaison model of service.

In analysing and exploring the data I have drawn conclusion upon both what are construed as mental health problems in old age in this setting and what are not. Through the data other issues of relevance have emerged, particularly in relation to organisational structures and the power structures that exist and influence perception. As I go on to explore, the clashing powers of biomedicine, psychiatry, organisational and political systems and consumerism all serve to complicate the perceptions of the older people, the relatives and the staff members.

Having provided a broad background to the research, I conclude this chapter by setting out the research questions and describing, very broadly and briefly, the content of each of the further chapters. I then move into the more detailed literature review.

1.7 Research Questions

The broad purpose of this research is to examine and explore how mental health problems in old age are perceived by those who experience them in the general hospital setting, in a culture in which such problems may be perceived as alien. These issues are addressed by interviewing older people, relatives of older people and staff members, in two hospitals who each employ different methods of mental health input, in order to address the research questions:

- What are the social constructions that are drawn upon and that generate perspectives on mental health problems in old age in the general hospital setting and
- Does the nature of mental health services provision affect and/or influence the social constructions?
I asked these questions in order to inform debate around the future provision of mental health care for older people in general hospital settings. I argue that service is currently provided in answer to the constructs as perceived by the professions of medicine and psychiatry, and due to political and organisational demands, rather than in consideration of how mental health and mental illness in old age is perceived by those directly involved in the general hospital setting.

1.8 Outline of the Thesis

The thesis consists of an introduction followed by three literature review chapters and a chapter on methodology. There follow three chapters of analysis and discussion prior to the conclusive chapter that evaluates how the findings relate to the theoretical literature as well as addressing the implications of the findings and indications for future research.

Within this, the first chapter, I have provided a broad outline of the thesis. I have described my background and the nature of the original source of sociological enquiry. The chapter has gone on to examine the historical and contemporary context of services for older people with mental health problems who find themselves in general hospitals. Although there has been some fluctuating political will to merge hospital services for people with general and mental health problems, this has not come into fruition. Service divisions between general and psychiatric medicine, and between young and old, perpetuate the social exclusion of older people with mental health problems.

I have also examined some theories of ageing and how ageing is viewed from biomedical, psychological and sociological perspectives to formulate a contemporary construction of old age. I explored the argument that old age has become pathologised and marginalised. I argue that the recent focus on ageing well may serve to further marginalise older people who have become dependent through ill health and/or disability. Lastly I have described my epistemological position as founded in Social Constructionism and touched upon detail of the research sites and the methodology.
Chapter 2 considers the literature around power and its potential relevance within this research. I examine professional, organisational, consumer and political power in turn. I conclude by considering the potential influence of vying power relationships upon care and service for older people with mental health problems in the general hospital setting.

Chapter 3 examines the literature relating to generic perspectives of mental health and illness. I seek to examine how a person becomes classified as mentally ill. I explore views from lay, medical, psychological, sociological and political perspectives. I include a section for the examination of stigma. In conclusion I note that one’s view of mental health and illness differs and may vary with one’s position in a culture, as well as due to the effect of stigma.

Chapter 4 specifically explores mental health problems of old age and considers how these may differ from the broad perspectives discussed in Chapter 3. Again differing perspectives are examined and I highlight the lack of research about mental health and illness in old age, other than dementia, as perceived from differing perspectives. I particularly note the dearth of sociological research examining depression in old age. I also consider the lack of political focus on this population group.

Chapter 5 details the research methodology. I consider the theoretical framework that underpins the chosen methodology and detail the processes and challenges involved in achieving sufficient data with which to address the research questions. The chapter content focuses specifically on the sensitive nature of research into a stigmatised condition and involving vulnerable people. I explore the ethical issues that such sensitivity uncovers.

Chapter 6 commences the analysis and discussion section of the thesis. Here I consider the social constructions that influence perceptions of mental health problems in old age in the general hospital setting. I return to issues of power and compare the expressed perceptions in this setting against lay and psychiatric views. I explore the data as it
centres around mental health problems in old age as defined by behaviour and perceived confusion.

**Chapter 7** explores and discusses the findings around those mental health problems defined within mental health service circles, but absent in this setting. I focus particular attention to the issue of depression in old age and consider how perceptions differ across the age ranges. I consider the possibility of *structured* depression in old age. I also examine the data as it pertains to stigma and conclude on the degree of its influence in formulating perceptions.

**Chapter 8** considers the implications of the research findings on future service structure and provision noting a need for radical change. It compares the two service models under scrutiny and introduces the concept of *osmotic learning* as a product of the consultation/liaison model of service. The broad political context of mental health services for older people is discussed with recommendations for a focus of attention aimed at improving recognition and service for this population group.

**Chapter 9** concludes the thesis by recapping on the core findings, reflecting on the research experience and making recommendations for the direction of future work.
Chapter 2

Power

2.1 Introduction

In reviewing literature relevant to my research, I divide consideration into three discrete yet interlinked chapters. Given the emerging importance of the influence of power throughout this research, Chapter 2 explores issues of power and their possible vying impacts on perceptions of mental health and illness. In Chapters 3 and 4 I move on to explore further various perspectives on mental health problems generally (Chapter 3) and in old age specifically (Chapter 4).

The nature and purpose of general hospitals necessitate the presence of an organisational culture whereby defined processes and procedures ensure that people gain entry, receive treatment and are discharged. Such structure can itself exert power and enable individuals within it also to wield differing, and sometimes conflicting, degrees of power over others.

The relevance of power is apparent in many guises throughout this research and influences all aspects of it. It is due to its extreme relevance that I explore it first, both here in the review of the literature and, when it comes to examination and interpretation of the data, in Chapter 6. Each research participant’s position within the general hospital setting, and the interviews themselves, involve power dynamics associated with age, health status, competence, professional status, expertise, gender, class and environment. Organisational and political power also impinges on the setting’s social structure. As I discussed in the previous chapter, the professional power of medicine, and of the psychiatric branch of medicine, also holds significant influence over how service is provided.
I examine issues of power within research relationships in Chapter 5; Methodology. In this chapter I consider professional, organisational, consumer and political power individually before discussing how the issues may impinge on, and affect the perceptions of people within the general hospital setting. First, however, I consider broad sociological perspectives on power.

2.2 Sociological Perspectives of Power

Definitions of power have long been disputed by sociologists. Probably the best known of definitions is that of Max Weber (1922, cited by Marshall 1999 p519) who suggests that power is “the probability of persons carrying out their will, even when opposed by others”. Possession of power, according to Weber, is grounded in the economic, social and political dimensions of the person or group. Power, the modernists postulated, is legitimised by those who see themselves as subordinate and behave accordingly, suggesting a somewhat linear power line from those who possess it, to those who do not. Foucault and the post modernists, conversely, suggest that contemporary society can be explained by mapping the network of power relations within it. Power is, he suggests, a generalised omnipresent resource, exercised rather than possessed (Watson 2001), and flowing through a political system. Power exists within all interactions and is apparent through inequalities. Power shifts between people and groups and therefore shapes reality for those people and groups, dependent on the needs/will of society at the time (Hoy 1986, Lupton 1994).

Symbolic interactionists argue that the organisation of social life, and the power structures within it, arise from society itself, there being no theoretical reason why one group should predominate. Marxist theorists tend to view power as oppressive and unjust, related to economy not prestige, the socially advantaged wielding influence over the disadvantaged, causing oppression and conflict.

Within this research I tend towards the philosophies of Foucault although notably his position moved with time. In his early work he perceived power as negative, oppressive
and exclusive (Foucault 1967), whereas he later defines it as positive and heterogeneous: "Power is an enabling force that permeates the social realm and constraint can lead to creative expression" (cited by McNay 1994 p142). Thus power constrains but is also fluid enough to offer opportunity for the expression of freedom (Watson 2001). Therefore, in principle, any person or group of people has the ability to be powerful. The question that I will continue to raise as this thesis progresses, is whether or not everyone can permeate and penetrate every social realm, in this instance the general hospital setting. As becomes evident, it may be that certain groups are able to permeate more readily than others, and as such have more control over the agendas in the setting.

Considering the concept of power within the general hospital context is complicated. I now go on to consider the differing potential sources of power in turn, firstly in relation to professional knowledge.

### 2.3 Professional Knowledge

Sociologists of the structural functionalist view hold that the professions are a stable force within society, acting in the interests of their clients and of society, therefore they hold legitimate power. Patients readily defer to doctors in order to return themselves to usefulness (Parsons 1951). Weberian tradition suggests that health professionals use strategies to enhance their social standing, thus ensuring ongoing need for their service. Doctors’ exercise enhanced power over three social groups: their clients, those subordinate to them and other occupational groups who are considered lower in social stature (Pilgrim and Rogers 1999). Thus nurses defer to doctors and health care assistants defer to nurses and patients defer to everyone. From a Marxist perspective the professions are seen as holding power due to their position within the ruling class.

Nursing has never had equal status with medicine. Medicine is a predominately male domain whereas nursing is female. Medicine holds power due to the positivist scientific nature of the knowledge it holds. Nursing, and indeed psychiatry, is not seen as factually scientific, being interested in people and emotions as well as medical knowledge. While
nurses may be perceived as agents of the medical profession and thus have vicarious power, they, and other health care professionals, are not afforded such prestige in the social hierarchy (Nettleton 1995).

Foucault asserts this clear link between knowledge and power (Porter 1998, Watson 2001). He argues that medical knowledge has achieved power through taken-for-granted position in assumed factual reality (Foucault 1974). In organising human beings from birth until death, it is argued that medicine has replaced religion (Bilton et al 1987). Doctors, and other clinicians, exert their power through their knowledge by using language that others do not comprehend (Porter 1998) and by use of the “clinical gaze” through which patients are objectified, observed and controlled (Foucault 1976). Their power is emphasised through the medicalisation of certain life events such as pregnancy, ageing and mental illness. Thus they define those who they manage and treat (Prior 1993) in terms of biological reality that they deduce using positivist methodology (Redfern and Ross 2005). Through such definition the patient surrenders his body to the expertise of the clinician (Vincent 1999) as is the patient’s expected role on entering hospital.

It is also through professional power that policy and service provision has historically been defined and organised, professional roles have developed, and systems have been put into place (Prior 1993). The dominance of the power of medical knowledge thus holds conditions, such as mental illness, within the biological reality paradigm and perpetuates its definition as such. Psychiatry dictates the need for separate general and mental health services and doctors and nurses, who are educated into one specialty or the other, defend their position.

As I go on to examine, there are moves away from the clinically dominated power base in health care. In terms of mental health problems in old age the move against the power of the clinical gaze is best illustrated by the work of Kitwood and others, as discussed in Chapter 4 (p65), in seeking to see the person with dementia and their disability rather than their disease state.
However, a more dominant threat to professional power arises from organisational and political power, as I now examine.

### 2.4 Political and Organisational Power

A major focus of current government policy, with regard to health care and other public services, is on standardisation, monitoring and the minimisation of risk, as forms of social control (Adams 2001). This focus can be seen, in terms of the organisation of the health service, as an extension of the managed health service that emerged during the Thatcher years and beyond, following the recommendations within the Griffiths Report (DHSS 1983). The legislation that followed implanted a clear management structure within the NHS and moved the focus of care towards efficiency as well as clinical effectiveness. The current increasing attention towards standards and monitoring through National Service Frameworks (see Chapter 4) lends the sway of power towards organisations that must develop systems through which standards can be enacted and developed in order to prove their efficacy.

Although similar to medical power, in its ability to lead and shape agendas, organisational power differs in that it is based in social and political rhetoric rather than in the scientific discourse. Foucault describes the notion of disciplinary power, or "panoptic surveillance" (Porter 1998 p218), in terms of the execution of techniques aimed at standardising conduct. He used the prison set up to illustrate ways in which behaviour of in-mates is regulated, controlled and maintained (Foucault 1979). The principle is transferable to schools (Watson 2001) and arguably to any setting where one group of people have expectation about the conduct of another group. Thus in a general hospital patients are expected to behave in certain ways, as indeed are clinical staff and administrators.

Thus the organisations, through territorial and disciplinary power shape what constitutes knowledge from a different perspective than that of those who hold professional
knowledge. Organisational knowledge is about systems and how they should efficiently operate. For example, an older person in hospital may be defined by a medical diagnostic label or by their position in the organisation as a "bed blocker" delaying throughput in the system. One may suppose that such a difference in paradigm has an effect on perceptions about elements of and within the environment, for example, interpretation of what constitutes an illness.

Organisational power has been said to dominate other social roles. For example social workers in the general hospital setting, especially since community care legislation in 2003 (DoH 2003b), tend to focus on moving people out of hospital rather than examining and addressing their social needs as they may affect their health (Simey 1998).

In recent years some of the treatments offered, in the UK, have been recommended by a central government body, the National Institute for Health and Clinical Excellence (NICE 2006). This body is tasked with reviewing current evidence in order to make recommendations based on clinical efficacy against cost. Such a challenge to individual practitioner autonomy and personal prestige can be said to disempower the omnipotent position of the prescribing practitioner.

Organisational power is itself shaped by political power and by the guidance and legislation that determines how services are provided. Thus the disempowerment of older people in society has been moulded both by the medicalisation of old age and by the organisational rejection of "bed blockers" but also, and arguably more broadly, by the way in which social policy has politically shaped their role. As discussed in Chapter 1 (p14), the Disengagement Theory of Cumming and Henry (1961) was widely accepted despite its methodological flaws. Within their study Cumming and Henry claimed to demonstrate that older people disengage willingly by making way for others to fulfill their former roles, thereby gaining the opportunity to enjoy leisure pursuits unavailable during the years of employment. The conclusions of this research were readily accepted despite its small-scale nature, both numerically and geographically, and the inability of other researchers to replicate the findings elsewhere (Coleman et al 1993). It appears that
the theory suited the political need at the time to identify older people as having different needs than those in middle age and thus to extract them from the workforce. With the influx of baby boomers, born in the 1950s, youth employment took priority. Disengagement then became prophetic in that compulsory retirement age was in place and was seen as desirable to all. Also moving older people to special sections of the community or into institutions where the expectation for any engagement is minimal is readily accepted. Subsequent social policies have ensured the lower economic status of many older people, as postulated in descriptions of structured dependency (Townsend 1981).

The evidence of suppression through political power for older people is mirrored in legislation and policy around mental health and illness. Increasingly, from a political perspective, mental illness is linked with societal risk. This leads to social exclusion and defensive clinical practice (Barker 1999, Social Exclusion Unit 2006). Older people with mental health problems are thus potentially doubly suppressed due to the negative views on their potential risk to society and their incompetence due to old age.

Having explored professional and organisational power, it is already evident that older people and, potentially more so, older people with mental health problems, are unlikely to be perceived as powerful in terms of their position as consumers of health care. I now move on to explore this agenda.

2.5 Consumer Power

The third player in the potential power struggle is that of the consumer. As well as the government intent on standardisation and measurement, current political focus emphasises the need for increased consumer choice in health service acquisition (DoH 2000). This is an extension from the growth in consumer power in the late twentieth and early twenty-first century. Within the health service the shift has been characterised by rhetoric about user involvement in many fields, including mental health (DoH 1999),
whereby the person is considered an expert in their own health experience particularly if they have a long term condition (DoH 2005b).

Moves in advancing consumer rights, or patient rights, are enacted in law. For example the Disability Discrimination Act (Office of Public Sector Information, OPSI, 1995) made it illegal to treat one person, or group of people, less favourably than another by virtue of their disability. The Human Rights Act, article 14 (OPSI 1998) calls for no discrimination from one human against another. Advocates suggest that this legislation should be more readily used to shift the mindset, from illness to disability, in the exclusion of people with mental health problems (Sayce 2001) or dementia (Gilliard 2002).

Within mental health services for younger people there have, since the introduction of the National Service Framework for Mental Health (DoH 1999), been significant advances in user involvement with many NHS Trusts employing service users as advisors and advocates. Such engagement with older people with mental health problems is less evident despite it being an aspiration (Killeen 2001). The voice of carers is more often heard, particularly through such organisations as the Alzheimers Society (2006).

The patient participants within this research are over 65. They may also be mentally ill and they may have dementia. The ability to exert power in old age is said to depend on income and gender and arguably intellectual ability, in this “ultra cognitive world” (Adams and Bartlett 2003 p5). Those falling within old and mentally ill social groups are often not seen as deserving of power or as having any ability to use it.

Within western culture attainment of personhood is achieved in reaching adulthood. In exploring experiences of growing old, Hockey and James (1993) suggest that in life one is not considered to have become the complete person, capable of independent autonomous thought and action, until one has reached arbitrarily allocated chronological points. At that time one achieves “personhood”. Defining one's place in society in these terms, the predominant dependent group is children. They are dependent on adults for
protection, direction and nurture, being naïve of the world. Adults interact with children in particular ways aimed at meeting their perceived needs. Older people, particularly if they have a mental illness, have become classified by society as a dependent group, beyond personhood, disengaged and useless to society. As such, older people are often treated “as if” they were children, dependent and powerless, as this is the way in which society has come to interact with its dependents (children). Childlike attributes are attached to older people, to those with disabilities, and to people whose perceived dependence is temporary, for example hospital patients. They are expected to comply without question, to not assert relevant opinion and indeed to be “seen and not heard”. They are powerless.

Such stereotypes diminish the older person’s feeling of control (Sykes 1995). To work is good, to be healthy is good, and to be ill is to be a burden. Power is to do with wealth, health, productivity, status and independence. It is difficult to assert one’s consumer power under such constraint. The older person is not seen as an individual consumer, but bundled together as part of a homogenous group irrespective of individual and societal differences (Walker 1981). At present the predominant discourse around older people, and particularly older people with dementia, is that they have no view, cannot express a view and, if they do, it is without value. Older people are perceived as passive recipients of care, lacking physical, mental and financial resources (Hey 1999).

However, let us return to the Foucauldian belief that any person has the potential to exert power. There are means of exerting power through one’s membership of a disadvantaged social group. Hockey and James (1993 p167) cite the work of Turner (1974). Turner argues that issues around social power are particularly prevalent at times of transition. He calls this “liminal” power, defined as being that which occurs at times of threshold between categories, for example, youth to adulthood, sickness to health, age milestones. He refers to two types of power, secular and sacred. Secular power is that granted to individuals according to their societal group, class, gender and ethnicity, as we have seen in the power of doctors and managers. Sacred power is accredited to those who are somehow set apart from the majority. Such power can be temporarily present only in
transition, for example during rites of passage from youth to adulthood or from working life to retirement. For the purposes of this work sacred liminal power may be present for people whose social role has changed through their hospitalisation. Turner suggests that when one is marginalised one is potentially inappropriately held in this limbo position, outside the usual being. He argues that this separateness can be powerful. It is from this liminal position that the older people can be seen to rebel. Cast as surrogate children with nothing to lose a person may become anti-social. An often cited example of this ability to exert power through eccentricity is the poem *Warning* by Jenny Joseph (1974, cited in Hockey and James 1993, Box 2.1), although it was written when the author had not yet reached old age.

### 2.6 Discussion

For the purposes of this thesis power is seen as omni-present. It is culturally, politically and institutionally embedded. It exists, overtly and covertly, enabling the possessor to, consciously or unconsciously, influence, shape or determine their agenda whilst minimising opposition. The power struggles in wards for older people in the general hospital are arguably predominantly between professional and organisational power, still leaving the consumer out in the cold. This struggle inevitably effects both perceptions about mental illness and the service provided to address it.

The way in which power structures are acted out in day-to-day life are described by Carolyn Baker through each individual’s “membership categorisation” (1997 p130). Within specific settings and situations people behave according to the social rules that govern their role in that place, as required at the time. In this way the influence and power of individuals, professionals and organisations causes people to behave in certain ways: patients are un-assertive, nurses are busy, doctors are knowledgeable, and so on. Despite current rhetoric encouraging consumer choice, hospital regimes and environments continue to restrict the opportunity for choice and independence. If, as a patient, one is assertive, there is a risk of being labelled as “difficult”, because of the
violation of membership category. Such execution of power can make one further marginalised (Bilton et al 1996).

**Box 2.1 Warning**

When I am an old woman I shall wear purple
With a red hat which doesn't go, and doesn't suit me
And I shall spend my pension on brandy and summer gloves
And satin sandals, and say we have no money for butter.
I shall sit on the pavement when I'm tired
And gobble up samples in shops and press alarm bells
And run my stick along public railings
And make up for the sobriety of my youth.
I shall go out in my slippers in the rain
And pick the flowers in other peoples gardens
And learn to spit.

You can wear terrible shirts and grow more fat
And eat three pounds of sausages at a go
Or only bread and pickle for a week
And hoard pens and pencils and beer-mats and things in a box.

But now we must have clothes that keep us dry
And pay our rent and not swear in the street
And set a good example for the children

We must have friends to dinner and read the papers

But maybe I ought to practice a little now?
So people who know me now are not too shocked and surprised
When suddenly I am old, and start to wear purple.

Jenny Joseph (1974, cited in Hockey and James 1993),

There are those who argue that the bureaucratisation of health provision has markedly changed the power structures within it. Professionals are now employees of large organisations and are, it has been suggested, allied with the proletariats against the power of the administrators (Oppenheimer 1975). This position of loss of power to the bureaucracy has proliferated since the 1990s with the introduction of the market economy in health care provision. There exists a conflict of new power over traditional power within today’s NHS. Adding to this conflict, recent years have seen the growth in consumer power, where the patient is seen as the expert in their condition and needs.
Thus a third, potentially conflicting voice vies for power. The traditional roles are no longer as clear in boundary, and diversity in interest provokes conflict.

However, although professional power is being challenged with this onset of consumerism, and changes in health service management (DHSS 1983), the shift of power is not achieved overnight. Barker et al (1999) suggest that the fear of litigation, particularly in mental health fields, is pressurising service providers back into a traditional paternalistic model, contradicting the will to empower users.

2.6 Conclusion

In this chapter I have highlighted and explored issues of power as they impinge upon every aspect of this work.

It is apparent that three core potential power bases exist in professional, organisational and consumer power. Historically professional power dominated the agenda of health care and delivery and arguably the older generation being studied here have formed their perceptions at the time when medical power held total legitimacy. However, since the 1990s both organisational and consumer power have entered into the health care arena and potentially serve to complicate and change the traditional constructions of health and illness held within general hospital settings. People who find themselves within the setting, as staff, relatives or patients, may find conflict in establishing what belongs in this social world and what constitutes a legitimate illness therein.

As this thesis develops I return again and again to the areas discussed in this chapter as it is clear that perceptions of mental health and illness are intricately linked with the power structures within a given culture.

I now move on to examine the literature with regard to perceptions of mental health and illness in Chapter 3 from a general perspective, irrespective of the age of the sufferer.
Chapter 3
Perspectives of Mental Health and Illness

3.1 Introduction

I have now outlined the broad issues under discussion and scrutiny in this research. In these next two chapters I explore the literature around varying perspectives of mental health and illness and then specifically that associated with the experiences of older people with mental health problems. Notably little non-medical attention has been given to mental health problems in old age, other than dementia, as I explore in the next chapter.

In considering the differing perspectives I do not aim to suggest any strength of one argument over another, rather I seek to emphasise that the concepts of mental health and mental illness are not firmly defined and that they differ dependent upon one's relationship to the concept and on the cultural setting. It is clear that the perspectives are not mutually exclusive and that they all carry influence on each other.

Here, in Chapter 3, I explore the literature as it explains how a person is classified as having a mental health problem using the differing perspectives of the lay public and of medical psychiatry. I also consider the psychological, sociological and political perspectives and explore how the attribution of mental illness has shifted with time. I focus particularly on the pathologisation of depression in Chapter 4.

In concluding this chapter I suggest that current perspectives on mental health and illness focus on the construction of a phenomenon that occurs in younger adult life. Mental health problems in old age are not considered using the same terminology.

I begin the chapter by looking at popular perspectives of mental health and illness and include a section examining the phenomena of stigma. I move on to consider the medical
viewpoint before considering how these two core constructions fit in with psychological and sociological thinking. Lastly I look at the political perspective.

3.2.1 Popular Perceptions

Mental health and illness are nebulous concepts, covering many potential situations. Notions of emotional and psychological difference are attributed according to various cultural and historical context (Pilgrim and Rogers 1999).

The popular view of mental illness has long indicated a link between madness and perceived social badness, criminality and violence. As early as the fifth century BC the Greek philosopher Socrates is reported to have stated that a low crime rate in Athens indicated a low rate of mental disorder in the city (Gregory 2004). Later Shakespeare described the decline into madness, and badness, in Macbeth.

The popular view continues to describe those who are perceived to be mentally ill as those who do not conform, those who do not fit into perceived normality; they are thought to be bad and dangerous. That the classifications of “bad” and “mad” can be synonymous has been characterised by some high profile convictions for murder. The trials of Denis Nilsson and Peter Sutcliffe are examples of this phenomenon. Both of the accused were seen to have acted unlawfully as a result of their mental illnesses by expert psychiatric witnesses, yet in each case the jurors judged their behaviour as bad and convicted them as criminals rather than defining them to be unwell (Pilgrim and Rogers 1999). This suggests a societal belief, or indeed lack of belief, in the phenomenon of mental illness as remediable through medical intervention. The juries for these cases felt that punishment for bad behaviour was required and could not accept that an illness could exist that was causative of their criminal acts.

More recently attention has been drawn to a case where psychiatry does not discern a mental illness, yet the popular view differs. The enquiry into the service responses to Michael Stone, who murdered a mother and her daughter after having been in contact
with Mental Health services, confirms a lack of consensus over what constitutes a mental health problem (Independent 2006). In the lay view Stone was perceived to be mentally ill and dangerous prior to the crime, and as such should have been incarcerated. However, in terms of medical psychiatry, and the legal framework of the Mental Health Act, personality disorder is not categorised as a treatable mental illness, therefore he could not be detained.

Clearly these cited cases are extremes, but many argue that the link, or assumed link, between mental illness and badness, particularly violence, is over emphasised through media portrayal (Ward 1997, Clarke 2004, Philo 2001). They suggest that media influence has the dominant presence in today’s society and underpins much of our culture including how we perceive mental health problems. Negative deviant labels, such as “psycho” “loony” and “bonkers” are stereotyped to portray badness, and are often firmly held and not easily changed (Philo 2001).

In a screening of press coverage of mental illness and related issues, Ward (1997) found that 50% of the references linked mental ill health with violence and criminality. Similarly Clarke (2004) suggests that the ways in which the media reports cases where someone has died at the hand of a person diagnosed with a mental health problem, such as the case of Christopher Clunis who was killed by a man diagnosed with paranoid schizophrenia, serves to create anxiety among the public. Clarke cites articles where the media have alluded to the involvement of people with mental health problems, when none was present, for example by noting the proximity of the crime scene to a psychiatric hospital. Contrary evidence does not receive an equal degree of publicity. For example, of the 1048 murders in 2003, in England and Wales, only 50 were committed by people with mental health problems, while the public are more at risk from those who are drunk than from those who are mentally ill (Gregory 2004).

Anxieties about the perceived risk caused by people with mental health problems, fuelled by cases such as Michael Stone, are evidenced in the current political agenda aimed at minimising that perceived risk. For example, the Mental Health Bill (DoH 2004) was
recently rejected and is being re-considered with the Mental Health Act Amendment Bill (DoH 2006), makes provision for compulsory care orders in the community, arguably meeting the public demand for protection. The Bill also seeks to tighten up definitions of what legally constitutes a mental disorder and will potentially widen the net of people who can be so defined and thus detained and/or compelled to receive treatment. Public debate about the rights and wrongs about further socially excluding people with mental health problems through restrictive and, possibly over prescriptive legal intervention continue as I write. At present it appears likely that amendments will be made to the current Mental Health Act (1983) that will address the perceived need for greater control over people with mental health problems who, rightly or wrongly, are seen as a potential danger.

In contradiction of this apparent social fear of people with mental illness runs a theme whereby the media cannot cross the invisible line of political acceptability. An example of this was the reporting of the boxer Frank Bruno’s mental health problems. The Sun (2003) newspaper headline originally screamed “Bruno is Bonkers” but later that day retracted its “inappropriate” remark, moving to a position of pity for the victim of circumstance. This apparent division, and ambivalence between bad and pitied, and acceptable and unacceptable mental illness, is depicted in a culture of tolerance and acceptability of some mental health problems that are seen as being evidence of human distress. I explore this further in the next chapter, where I consider the development of the illness called depression.

We are currently bombarded with media images about unfortunate people who are experiencing depression, substance dependency or dementia. Lineham (1996) believes that making mental health problems into light entertainment, by knitting them into soap opera story lines and making them the focus of chat shows, is a worrying development. This view is shared by Philo (2001,p58) who reports his finding that soap characters who had mental illness evoked hostility in the audience, in line with the popular view that mental ill health is equivalent to badness. Arguably such focus, “providing clichéd sound bites and easy solutions to human suffering” (Philo 2001), serves to belittle the
experience, the distress and the, often lengthy, route to recovery. This latter has recently been evidenced in “Coronation Street” (ITV 2006), where a character, Mike Baldwin, developed and was diagnosed as having Alzheimer's disease only to die within six months. Although the depiction of someone with this stigmatised and often hidden condition has received congratulation (Alzheimer's Society 2006), the course of the condition and the social impact over years rather than months was not reflected, arguably because the audience could not have tolerated such exposure.

In his work Greg Philo (2001) also examined how media images are more powerful than personal experience in shaping concepts of what constitutes a mental health problem. He found that even those who had personal or family experience of a diagnosed mental illness reported mental illness in terms of social badness rather than through their lived experience. This suggests that the way in which the media portrays mental illness as dangerous and undesirable somehow enables the public to disassociate any personal experiences from being so defined. Hence one is protected from association with the stigmatised, socially unacceptable phenomenon.

As I progress through this literature review the dearth of literature on mental health problems of old age becomes apparent. Popular perceptions of mental health problems in old age have not been explored, even within the extensive work on dementia that I look at in the next chapter.

In summary thus far it appears that, in order to be classified as mentally ill, from a lay perspective, one is defined as socially bad and/or as a risk to society. However, there emerges ambivalence about how to classify mental health problems within one's own experience and/or when people are defined as unfortunate rather than bad.

Before I move away from the popular perspective of mental health and illness, I will spend some time exploring the phenomenon of stigma as it influences perception of both mental health and old age, not solely from a popular lay perspective. It is the ongoing
presence and nature of stigma that facilitates caricatures of mental illness as bad and
dangerous to readily persist and remain embedded within a culture.

3.2.2 Stigma

Stigma is the discreditation of a person due to the stereotypical view of an aspect of their
social identity, making them “unacceptable or inferior beings” (Scambler 1997 p173).
The stigmatised person becomes not quite human and is not accorded the same degree of
respect and regard that the uncontaminated receive (Goffman 1964). Hence the socially
bad person, as discussed above, is judged by their negative attribute. According to
Goffman there are two distinct types of stigma, the “discrediting” and the “discreditable”.
A discrediting stigma prevents others from perceiving and treating the person according
to any attribute other than that of the dominant label. Thus the person diagnosed with
schizophrenia is determined as bad and dangerous and the person with dementia is treated
as a diseased object (Kitwood 1997) rather than, for example, as a mother, a teacher and
an expert chess player.

A discreditable stigma is not visible or known. People try to hide their condition in the
hope that they will not be socially affected by it, due to the fear and behaviour it may
provoke in others. Scambler (1997), for example, writes of people who do not disclose
their diagnosis of epilepsy. Attempts to hide the stigmatised attribute are also made by
friends and relatives (Simpson et al 1995) who may use complicated rationale to explain
away their loved one’s behaviour in terms of anything but a discreditable illness.

The general public hold media portrayals of mental illness, such as those seen in soap
operas, as more accurate in definition than that of their own experience (Philo 2001).
This potential extreme of definition enables stigma to be avoided. Lindsay Prior (1993)
described that the patients he studied, in a mental health institution, did not term
themselves as having a mental illness even though they recognised such problems in
other people. Rather they used euphemisms associated with a nervous disposition or
described physical symptoms as if to give credence to their presence in the establishment.
A small number of people did acknowledge some sort of mental illness, particularly for depression.

"...that they suffer with their nerves, that they come from a nervous family, that they are constantly bothered with their nerves, that they feel unwell or just not themselves or more likely refer to some general notion of dis-ease. Sometimes they point towards specific somatic conditions – excessive sweating, constipation, pains in the neck, stomach aches, giddy spells and sometimes even specific (but imagined) organic conditions of the liver, heart or kidney"

Prior (1993 p161)

Description of stigma can be linked with that of the labelling theory in that those attributed with a mental illness label are discriminated against (Rosenfield 1997). The labelling theory suggests that the diagnostic tag of a mental illness is what causes certain behaviours to occur. Tomas Scheff (1966) used labelling theory to explain and define mental illness in terms of violation from the social norms (Porter 1998). Those who do not follow social norms are labelled as mentally ill. In this way the role of the deviant patient is identified and maintained within certain structures in society. The role, as affected by the stigma, is exhibited both in the behaviour of the person attributed with the label and also in the response of others to him/her. Thus stigma is both causative of and caused by the attributed label.

As with stigma, labeling theory is sub-divided into primary and secondary deviance. It claims that a certain degree of deviation (primary) from the norm is denied, in order that the status quo is not challenged. For example, a man who has become more forgetful and loses his way home is excused this due to ageing or everyday stress. It is only when secondary deviation, such as walking down the central reservation of a dual carriageway or increasingly losing objects, is construed, that a mental illness “label” is attributed. Once labeled as mentally ill the person is said to take on certain roles expected of that diagnostic label (Goffman 1961, Scheff 1966), they will never be seen as quite the same again. Such defined roles are emphasised by the language and actions of those around people with mental illness, undermining the person, as evidenced in Goffman’s (1961) account of the Asylum. The person is disempowered and socially excluded, arguably as society desires them to be.
In criticism of this perspective is the argument that the attribution of a diagnostic label is not always perceived as negative. For example, some take comfort in having feelings and behaviour thus explained and find it reassuring to be less unique and extraordinary. This has been demonstrated for people diagnosed with dementia who found diagnosis reassuring in that they felt less alone and less scared (McKillup 2002). Another contention with the theory is that the labels described are those of psychiatric medicine rather than reflective of the popular view of mental illness. Pilgrim and Rogers (1999 p15) cite the example of schizophrenia, thus classified by psychiatrists but not by the general public. The theory suggests that, through labels, mental illness is socially negotiated, yet it seems to apply only from a professional perspective rather than reflective of the attributions of the public who may hold a more nebulous generic perception of what is socially unusual.

People with mental illness are stigmatised, not only because they do not fit in, but also because of associated popular fear. Arguably legislation and the way in which services are organised, commencing with the Lunacy Act of 1890 (Pilgrim and Rogers 1999), serves to emphasise stigma by controlling the whereabouts of those legally defined as being mentally ill. Despite ongoing changes in mental health legislation and the closure of large institutions, replaced by mental health care in the community, the stigma of mental illness persists. As well as physical exclusion from society, people with mental health problems have long been denied involvement in their own care and in consultation about mental health service provision. While recent political direction (e.g. DoH 1999) seeks to address these issues the burden of historical exclusion will take time to dissipate.

In examining the changes in perception about stigma since the advent of community care, Crawford and Brown (2002) conclude that stigma has become less a burden that is placed upon institutionalised people who have been given a diagnostic label and more an issue of wider social exclusion. In their study, examining community mental health nursing visits with people with mental health problems in their own homes, they noted that
nurses used euphemisms such as “it’s like a friend coming to visit” rather than openly acknowledging the reasons for their visits. Such covert pretence, even between involved parties, arguably serves to ensure that negative attitudes persist. In a similar, single centre, study with low participant numbers, Rosenfield (1997), looking at the effect of stigma on life satisfaction, suggested that while stigma can be minimised through “high quality services”, the provision of such service can perpetuate a social bubble in which the person with mental illness exists in exclusion from the wider world that continues to stigmatise him/her. Such criticism is often raised against day care facilities for an exclusive client group, such as people with dementia.

Older people with mental illness may experience double stigma due to the combination of their diagnosis and their chronological age. Ageism, inequality and stigma due to age, has been less studied than other inequalities and can often been exhibited through the use of professional power (see Chapter 2). Its presence is evidenced within the theory of structured dependency, as discussed in Chapter 1 (p15) and in societal actions such as the exclusion from breast screening of women above the age of 65. Older people are denied their rights as citizens due to ageist assumptions of homogeneity and assumed infirmity (Turner 1989, Higgs 1997).

Negative stereotypes about age abound within our culture. It is difficult to find a humorous birthday card that does not allude to the negativity of growing old. The youth culture demands that we strive to appear younger than our years and avoid the perceived inflexibility and decrepitude of old age (Bytheway 1995). Despite lack of evidence an impression that old age is primarily a time for health problems and dependency persists (Arber and Ginn 1991, Fries 2002). This is emphasised by, often alarmist, reporting that the older population is rising to the extent that society cannot provide financial or functional support, as discussed above (p16). Older people themselves can, due to ageism, live with feelings of failure, pointlessness and disintegration (Hazan 2000) as can others stigmatised by their pejorative societal label.
An interesting aspect of ageing and ageism is that, like mental illness, it is always treated as something external to oneself. Unlike other campaigns against unjust negative bias, such as race, gender or sexuality, and indeed mental illness, those campaigning rarely place themselves among the abused (Coleman and O'Hanlon 2004).

As I have suggested, the combination of stigma associated with both mental illness and ageing means that older people with mental health problems can experience a double stigma. Add to this that the majority of older people in hospital are women and this can been seen as triple jeopardy (Bytheway 1995). Golander and Raz (1996) in their examination of how older people who have dementia in nursing homes are seen, succinctly describe how stigma is attributed differently by different societal groups. In attributing dementia to other older residents people ensure that they never quite reach the realms of the discreditable (Goffman 1964).

"If elders are society's others, then demented elders are elderly peoples' others."

(Golander and Raz 1996)

I now move on to an examination of the medical perspectives of mental illness. The available literature is huge, but again often lacking in focus with regard to the issues of mental health problems in old age other than dementia.

3.3 Medical Models

The psychiatric medical perspective suggests that mental illness comprises symptoms and behaviours that are fundamentally biological in origin. However, for some conditions, for example schizophrenia, there is a lack of conclusive supporting biological evidence. In the minds of some, this lack of empirical rigour renders mental illness less plausible than medical illness. This presence of less scientific evidence is indicated in the Cartesian split (Lloyd 1996, see p5) between general medicine and mental health services. The French philosopher Descartes perceived the body and the mind as two separate entities, the former being comprehensible in terms of science whereas the latter could only be understood through introspection. An illness can thus be defined as either
somatic, of the body, or psychic, of the mind. Psychiatry has, since the 1940s, been defined as separate and different from neurology and general medicine as, although both sets of condition originate within brain function, mental illness exhibits through behaviour (Prior 1993). Therefore, although mental illness is medicalised it does not exist within the same paradigm as physical illness.

Despite political and service rhetoric the Cartesian dualism between mind and body divisions exists and perpetuates both in professional education and speciality and in service provision (Harrison 2006a) and although we have moved away from the rural asylums, services for those with mental and physical illness remain largely separate. A gulf between the philosophies and behaviours of general and psychiatric nurses was recognised by Peplau (1964). When presented with a patient with a headache, the general nurse assumes a physical cause and the psychiatric nurse assumes an emotional link, neither readily considers that which is seen to be within the territory of the other.

Those who defend the position of medical psychiatry, as founded in positivist science, cite the efficacy of pharmaceutical intervention as evidence that bodily chemistry must have been disturbed in order to be remedied. However, critics suggest that suppression of symptoms does not necessarily mean that they have been cured through intervention. The lack of recordable signs of disease, that is bodily markers such as changes in blood pressure or skin pallor, rather than perceived symptoms exhibited through what one says or does, is seen as a fundamental problem in firmly placing mental illnesses as biological diseases. The most notable in such criticism was Thomas Szasz (1966) who defined mental illness as a myth. Szasz believed that for an illness to exist it has to be perceived as such by both the doctor and the un-well person, and it must have a clear cause and signs. He suggested that the attribution of a medical diagnosis to certain forms of behaviour, notably hysteria, served to exonerate people from responsibility for their behaviour.

This position contradicted that of Charcot who sought this very differentiation in order to medically define hysteria (Busfield 2000), thus defining people as unwell rather than as
malingering. Such an attribute, that is one of medical illness, aligns the “patient” within the sick role (Parsons 1951) and, as such in need of treatment and deferring to the expertise of the medical profession. Mental illnesses were, Szasz (1966) believed, created through moral and political necessity rather than in the presence of scientific evidence; physical illnesses are discovered whereas mental illnesses are invented, he asserted.

This deconstruction of the biological model of mental illness is clearly extreme and, as such has been much criticised particularly due to Szasz’ assumptions that treatment always occurs without consent due to the lack of awareness of the problem in the person affected. Many people accept treatment for mental illness readily (Prior 1993) and organic signs are often present (Pilgrim and Rogers 1999). One can have diabetes without clear cause and one can have a headache with no visible signs. However, the argument that diagnoses are used as forms of moral judgement and social control is evident in changing patterns of psychiatric diagnoses in line with the political and moral thinking. For example, neither having children out of wedlock nor homosexuality are currently defined as mental illnesses, but they once were. Conversely new psychiatric diagnoses emerge, arguably in response to the demands of society. Hence hyperactivity (attention deficit disorder) and situation specific stress (post-traumatic stress disorder) have become classified as psychiatric illnesses (WHO 1993).

Current services for people with mental health problems are based upon the assumption that the identified disease can potentially be cured. Doctors, and other mental health workers, seek to identify people and their problems through diagnosis and subsequently prescribe a course of action aimed at curing or easing the position (Pilgrim and Rogers 1999). For example Box 3.1 shows the diagnostic criteria for depression as defined by the World Health Organisation in the International Classification of Diseases, tenth version (WHO 1993). When a person is diagnosed as having depression the practitioner may prescribe anti-depressant therapy and anticipate amelioration of symptoms, for example, sleep patterns and appetite may improve.
Much of the research evidence and literature about mental health and illness reflects the dominance of the illness framework, for example, a recent publication on depression in later life (Manthorpe and Iliffe 2005) seeks to provide a broad conceptualisation of the condition, suggesting that biological, psychological and social models are not used in isolation from each other and, in practice, a combination of approaches are used. However, the majority of the text goes on to describe depression and its treatment from the predominant perspective of mental health service providers, in absence of sufficient evidence from other perspectives to do otherwise. The authors acknowledge that this imbalance is due to a dearth of research into other approaches and perspectives.

**Box 3.1 F32 Depressive Episode (WHO 1993)**

For more than 2 weeks, the individual usually suffers from depressed mood, loss of interest and enjoyment and reduced energy leading to increased fatigability and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are:

- A – reduced concentration and attention
- B – reduced self-esteem and self-confidence
- C – ideas of guilt and unworthiness (even in mild type of episode)
- D – bleak and pessimistic view of the future
- E – ideas or acts of self-harm or suicide
- F – disturbed sleep
- G – diminished appetite

Joan Busfield (2000) suggests that the hierarchical position of medicine in determining and dominating the disease agenda is helped by recent advances in science, notably genetics, which indicate the likelihood of biological influences in the development of mental illness. She goes on to emphasise the position of doctors as powerful and also suggests that, for people with mental health problems and for society, the diagnosis of a disease holds attraction as it suggests that there is a problem in the body rather than in the individual or in the wider society. Responsibility therefore lies with neither the individual nor the dominant culture. Crossley’s (2000) view of emotion, psychiatry and social order suggests that when emotions are seen as inauthentic, insincere or abnormal, they are perceived as a threat to social order. If the deviance cannot be brought back into
line, psychiatry is asked to step in. The “illness” becomes an objective medical reality, independent of external influence. It is owned as a mental health problem and addressed solely as such. Proposed changes to mental health legislation (see p44) appear to reflect this element of social order by aspiring to lock away people who are perceived to be a risk.

Up until now I have described a purist medical perspective; however it is currently rare for any psychiatrist to claim that explanation for mental illness is founded in biology alone. More often practitioners take an approach that encompasses some combination of the theory explored below. Although there is now a preference to talk in terms of mental health problems rather than psychiatric illness, as I do in this research, the medical model continues to hold the dominant power and continues to carry enormous political and professional credibility and authority (Beresford 2002) in the way that services are legislated for and organised.

Here I have described the historical domination of psychiatric diagnosis as the determinant of treatment and of the mental health service provided. In recent years however there have been moves towards perceiving mental health problems as more than a diagnostic condition that can be medically treated and more as a social condition with which one can be enabled to survive.

3.4 New Perspectives in Mental Health Service Provision

There is a growing body of evidence examining alternatives to the medical approach in the care and support for people with severe mental health problems, such as schizophrenia, as defined within the National Service Framework (DoH 1999). The Tidal Model, as described by Phil Barker (2001), encourages practitioners to help those with mental health problems to ride the highs and lows of their mental health problems, and to develop methods of coping with their disability. Such a “Recovery Model” (Armstrong 1993, Repper and Perkins 2003) describes a philosophical approach aimed at enabling people, who are disabled by a mental health problem and the associated social stigma and
exclusion. The approach aims to help people to use their capabilities and personal attributes in order to become comfortable with their problems, rather than striving against the deficits attributed to them through diagnostic definition. Such approaches operate in tandem with the use of medication, prescribed in line with medical diagnosis. I explore the application of such models, as they relate to dementia care, in the next chapter.

In looking towards the development of these, more social, models of mental illness that oppose the dominance of the medical model, activists are engaged in considering the applicability of the social model of disability to mental health problems whereby mental distress is perceived as something that incurs social barriers, discrimination and oppression, as opposed to being seen as pathological and inevitably tragic (Beresford 2002). As described within the recovery model, focus is placed on normality rather than difference. The disability movement has facilitated marked improvement in social inclusion and it is anticipated that a social model of disturbance of mind and distress could do likewise for those with mental health problems. There is currently much political activity aimed at promoting social inclusion for people with mental health problems (Social Exclusion Unit 2006). In the field of dementia Jane Gilliard (2002) suggests that dementia should be seen as a disability rather than a disease as I go on to discuss in Chapter 4.

However, despite such efforts, and works by sociologists in the past, for example Brown and Harris's (1978) work on social influences in depression, the field of research around mental health and illness remains dominated by pharmacology and genetics. A call for more research that incorporates the psychological and the social is needed in order to redress this imbalance (Busfield 2000).

Mental health practice trends, with regard to non-medical approaches, change with time and dominant theory. Schools of thought vary from the psychoanalytical to the cognitive behavioural, to the person centred approaches as described within the recovery model, above, and by Tom Kitwood and others with regard to dementia (p95). Although such models are growing in influence and application they remain a lesser force than that of
biological psychiatry. Within National Health Service settings associated therapies and philosophical approaches still tend to be adjuncts to medical intervention and recommended through a system within which medical psychiatry dominates and prescribes. I now move on to look at some of these approaches.

3.5 Psychological Perspectives

There are many streams of psychoanalysis, which I do not explore here particularly as such approaches remain the exception rather than the rule in the UK. The underlying principle of psychoanalytical approaches is that the mind is separated into the conscious and the unconscious and that mental health imbalance occurs when the conscious and the unconscious are out of alignment. Therapy aims to examine cause, by exploring personal history, and thus improve self awareness and ability to cope with one’s inner conflicts. The main criticism of these approaches is that, like biomedicine, they assume a single explanation for distress. In the medical model this is biological imperfections and here it is imperfections of the mind. As well as minimising the impact of biology it also fails to account for here and now social pressures that may be causative in distress.

Cognitive and behavioural psychology provides an alternative to the psychoanalytic school by viewing mental distress in terms of precursors and response (Lloyd 1991). Mental health problems are defined within behavioural psychology, as exhibited through maladaptive behaviour, outside the realms of normality for society. This correlates with the popular view as discussed above. In using this approach, therapists consider both the cause and the inability to cope or adapt, particularly in the presence of life changing events, such as bereavement or illness. How one can adapt is examined and treated in terms of life experience, thought and behavioural responses. Cognitive behavioural therapy addresses thoughts, feelings and actions by examining those thoughts and behaviours that provoke the "maladaptive" presentation (Kennedy 2000).

In recent years the use of cognitive behavioural approaches have increased in mental health circles with recent innovations focusing on the use of this approach for helping
people with psychosis address their distress (Kingdon and Turkington 2002). It is recommended as the treatment of choice, in combination with medication, for depression, and particularly for depression in old age where research studies have shown clear efficacy (DoH 2001a, NICE 2004). However, while there is growing evidence around the efficacy of cognitive approaches in addressing psychiatric symptoms (DoH 1999, 2001a) concern centres on the medicalisation of the approach in that treatment is initiated following medical diagnosis thus the parameters of normality and abnormality continue to be defined within the medical paradigm.

Up until this point in this chapter, it is apparent that there exist, according to the literature, two core and diverse conceptualisations of mental health problems: the popular lay view of social badness and the medical view of biological disease. However, both in the popular and professional views, I have noted some potential for variation and ambivalence. For the general public there seem to be some problems, particularly when they are within one's own social network, which are not as bad as being properly mentally ill. For professionals, approaches such as cognitive behavioural therapy and recovery models suggest that medical diagnosis may not be seen as the sole descriptor of the phenomenon.

I now move on to examine how sociological theory fits in with the discussion so far. I have already discussed the labelling theory as it pertains to stigma (p48).

3.6 Sociological Perspectives

Sociological theories on mental health and illness vary with the differing sociological philosophies. Examining this literature underlines the nebulous nature and lack of clarity around what constitutes a mental health problem.

The Durkheimian structural description of mental illness is one of social causation. Social forces determine social life, thus mental illness is defined as that which is abnormal, in order to strengthen the position of the normal (Busfield 2000). The starting
point, in relation to mental illnesses, is the medical diagnosis with social causes attributed to various diagnoses. In their seminal work Brown and Harris (1978) explain depression, for women, in terms of socially generated vulnerability and loss, for example with poverty and adverse life events being cited as causative. Indeed social disadvantage is often seen as causative in mental ill health with Bury (2000) noting that class and gender are often cited, with age being less so. Others note race and ethnicity as causative in light of the over representative presence of the non-white population in admissions to psychiatric services (Blackmore and Boneham 1994).

Alongside this definition and categorisation, a system of social control exists in order to aid the smooth running of society. Arguably therefore this is not a theoretical perspective of mental illness at all, merely a further examination of an assumed biomedical reality and the resultant behaviour of society. The attraction of theories of social causation to psychiatry is that it adds empirical rigour to the discipline in the absence of biological evidence, as discussed above.

As discussed in Chapter 1, the social constructionist view seeks to identify the taken for granted view, and acknowledges that such a view is dependent on context, culture and geography. How mental health problems are socially constructed is a product of individual perceptions in the presence of wider societal influences; where one lives, the specific social setting and the laws that govern the definition and social processes. Thus mental illness in England is different to mental illness in another country, and mental illness in a general hospital may be different to mental illness in the wider community.

Foucault (1974) talked of the interconnectedness between knowledge and perceived reality, defining the two as ever-changing with time and development, with no clarity that any one perception is any more real than another. Hence, the social construction of a thing, for example mental illness, is necessarily transient and nebulous and cannot consistently be construed as the product of society but rather as a combination of biology, individual characteristics and societal influences. Foucault, examining “madness and civilisation” (1967) described madness in terms of unreason and irrationality, linking it
with the combination of thought, feelings and behaviour in criticism of those who tended to concentrate on either the biological or the behaviour. Such unreason and irrationality may be noted in one place but not in another, by one element of society and not by another.

In an attempt to untangle the differing views about mental illness within social constructionist theory, Pilgrim and Rogers (1999 p19) describe three core elements. Firstly questions are asked about the existence of the phenomena at all, as asserted by Szasz (1966, see p52). Secondly examination takes place into the potential creation of the phenomenon by psychiatric knowledge and professional interpretation. Thirdly, issues of social control and conformity are examined as influential in a similar way to the exploration of structured dependency (p36). Hence in seeking to discover what constitutes a mental health problem in the general hospital setting, I need to see if such problems exist for those in the setting. I need to find out how mental health problems are defined and also consider the organisational and political systems that may influence the perceptions.

Stephen Hacking (1999) terms the original definitions of social retardation and madness as forms of social control, which due to liberalisation and an increasing focus on community integration have had to be modified with time in order to enhance acceptability, with an arguable aim of reducing societal fear. Such changing definitions of what constitutes a mental illness are reflected in changing policy and service boundaries, as I illustrate below.

Theories of social realism can be viewed as complementary to the description of constructionism, whereby one's perceptions of reality are influenced by some societal facts and structures. Such a position potentially perpetuates the status quo whereby the power of influencing societal view remains with professionals who weald scientific fact as the major influence. Social realist theorists use the term "social framing" rather than "social construction" (Busfield 2000) indicating that the concept, in this case mental illness, is placed firmly within a framework of perceived reality dependent upon the
historical and geographical context of the time. Framing is evident in the classification of
diseases and within mental health law. Those who argue in favour of framing, rather than
constructing, suggest that the framing approach is tighter and more precise (Busfield
2000).

In terms of mental health and illness, psychiatric knowledge and the use of law to manage
mental illness are seen as the major influence in society's perception of the phenomena
and are thus exaggerated and postulated further. Such a position is further embedded
through research that focuses on the professional rather than the popular perception, as if
it reflects a wider view. This seems to explain why current political imperatives, in
health and elsewhere, aimed at lay service user involvement, founded in the philosophy
of consumer power is finding it difficult to emerge into a position of power. As
discussed in Chapter 2, organisational and professional power dominate the agenda with
each reflecting and perpetuating the powerful position of the other. The consumer,
particularly if they are old and/or mentally unwell and thus defined as having lesser social
standing, remains submerged under the social constructions of medicine and organisation.

The potential criticisms of this approach are two-fold; firstly there is a danger that the
realist view focuses too heavily on the macro issues of society, for example on the
provision of mental health service, with insufficient attention to the micro perceptions of
those within the experience. Second is concern over the use of the word realism in that it
does not reflect the essence and fluidity of the changing social world that is fundamental
within its philosophy. To an extent this research seeks to take on a critical realist stance
in order to bring together understandings of mental health problems as 'real' in that they
have a physiology and a psychopathology, and the ways in which these underlying
processes are constructed and reconstructed in medical setting. I seek to discover
whether the perceptions of individuals, within a specific setting, are a reflection of a
particular view; that is whether people in the general hospital setting perceive mental
health problems in old age in the terms of psychiatric medical definition.
Before concluding this chapter, I consider how the political response to the social problem of mental illness, over the years, has been affected by or causative of perspectives of mental health and illness.

3.6 Political Perspectives

In Chapter 1 I described the historical development of mental health services in England. In this section I look at some of the political drivers as they are evident in change in service provision and thus in defining the political, and indeed legal, description of what constitutes a mental health problem. I draw the literature largely from the works of Kathleen Jones (1993) and Anne Rogers and David Pilgrim (2001).

Again I start at the time of the development of rural asylums. As I have discussed (p4) the establishment of these havens, following the Lunacy Act of 1845, separated the mad from other undesirables within society. It was anticipated that the peace, order and expert attention, from the emerging medical speciality of psychiatry, would restore them to social acceptability. Such separation was facilitated by the emerging definitions of mental illness by medical category, which at the time was often associated with immoral behaviour such as masturbation (Rogers and Pilgrim 2002 p43).

Once the public asylums existed the numbers of those within them, and therefore defined as being mentally ill, quadrupled (Scull 1979). Several reasons are cited for this escalation ranging from increasing incidence of mental illness to an increase in society’s will to be benevolent towards the unfortunates within it. Scull (1979) asserts, however, that the most plausible reason is that the new profession of psychiatry expanded the definition of what constituted a mental illness and therefore was required to treat more people. One may also suggest that medical psychiatry had an interest in developing a credible power base.

The descriptions of shell shock, as I further explore in the next chapter, during the First World War, served to bring depression within the scope for asylum care. Thus by the
1920s, the asylums were occupied by those originally defined as lunatics due to their socially unacceptable behaviour and those defined since, by psychiatry, as having neurotic and psychotic conditions (Jones 1993). In 1930, the Mental Treatment Act changed terminology and Asylums became Mental Hospitals, thus emphasising the definition of these problems as illnesses.

With the development of the Nation Health Service psychiatry, as a medical speciality, was granted equal credibility with general medicine. Psychiatric services formed part of the new organisation. In its inception it was anticipated that mental hospitals and psychiatrists would deal with psychosis, leaving neurosis to general medicine, but, as I have already noted when discussing the development of mental health services in general hospitals (p7), this did not occur. Psychiatric services maintained control of the mental health agenda. The Mental Health Acts of both 1959 and 1983 facilitated this broad, all encompassing focus, by using very broad definitions of mental illness. The 1983 Act excludes people whose condition is felt not to be medically treatable, for example alcoholism, learning disability and personality disorder. Those who fall into these categories are no longer deemed to be mentally ill. The Act also introduced the concept of dangerousness as the reason for compulsory detention, with those perceived as a risk to themselves or others potentially subject to compulsory detention and treatment.

Despite the major service changes brought about by the development of community models of care, and the resultant loss in service capacity to provide care for so many people with mental health problems, it was not until the publication of the National Service Framework for Mental Health (DoH 1999) that attention was politically drawn again to the differentiation between major and minor mental illness. As I have stated elsewhere, this document makes clear that, for adults of working age, a mental illness defined as needing specialist service is "severe and enduring", or to coin old terminology psychosis or lunacy.

It is evident that policy dictates what is organisationally defined as constituting a mental health problem. Such direction has an influence on society members or, one may argue,
society members have an influence upon the creation of that policy. That mental health services now only provide for the most severely unwell is in line with the general view of extremes of socially bad behaviour; however, the descriptors and definitions differ.

3.7 Conclusion

In this chapter I have outlined the various ways in which mental illness is viewed from differing social and philosophical perspectives. I suggest that it is not possible to claim that any one perspective holds more credibility or is any more "real" than any other. Examination of the literature suggests that one's perception of mental illness depends upon one's relationship with it. Thus professionals are likely to favour the dominant views integral to their needs in fulfilling their jobs. For health professionals this is likely to be a combination of the dominant biomedical assumption that mental illness is founded in biological structures, with a combination of the legal requirements of mental health law at the time. A popular lay view is more likely to reflect mental illness as unusual behaviour and social unacceptability, potentially influenced by images of dangerousness from the media. It is evident that perceptions of mental illness change with time and may be politically driven. However, the view of any member of society is likely to be influenced by the broad pejorative view rendering mental illness highly stigmatised and to be avoided.

It is my contention that the biomedical setting of a general hospital is a potentially confusing setting in which to work out what constitutes a mental health problem. The professionals who work there may work from a different paradigm from staff in mental health services and others in the setting. Patients and relatives, may have yet different views of what constitutes normality and abnormality in a strictly organised environment.

I also argue that the broad perspectives of mental health problems described in this chapter are not inclusive of perspectives about mental health problems in old age. They rather define, as is reflected in government policy, perceptions of the severe mental illnesses associated with "adults of working age" (DoH 1999).
In the next chapter I go on to explore specific perceptions, from the literature, around mental health problems in old age. I explore the literature around experiences of depression, dementia and delirium and consider how they are perceived. I spend more time examining dementia and depression, in the presence of a wider literature, particularly around dementia. As in this chapter I consider how perspectives have changed over time and consider whether or not mental health problems in old age are considered using the same criteria as described here.
Chapter 4

Perspectives of Mental Health Problems in Old Age

4.1 Introduction

In this chapter I examine the literature as it relates to perspectives on mental health problems in old age. I have already noted that much of the literature on mental health and illness does not separate issues as they pertain to older adults and yet policy has recently made clear demarcation by being specific about the issues for adults of working age. Here I particularly seek to examine potential contradictions between political, medical and lay perceptions of mental health conditions in older people as opposed to their younger counterparts.

On many occasions in this chapter I allude to the lack of research examining the issues of mental health problems in old age. However, within the last 20 to 30 years there has been a growing interest in the study of dementia, both from the biomedical and psychosocial standpoints. Arguably this focus has started to bring dementia out of the stigmatised cold and it is beginning to move towards being accepted as a social disability rather than a mental illness, as I go on to explore. The experiences of depression and delirium, on the other hand, are under-researched and, I suggest, without a clear place in the current state of service and psychiatric organisation. In biomedical terms they are both readily defined as illness but not necessarily recognised and addressed as such. This lack of attention, particularly of depression, runs counter to an escalation of the medicalisation and social acceptance of the stress related, readily diagnosed and treated condition in younger adults.

Before I explore further the perspectives and experiences of mental health problems in old age I start this chapter as I ended the last, by focussing on political direction in consideration of the impact on perceptions. Here I concentrate on the broad current political agenda as it pertains to health care and older people, highlighting the nebulous
position of this social group. Next I look at mental health service provision in general hospitals, considering how services have developed, and the literature around experience and efficacy. I then move on to consider depression as perceptions about it have changed with time, with its medicalisation applying to the general population but maybe not to older people. I explore the limited literature on delirium, or acute confusional states, before looking at the large amount that has been written about dementia, concentrating on that which pertains to the experience of people with dementia in the general hospital setting.

I conclude, as I did in the last chapter, that there is a clear differential in perceptions about mental health problems in old age compared with those in younger adults, with less clarity about what constitutes a mental illness in old age. Older people with mental health problems seem to have fallen out of the mental health agenda and have not yet arrived within the long term conditions agenda for older people with general health problems. The lack of research in this area, other than on dementia, is very evident. I particularly note that the construction of depression in old age is unclear.

4.2 The Current Health Agenda for Older People

I begin this section by examining service and policy direction from the perspective of medical psychiatry before moving on to look at policy as it relates broadly to the health care of older people. Lastly I consider the impact of these, possibly conflicting, agendas, on older people with mental health problems.

As described in Chapter 1 (p10), in the 1970s psychiatrists who sought to specialise in the treatment of older people, particularly people with dementia, formed a new specialism separate from their colleagues who worked with younger adults. In the years that followed clear division developed between these two groups with psychiatric career pathways developing consultants into a particular branch of psychiatry (RCP 2006). As community care developed in the 1980s and 1990s, discrete mental health services were
developed for each group with a clear demarcation based on the chronological age of 65. Such definition remained in place, largely unchallenged, until 2000.

Since the turn of the twenty-first century the UK government has, as part of its broad NHS Plan (DoH 2000) driven forward the programme of National Service Frameworks, aimed at prioritising and focusing attention on treatment and standards of care for targeted population groups. The National Services Framework (NSF) for mental health (DoH 1999) was much heralded as the vehicle to enable mental health services to improve into the new century. In line with bio-medically driven practice and the separation of services just described, the NSF focused on the perceived core business of mental health services, those for adults of working age. Of course this concentration of attention can also be attributed to the lay anxiety about societal risk and possibly also on institutional ageism.

As discussed in Chapter 3 (p43), popular perceptions of mental illness have long been associated with social badness and a fear of violence. As such the group of people with mental health problems who receive particular attention are those who, rightly or wrongly, are the most feared; that is younger adults with severe mental health problems and afforded diagnoses such as schizophrenia.

In arguing that institutional ageism was a feature in the development of the NSF for mental health (DoH 1999), I return to the theory of Structured Dependency (Townsend 1981). Older people have, it argues, through the ongoing direction of social policy, been focused into a subordinate social position of dependency and invisibility. I suggest that the focus on mental health issues for working adults alone is evidence that such exclusion continues.

This overt focus on adults of working age as the population group for whom mental health problems and services are an issue has arguably exaggerated the separation between services for younger and older adults. As directed within the NSF, services for younger people have concentrated their efforts on those with defined severe mental
illnesses, leaving older peoples' services unsure of their place in the psychiatric world. In a focus against potential ageist bias, there has been attention to ensure that those older people who have those mental illnesses, defined by psychosis as severe enough, continue to receive mainstream services and are not moved to older peoples' services as soon as they reach their 65th birthday. The questions that emerge concerns older people with mental health problems not perceived as severe enough.

Given that older people with mental health problems, and the service for them, do not now seem to fit readily into the core mental health service model, I now consider how they fit in with the policy direction for older people. I suggest that, in this agenda, it is the stigma of mental illness rather than that of age that serves again to exclude them.

The escalation in the population of older people, against a decreasing proportionate workforce and increasing health care costs, is, as I have discussed earlier, an issue of economic concern and, as such, is being addressed through focus on pension provision as well as through radical health service reform (DoH 2000, DoH 2005b, DoH 2006a). Reform aims at minimising the need for hospital care by encouraging healthy ageing and concentrating on the care of people with long term conditions at home. In terms of sociological theory, this political focus follows the work of Fries (1981) and subsequent others (e.g. Laslett 1989) who defined a period of "compressed morbidity" at the very end of life, preceded by a period of health in retirement, and potential social usefulness (see p18). Current policy seeks to ensure that those who have not yet reached their period of compressed morbidity avoid hospital admission, and that those who are experiencing chronic disease receive, as far as possible, the care they need at home, as is often their preference and as is economically desirable. The chronic diseases described include breathing difficulties, diabetes, kidney problems and others. Figure 4.1 describes diagrammatically the perceived nature and care requirements of people with chronic disease. The majority, at level 1, are able to manage with minimal care and guidance from health services. Changes in the provision of community nursing services address the needs of those who require higher levels of service, particularly those 5% in level 3.
who have complex needs, who receive intensive specialist care through “case management” (DoH 2005b).

**Figure 4.1 The Kaiser Permente Triangle. (DoH 2005b)**

Level 3: Case management – requires the identification of the very high intensity users of unplanned secondary care. Care for these patients is to be managed using a community matron or other professional using a case management approach, to anticipate, co-ordinate and join up health and social care.

Level 2: Disease-specific care management – This involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework.

Level 1: Supported self care – collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively.

DoH 2005b
It is interesting to note that the new service model for those with long term conditions replicates the nature of service for people with mental health problems, particularly as advocated within the National Service Framework (DoH 1999). That is, only those in the severest need require specialist intervention. However, the agendas do not come together, nor receive any cross-referencing with regard to approach. Issues of mental and physical health are not aligned. As I have already noted (p18), the work of Fries (1981) failed to define late life mental health problems within the concept of compressed morbidity. Neither are they specified within the policy for the management of long term conditions, even as it refers to neurological conditions. As with the division between young and old in the mental health agenda, this exclusion appears to reflect social stigma against the inclusion of mental health issues within the general health service paradigm.

It remains something of a conundrum that there exists national and international recognition that older people with mental health problems are a priority and yet this is seen as completely separate from the greater focus on acute general hospital care, emergency care, waiting lists and reducing bed occupancy and delayed discharges, although these latter are often older people with mental health problems. (RCP 2005 p40)

Box 4.1 National Service Framework for Older People (DoH 2001a)
Extracts from Standards 4 & 7

<table>
<thead>
<tr>
<th>Standard 4</th>
<th>Aim – To ensure that older people receive the specialist help they need in hospital and that they receive maximum benefit from being in hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through</td>
<td>Providing attention to acute confusion, depression and cognitive impairment. Training of staff in recognising and managing the needs of people with behavioural problems.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 7</th>
<th>Aim – To promote good mental health in older people and to treat and support those older people with depression and dementia.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through</td>
<td>Integrating services Accessible expertise Educating and guiding non specialists</td>
</tr>
</tbody>
</table>
The National Service Framework for Older People (DoH 2001a) went some way towards embracing the mental health agenda into mainstream concerns about health service provision for older people with mental health problems. It includes specific standards with one aimed at improving general hospital care, and another aimed at improving the recognition and care of older people with mental health problems. While there is evidence of some improvement in some geographical areas (DoH 2003a), the two standards (Box 4.1) have not generally been seen as inter-related and thus the intention of the integration of mental health provision within mainstream primary and general hospital care remains elusive.

In recognition that additional focus is required on the needs of older people with mental health problems, "Everybody’s Business" (CSIP 2005), a service development guide, again aims towards integration of mental health services for older adults and further reiterates the view that the assessment of mental health should be part of generic care. The message echoes the view that “as long as mental disorder is referred to a geographically and organisationally distant mental health service, on a consultation basis, it will remain the responsibility of mental health services rather than that of the general hospital” (RCP 2005). “Everybody’s Business” intends to encourage services other than mental health to embrace older people with mental health problems as part of their business and to address the issues that they bring.

“Our aim is to ensure that older adults with mental health problems, and their carers, have their needs met wherever they are in the system, without encountering discrimination or barriers to access”

(CSIP 2005 p5)

It appears that this, most recent, government guideline is evidence that political efforts are being made to determine the right place within a service model for issues related to older people with mental health problems to exist. Policy direction seems to be moving away from the inclusion of mental health within a psychiatric model yet such issues do not feature significantly in general health service provision. As I discussed in Chapter 2, this is evidence of the vying agendas of political power and bio-medical power, with
professionals and organisations seeking to hold onto their sphere of influence. As this thesis progresses I continue to explore where this leaves the older person with mental health problems, particularly when they find themselves in, traditionally, the "wrong" setting.

In this section I have highlighted that the issues of service for older people with mental health problems are not readily politically embraced within either psychiatric or general health service models at present. I suggest that this lack of focus renders people, already vulnerable due to the stigmas of age and mental illness, as even more powerless and potentially invisible.

Before I go on to look at specific mental health problems in old age, I will spend some time looking at the current models of service in place for those who find themselves in the general hospital setting. I make some comparison with equivalent services for younger adults.

4.3 Service Models

In Chapter I (p2) I described the differences between the traditional model of psychiatric service delivery for people with mental health needs in the general hospital setting and the consultation/liaison model. The latter emerged and developed as a service model, for younger adults, following the publication of "The Health of the Nation" (DoH 1992). This document highlighted high suicide rates in the United Kingdom and suggested the need for the increased presence of mental health nursing expertise within Accident and Emergency (A&E) departments in order to better address issues of self harm. In some areas such services have developed into large multi-disciplinary teams who provide comprehensive service for younger adults with mental health problems in the whole general hospital setting, not solely in A&E. Expertise focuses on the somatic elements of illness and the use of interpersonal skills in providing care for patients and education for staff. The proliferation of such services has lead to the establishment of a Faculty for
Liaison Psychiatry, as a sub-specialism, within the Royal College of Psychiatrists in 1987 (Lloyd and Mayou 2003, Molodynski et al 2005, RCP 2006).

In line with the political and social focus described above, services for younger adults are more evident than those for older people. However, this is out of line with the figures showing the incidence of mental health problems in general hospitals as being markedly higher in the older population who occupy most of the places available (CSIP 2005).

There are several potential approaches in providing mental health service expertise for older people in general hospitals. These are comprehensively described within “Who Cares Wins”, a Royal College of Psychiatry publication (RCP 2005) advocating for increased health service commissioning of such services. Here I concentrate on describing the two modes of intervention: traditional consultation and consultation/liaison being the modes in use at Glimster General and Chapley Hospital respectively.

“Traditional consultation” (Lipowski 1983a, Roberts 2002, Harrison 2006b) is described as reductionalist in theoretical background, based upon the predominant position, in medicine, that sees mental and physical problems as different in property and therefore requiring separate intervention (Roberts 2002) as discussed above. Using this philosophy the process of consultation is initiated by a formal referral from a physician to a psychiatrist. “Consultation involves diagnostic assessment and advice on management of a patient referred by a non-psychiatric physician.” (Lipowski 1983a). The intervention involves little contact with the consultee and is usually followed by a formal written report.

This method, of a consultation only approach, is a process with clear parameters. The consultee refers for an expert opinion; the consultant assesses and gives that opinion answering the question(s) asked, and there the process ends. The underlying theory here, as well as being indicative of perceived mind/body split, finds its basis within the power dynamics and rules of play between medical practitioners and their “lesser” colleagues. It thus serves to perpetuate the division and maintain the basis of power through expert knowledge.
The consultation/liaison mode of provision is based on an intergrationalist theoretical background (Roberts 2002, Harrison 2006b) whereby the patient is seen as having physical, social and psychological needs (Mayou 1991). Such an approach sits more easily within the philosophy of nursing, particularly psychiatric nursing, which has long subscribed to the concept of holism, a belief that the person is greater than a sum of his/her parts and that all behaviour is meaningful (Peplau 1964, Roberts 2002).

Using the consultation/liaison of service provision, referral, formally written or through informal discussion is made to the team, or an individual specialist, by any member of the referring team, or at the request of the patient/relative. The consultation/liaison response involves consultation, collaboration and liaison (Tunmore 1997, Roberts 2002, Harrison 2006b). Consultation, rather than the traditional once only patient assessment and advice, described above, comprises three additional activities as well as the diagnostic, assessment and care management advice described above. These were originally described by Caplan (1970) and have since been echoed by others (Tunmore 1997, Roberts 2002, Harrison 2006b). The liaison specialist may assist the consultee in managing difficulties with a case or situation through discussion, without directly meeting the patient. Secondly consultation may involve advice on service development. Thirdly administrative consultation occurs when advice is sought on how to manage a service. The collaborative element of the model is concerned with professionals working together, using their joint expertise, with the patient, to improve health and wellbeing. This involves an integration of the specialist whereby s/he becomes a proxy team member, often of many teams. Liaison is therefore defined as a bridge between services involving mediation. It involves a clear educative element, with an aim of sharing knowledge and skill and thus influencing the service provided. In terms of mental health practitioners, the main increase in service providers has been from mental health liaison nurses. Finally, here, I examine this perspective.
Some suggest that the major impetus, in using nurses to fulfill the liaison role, is coming from medicine, due to decreased junior doctors’ hours (Read 1998) or in order to absolve an unwanted and unpopular chore (Roberts 1997) saving medical time. This may be particularly so in view of the increasing demand, discussed above. Others suggest that developments in advanced nursing (Rolfe and Fulbrook 1998) are well suited to a speciality where a holistic approach and a readiness to cross professional boundaries are embraced (Stickley and Hall 1981, Roberts 1997).

Many claims, mostly unsubstantiated in research evidence, are made in favour of nurse led liaison/consultation service provision over the traditional consultation model. Nursing intervention is said potentially to affect mortality positively following hip surgery (Nightingale et al 2001) and reduce violent behaviour (Sharrock and Happell 2000). Catalan et al (1980) had earlier demonstrated that there was no difference in the ability of nurses and doctors in appropriately assessing those people who had harmed themselves. Various authors claim improved service due to the presence of a dedicated enthusiast, rather than a psychiatrist who is not a liaison specialist who may tend to be “perfunctory and hazy” with little recourse to the consultee (Lipowski 1983a, Roberts 1997, Harrison 2006b). Improved patient satisfaction is also claimed (Roberts 1997, Sharrock and Happell 2000). Being approachable and open to requests for advice, from professions other than medicine, is said to improve rates and pertinence of referrals (Sensky et al 1985). The accessibility of nurses is said to positively influence the knowledge and skills of general hospital staff (Roberts 1997, Huyse 2000, Royal College of Nursing 2000, Sharrock and Happell 2000) and their attitude towards mental illness (Roberts 1998).

In examining two general hospital sites, each using a different model of mental health service, I seek to consider any effect on perceptions of mental illness due to the nature of the service, particular with regard to education and perceived integration.
There is little literature on the nature and spread of specific models of service for older people with mental health problems in general hospitals. I summarise below two large and useful studies and note that they are both led, and draw their samples from, psychiatrists, excluding other service providers.

Both Huyse (2000), studying in Europe, and Holmes et al (2002), in the UK, report a wide and sporadic variety of services, few of which are perceived to meet demand and need. Both studies conclude that the majority would prefer a consultation/liaison model but use a traditional model. The barriers to change cited include achieving focus on the problems and in overcoming different management and logistical arrangements between service providers. As I have highlighted these, and other generated reports (CSIP 2005, RCP 2005), are led from the position of medical psychiatry. It appears that psychiatry, and NHS Mental Health Trust organisations are keen to dissipate the focus of their speciality by providing in-reach services to others, yet they are not ready to let go of control over the agenda. This seems to maintain division despite an apparent will to overcome it.

Notwithstanding the exclusivity of these studies, they highlight increasing interest in mental health consultation/liaison for older people and its focus on the “the 3 Ds”, depression, delirium and dementia. Others note that referral numbers are increasing by as much as 180% over 8 years (Anderton and Philpott 1991). Yet there remains consensus that gross under-recognition of mental health problems in old age in the general hospital setting is present (RCP & RCP 1995, DoH 2001a, CSIP 2005). Several studies have sought to determine the reasons for under recognition and referral, with suppositions that this is because mental illness is perceived as out of place, and therefore not sought as rationale for a person’s presentation. Alternatively it has been suggested that depression and confusion are seen as inevitable in old age and therefore seen as pointless to pursue (RCP 1995, Godfrey and Demby 2004). There is evidence that, despite under-recognition, under-referral may occur due to lack of co-operation between services and poor processes (Scott et al 1988) or because response is slow (Lloyd 1991). Referral may
be more readily made in order to remove a patient rather than to address need (Brooks 1991).

Despite a stated preference in favour of a consultation/liaison model for service provision for older people (Holmes et al 2002) supporting research evidence remains rare. Those studies that have occurred generally centre on the number and quality of referrals rather than on any experience and outcome for the user, their relatives or the service.

There is dispute about whether the presence of a consultation/liaison mental health service increases or reduces referral rate (Scott et al 1988, Anderson and Philpott 1991, Swanwick et al 1994, Collinson and Benbow 1997, Baheeratha and Shah 1999) with the difference probably due to the definition of a referral. That liaison provision improves the quality and specificity of referrals is agreed (Scott et al 1988, Swanwick et al 1994, Baheeratha and Shah 1999), with a supposition that this is due to the educational influence achieved through liaison. Further research is required to support evidence suggesting a reduction in waiting time (Collinson and Benbow 1997), improved recognition of mental illness, and decreased need to move to long term institutional care (Baheeratha and Shah 1999).

Few studies have attempted to calculate cost efficacy of improved psychiatric liaison. Most notably Strain et al (1991) demonstrated a reduced hospital stay, of 2 days, for older orthopeadic patients who had been seen by a mental health practitioner pre-operatively. John Holmes and Alan House have performed similar studies and replicated results in the UK (Holmes and House 2000a, 2000b). Baldwin et al (2004) conducted a randomized control trial looking at the effect of mental health liaison nursing intervention on diagnostic and outcome tool scores and on the use of psychiatric medication. They found a marginal improvement in the rates of diagnosis of depression and no measurable change around dementia or in outcome scores. There was no difference in length of stay or morbidity but there was an increased use of antidepressants. However, some methodological problems were noted to have potentially contaminated the findings in that it is likely that there was some cross-contamination particularly of the educative effect of
the role on staff who will have used their new-found skills on the control group. This highlights concern about using a randomized control trial as the sole method particularly when seeking to consider a quality of service and its effect on practice. These findings may begin to support the supposition of a positive educative value in liaison consultation models of service and the call for improved education for general nurses in working with people with mental health problems in the general hospital setting (Dormer 2004).

Along with limited research evidence there exists, as described above (Huyse 2000, Holmes et al 2002), much support for the development of mental health consultation/liaison services for older people in general hospitals. Mental health consultation/liaison services, for older people in the UK, remain a minority service, they are sporadic and often lead by individual champions (Roberts 1997, Holmes et al 2002). However, there is a proliferation of interest. As I have already highlighted this is evidenced in the course of this work. When I started considering sites that provided a consultation/liaison model of service in 2001 I could identify only two such sites. The increase in liaison provision is characterised not only by a marked increase in services, but also in research projects and the development of a national interest group.

In the US, despite reported wider provision of mental health consultation/liaison services, particularly for younger adults, a recent review was conducted to examine shortfalls in mental health service provision for older people with mental health problems (Bartels 2003). While conclusions do not draw comparison between the models of provision examined here, the report makes many policy recommendations particularly noting the detrimental effect of the fragmentation of physical and mental health service provision, recommending more shared services, and financing, and better generic education for those who work with older people. These suggestions are echoed by recommendations within “Everybody’s Business” (CSIP 2005), where a section is dedicated to advocating for improvements in this area.
In this section I have examined the development of mental health consultation/liaison services as they escalated from the agenda of reducing suicide in younger adults. The wider spread of services for adults of working age, and thus the investment of resources therein, again suggests a difference in political drive in addressing the needs of this population group.

I now go on to explore the literature as it considers the experience of mental health problems. Here I do not focus on those older people who have ongoing "severe" problems such as schizophrenia, as their needs are addressed within the broad mental health agenda, as discussed above. First I look at the issue of depression and consider how it has become defined as the acceptable face of mental illness, yet maybe not so for older people.

4.4 Perceptions about Depression

In this section I consider the historical development of depression as an accepted mental health condition noting the influences of both gender and age in the medicalisation of the phenomenon. It emerges that, despite vast movement in social acceptability, depression in old age barely features within the non-medical literature. It is this literature that I consider first, starting with the feminist perspective. I go on to look at the medical perspective.

4.4.1 A Feminist Perspective

Here I précis some of the significant literature on the gendered nature of perceptions and definitions of mental illness, focusing particularly on that which pertains to the medicalisation of depression.

For many centuries hysteria, the social condition that preceded depression, as it was later labelled, was "the quintessential female malady" (Showalter 1985 p33). Indeed the word hysteria is derived from the Greek for the womb *hysterion*. In the late nineteenth century
the condition, and its association with women, was the focus of much attention from the male dominated Darwinian psychiatric model of the time. They saw the nervous disposition of women as a natural part of the fragility of the female condition. The definition of hysteria as merely a gender specific condition was rocked in 1914 when World War One soldiers were seen to experience “shell shock” as a response to their traumatic experience. However, despite similarities in presentation, differential categorisation remained in place in order to perpetuate the perceived “absolute and natural” differences between men and women (Showalter 1985 p68).

During the equivalent World War 1 historical period the feminist movement was emerging. Women sought and fought for the vote and challenged the accepted role of female inferiority. As the twentieth century progressed and tranquilising medication was developed, attention towards the nervous disposition of women achieved further scrutiny. As I noted earlier (p4), the mental hospital population was predominantly female.

Noting that women continued to be more readily defined as neurotic, research and discussion on the reasons for the gender differential became the subject of much feminist research in the middle of the twentieth century. Potential explanations suggested that in defining women as mad, men continued to place them as second-rate citizens. Alternatively women may be diagnosed with an illness because they disclose their symptoms more readily than men. It is said that the male population are more likely to mask depression with alcohol use, and to exhibit anger rather than sadness/tears. Men are more likely to be institutionalised in prison for violent badness as opposed to social sadness (Ussher 1991). This is in line with gender and social expectation of the “stiff upper lip”. Depression as a diagnosis, Joan Busfield (1996) suggests, has become more about gender culture than biology.

In classic feminist research both Betty Frieden (1963) and Ann Oakley (1981) talk of the societal bonds that tied women, in the 1950s and 1960s, to the image of a gender-based requisite stereotype. Those who felt unable to meet the expectation, as the perfect wife and the perfect mother felt incompetent and inadequate, were labeled as neurotic. Doctors readily diagnosed these women as being depressed and prescribed tranquilising
medication, or mother’s little helpers (Rolling Stones 1967), to mask their feelings of inadequacy and help them get through their intolerable life style. In one study a third of all women patients, aged 45-59, of one GP practice were receiving such medication (Oakley 1981). This “problem that has no name” (Frieden 1963 p15) was the bond that held housewives into the lives that society demanded of them (Ussher 1991). The diagnosis and the use of medication were defined to be a form of social control. Although anti-depressants continue to be prescribed in large numbers, with prescription numbers increasing from 8.9 million in 1991 to 26.3 million in 2002 (Department of Health Statistics 2003), I have not uncovered more recent research considering any ongoing potential rationale suggesting that such treatment continues to be used as a form of social control for women. It is interesting to note that the cohort of older people, mostly women, who I have interviewed for this research are potentially of the same generational cohort as Frieden and Oakleys’ women in the 1960s.

I seek to investigate the experience and perceptions of depression for older people in the general hospital setting, and to consider whether or not it continues to constitute a form of social control associated with gender, and also possibly with old age. I consider their different social position, as it is now and as it was in the 1950-60s, as I explore the phenomenon of depression further in Chapter 7.

Before I examine further the development of depression as a biomedical condition, since the recognition of shell shock, I consider depression as a social phenomenon from angles other than the feminist. I also consider age related differentials evident within the literature.

4.4.2 Depression as a Social Issue

There has been a proliferation of lay interest and acceptance of depression as a life experience as evidenced through media coverage in media chat shows, discussions in popular magazines and in lay literature (e.g. Cembrowicz and Kingham 2002, Massey 2004). It is acknowledged that more work days, 42% of the total, are lost to stress and
depression-related issues than any other (DoH 2005a). The social pressure and the demands of modern life are cited as causative. As Joan Busfield declared back in 1986 (p52) “society is the pathology, rather than the body or the mind”. Depression appears to have become the acceptable face of mental illness as evidenced by Lindsey Prior (1993) in relating that patients in psychiatric wards more readily acknowledged depression, and suffering with their nerves, but avoided being associated with stigmatized conditions such as schizophrenia (p47). General use of the word “depression”, to describe a feeling of being glum or fed up, is disappearing from lay vocabulary as it has developed into a medical condition.

I have already demonstrated the escalation in the prescription of anti-depressant medications, with a particular increase since the introduction of the newer anti-depressants, such as Prozac. The escalation has lead to descriptions of a “prozac generation” (Marchant 2000) who are readily defined as being medically and therefore biologically depressed. There is, however, no evidence of an equivalent acceptance of depression in old age as evidenced either in drug prescribing or in the level of social attention.

A conceptualisation of depression as multi-faceted and with multiple potential causes is shared with those from both sociological and bio-medical persuasion. Notable in terms of focus on social aspects are the works of Brown and Harris (1978) and, for older people, Elaine Murphy (1982). The latter demonstrated that depression in old age is caused by significant life events and that such events are often related to failing physical health and material adversity. One could possibly add the adversity of being old within an ageist society that has structured the dependency of older people (Townsend 1981) as causative of depression. Several other authors allude to ageism as a factor that causes under-identification (see Godfrey and Denby 2004, Manthorpe and Iliffe 2005) in absence of any more recent research evidence.

Brown’s work was concerned with younger women, in England and internationally. Like the feminist authors already discussed, Brown (1996) describes specific examples of
humiliation and entrapment that he sees as rendering women at high risk of depression. Interestingly these can be readily transferred to the experience of hospitalisation due to ill health in old age. For example, he talks of people being forced into a subordinate position, feeling defeated, of having one’s value undermined, and of having escape blocked. Such experiences could be attributed as common with the experience of being a patient, trapped within an alien organisation and environment away from one’s friends and family. It has also been argued that depression can occur due to lack of stimulation within the institution (Pitt 1988).

Like Tom Kitwood, describing the components of dementia (p95), Brown produced a formula for depression demonstrating its multiple causes. He included the biological element alongside the findings of his research demonstrating that some women are more resourceful than others in dealing with adversity:

\[
\text{Depression} = \text{significant life event + psychosocial vulnerability + sense of defeat or hopelessness (possibly + poor potential to cope) + depletion within brain chemistry.}
\]

Both Brown and Harris (1978) and Murphy (1982) note the importance of strong social and emotional support, in the form of a “confidante”, as protective against depression. A confidante is the one person in the world, in whom one can confide and share every day worries and concerns. Such support is often received from a spouse or a close friend of one’s own peer group and is often lost in old age. Such a confiding relationship is much less commonly found between family members from different generations. Relatives from another generation tend to offer more practical functional support (Norbeck 1991). In old age, particularly if a person is in an institution, contact with friends and peers is often lost. Rather older people in institutions are visited by relatives who do not provide the level of support that protects against depression (Cutrona 1990, Godfrey and Denby 2004, Boyle 2005).

It is worth noting here that generally perceptions of well-being are said to improve with age (Vincent 1999). However, this is not the case in the presence of health changes,
unless aids are provided to minimise the feelings of dependency and associated lower morale (Pilgrim and Rogers 1999). Some authors note that abuse may be influential in development of depression (see Pilgrim and Rogers 1999, Kennedy 2000).

Recently two publications have been dedicated to examine the issues of depression in old age (Godfrey and Denby 2004, Manthorpe and Iliffe 2005). They highlight the dearth of research in this area and, reflecting the gap in non-medical research, tend towards examination of biomedical perspectives. Notably, neither makes reference to depression as it may exhibit in the hospital setting, nor have I discovered any such research elsewhere.

Godfrey and Denby (2004) in their review of the literature on depression in old age, describe stressors and protecting factors in relation to the risk of development of depression in old age. Building on the work of Murphy (1982), Prince et al (1998) focused on issues of poor mobility and pain as social isolators that remove one from social situations in which that essential "confidante" support is received. Neither retirement nor being alone increase risk of depression, but self perception of loneliness does so. Those who maintain high levels of self-esteem, personal resilience (Zarit et al 1999) and adequate levels of reciprocal social support, from peers and friends rather than family (Coleman et al 1998), are protected, with perceived acceptable quality of life being the key.

There is a view that the occurrence of depression is influenced by personality, or high neuroticism (Ormel et al 2001). The way in which one adapts to change and stress is supported by the assimilation and accommodation model described by Brandtstadter and Greve (1994, cited by Coleman and O'Hanlon 2004 p164). As discussed earlier (p20), Brandtstadter and Greve suggest that, in extreme old age, or debilitated old age, there comes a time when the results of ageing and illness are accommodated rather than striven against. Older people often do not describe the obvious symptom of low mood and may talk about death and pessimism in absence of depression (Katona et al 1995).
Geraldine Boyle (2005) examined the impact of loss of autonomy on mental ill health in older people receiving care at home and older people in residential care. She found more mental ill health, in the form of depression, at home than in institutions alluding to the importance of the social support of one's peer group. She discovered correlation between loss of decisional autonomy and depression. These findings, together with consideration of the assimilation model, are interesting and could suggest one of two possible explanations, both of which I explore as I move through the data and analysis. Medical research suggests that the incidence of depression is higher in institutions than it is for people at home receiving care (Godfrey and Denby 2004). However, it appears that maybe, in care homes, people are less depressed possibly having found new confidantes, as Boyle suggests. Alternatively we may consider that it is possible to cease being depressed as one moves towards the end of life. When one is at home the feeling of loss of autonomy, in one's own world, is acute, whereas in a care home one becomes resigned to this loss of self. Depression may be different, or not exist so readily, for those in the fourth age, as discussed in Chapter 1 (p18), which Joan Erikson would argue is part of the life resolution towards death. Clearly specific research is required to fully consider the impact of these differing social positions. I continue to explore the issues further.

Before going on to consider the gaps within this literature that I seek to explore, I now look at the biomedical perspectives on depression.

4.4.3 A Medical Perspective

As I have already suggested, the medicalisation of depression, by psychiatrists, emerged following the recognition of shell shock in 1914 (Showalter 1985) and became entrenched. Medical intervention, in the form of tranquilising, anti-depressant medication and electro-convulsive therapy developed through the twentieth century.

In medical terms depression is described as an illness of biological, genetic and circumstantial cause, leading to feelings of extreme unhappiness and hopelessness (Katona et al 1995). Depression ranges from "minor degrees of sadness, to feelings of
complete dejection and hopelessness accompanied by a gross degree of pessimism” (RCP 2005). Box 3.1 describes a diagnostic model for depression, defining the requisite symptoms which must include either low mood or anhedonia, loss of interest in one’s usual pleasures. Depression is said to be the most common mental health problem affecting one in five of the population over the life course; it has been noted as the second most debilitating international condition, second to heart disease, with incidence escalating (Depression Learning Path 2006). The definition of depression is generic across population groups. In language, depression has become a medical diagnosis rather than a feeling of emotion. It is now owned by medical psychiatry as its own, and is therefore within its realm of influence.

Depression in old age occurs at the same rate as it does for younger people, at 10-15%, with age itself not causative (Manthorpe and Iliffe 2005). Figures for prevalence and incidence of depression differ widely dependent on research methodology. However, prevalence increases in the presence of a physical health problem with approximately 25% of older people in hospital being depressed (Anderson 2001, RCP 2005). Figures increase further, to approximately 40%, for those in long term institutional care (Godfrey and Denby 2004).

Various research has suggested a higher incidence of depression in the presence of thyroid problems, cancer, chronic pain, heart disease, parkinsons disease, malnutrition and following stroke (Katona 1994), though clear evidence is sometimes lacking (Manthorpe and Iliffe 2005). Conversely depression may be the cause of physical health problems because of the poor compliance with prescribed medications, reduced biological activity and a weakened immune system (Mayou 1991, Kennedy 2000, Godfrey and Denby 2004). The presence of depression has a major impact, not only on the older persons’ quality of life, but also on recovery rates, rehabilitation potential, institutionalisation rates and indeed on mortality. Without treatment, depression in old age produces high levels of both morbidity and mortality. A depressed unwell person is two to three times more likely to die, having experienced a similar physiological event, than a non depressed person and this is not explainable in terms of physical health.
condition (O’Brien and Ames 1994). While the biomedical literature tends to focus on symptomology and physical treatment options, it also widely acknowledges clear links to pain, disability, loss and poor social support (Godfrey and Denby 2004).

Many papers, for many years, have described the under-recognition of depression in old age, particularly when it occurs alongside physical health problems (Koenig et al 1988, Katona 1994, Shah and De 1998, Anderson 2001, Kivela 2001) with some going on to detail the lack of sufficient evidence of efficacy of treatment once the condition is identified (Draper 2001). Holmes et al (2002) suggest that 75% of depressed older people in hospital do not have their condition recognised, with others suggesting a detection rate at only 15% (Godfrey and Denby 2004) and, an even lower, 8.7% (Rapp et al 1988).

Although practitioners claim to have the knowledge and skill to recognise the condition (Rothera et al 2002), evidence suggests that they do not do so (Rapp et al 1988, Grout 1997). Several possible reasons for this under recognition have been cited. For example, it is argued that several of the indicators for depression are present in older people with physical health problems due to their general frailty, for example poor appetite and poor attention, and are therefore attributed to general health rather than mental health deficits. Older people often do not describe the obvious symptom of low mood (Katona et al 1995). Several authors allude to ageism as a possible factor in under identification, with a societal assumption of the inevitability of being circumstantially depressed in old age (Boyle and Chambers 2000, Godfrey and Denby 2004, Manthorpe and Iliffe 2005).

In terms of biomedicine, proponents note that depression is influenced by the imbalance of chemicals within the brain and thus, although social causation is acknowledged, pharmaceutical intervention is required in order to redress that balance (Busfield 1986, Katona 1994, Phair 1999, Evans and Mottram 2001, Manthorpe and Iliffe 2005). Despite empirical and anecdotal evidence of social causation, explored above, physical intervention remains the primary form of treatment. Recent government guidelines for the treatment of depression, once it is identified as lasting, recommend a combination of
pharmaceutical and talk therapies (NICE 2004), although it is widely recognised that the latter are not readily available (Anderson 2001, Manthorpe and Iliffe 2005).

4.4.4 Concluding on depression

As discussed in considering social policy above (p12), there exists potential ambivalence about how depression is classified and addressed within the scheme of service provision. The National Service Frameworks for Mental Health and for Older People (DoH 1999, DoH 2001a) do not generally designate depression as a severe mental illness and therefore it is deemed the clinical responsibility of primary and non-specialist health care services. Referral to specialist mental health services is advised only if treatment fails to address the problem or presentation carries significant risk to the person with depression or to others.

The literature suggests that depression has become accepted within the general health paradigm for younger people. It is less clear as to whether depression in older people sits in a parallel position. The levels of under recognition may suggest that it is less socially accepted in old age. The literature and policy direction suggest that depression in old age may sit in a limbo position, under researched, under recognised and not clearly represented within the social, general or mental health agendas. It is this apparent gap that I seek to explore.

I now go on to look at the literature on the second of the three Ds, as described within liaison psychiatry circles (Holmes et al 2002), that of delirium. This literature, like that for depression in old age, exists almost exclusively within the biomedical field.

4.5 Delirium

In medical terms delirium, or acute confusion, is diagnosed in the presence of impaired thinking caused by disruption to normal brain function. It differs from dementia in that, once the cause is established, the condition is reversible. However, the condition may
become permanent if the cause is undiscovered and unattended (Phair 1999). Delirium is usually sudden in onset and is accompanied by disturbances in consciousness; attention difficulties and marked fluctuation in presentation, none of which are noted in people with dementia alone (see Box 4.2). In terms of diagnosis, delirium is differentiated from dementia by conducting physiological tests and gaining a clear history about the speed of onset and the degree of change from normal health and behaviour. There are a multitude of possible biological causes ranging from systemic infection to direct head trauma, the most common causes include changes in drug consumption, heart attack, stroke, the spread of cancer, chest infection, urinary tract infection, anaesthesia and alcohol withdrawal (Taylor and Shah 2001). Between 10 - 30% of older people admitted to hospital either have delirium at the time of arrival in hospital, or will acquire it during their stay (RCP 2005). People with dementia, with already vulnerable brain function, are at higher risk of developing delirium in response to physical illness, drug intoxication and/or psycho-social stressors (Phair 1999).

**Box 4.2 Diagnostic Criteria for Delirium**

A. Disturbance of consciousness (i.e. reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention.

B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a pre-existing established or evolving dementia.

C. The disturbance develops over a short period (usually hours to days) and tends to fluctuate during the course of the day.

D. There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition or substance.

American Psychiatric Association DSM-IV 1994
I have discovered little literature on the subject of delirium other than within the medical health field. Non-medical texts on dementia mention delirium rarely (Phair 1999, Cantley 2001, Adams and Manthorpe 2003, Bradbury et al 2004, Redfearn and Ross 2005) and solely in a medical context, or not at all (Adams and Clarke 1999, Stokes 2000, Jones and Meisen 2004) even when they are considering issues associated with general medical needs and hospitalisation (Norman 2003, Watson 2003). Similarly Anthony Harrison (2006a) in considering how general nurses can provide skilled care for older people with mental health problems, describes delirium from a medical positivist perspective.

A review of the literature on intervention strategies for delirium was conducted by Milisen et al (2005) and uncovered just one qualitative research study into the experience of delirium, and no studies that considered the efficacy of interventions from the perspective of the people who experience delirium themselves, or from the perspective of their families. Irene Schofield (1997) used semi structured interviews to consider the experience of older people following an episode. She found that, contrary to earlier literature supposition, older people did not fear that they were experiencing the onset of dementia or madness although they described feelings of acute transient fear. They did feel that others, notably staff, assumed a permanent change and treated them as though they could not understand anything. Although there was some evidence of a need for greater engagement and information from staff during the period of confusion, most of the participants didn't seek information or search for explanation once the episode was over. In one study that involved interviewing family members, it was noted that information about the speed of onset and change from usual presentation was not sought or noted by clinical staff (Fick and Foreman 2000) despite the acquisition of such information being key to diagnosis and treatment. This finding supports the view of Irene Schofield's participants who felt that it was assumed that they had dementia and therefore a differential diagnosis was not sought. Several authors suggest that providing information to family members about the condition and prognosis is important (Schofield 1997, Meagher 2001, Milisen et al 2005), yet this recommendation is made in the absence of any supporting research data.
It is interesting to note that while delirium is so prevalent in old age, particularly in the
general hospital setting, it has received barely any non-medical research attention. It is
possible that this lack of attention is founded on its precarious position between medicine
and psychiatry. As a curable condition of clear biological cause, it sits soundly within the
paradigm of medicine, yet it manifests through behaviour perceived as outside the norm
and hence, especially in old age where a presence of inevitable cognitive decline is
assumed, can be seen as coming under psychiatry. Delirium therefore does not fall clearly
into either camp, and as such may run the high risk of being missed. The lack of research
data attention has also been attributed to methodological challenges, assumed to be
associated with gaining and identifying a sample and achieving consent (Meagher 2001).
It is clear that greater research attention is warranted, especially in the light of findings
that suggest that this life threatening condition undermines quality of life and is under-
recognised by hospital staff, especially in people with dementia (Inouye et al 1993, Fick
and Foreman 2000).

I now move on to the last of the mental health conditions of old age that I explore here,
the well-researched area of dementia.

4.6 Perspectives on Dementia

There is a wealth of literature on the subject of dementia, particularly in the last twenty-
five years. This increase has been fuelled by several different yet converging drivers that
have brought research funding for both medical and psychosocial projects. The social
and political perceptions about population change as discussed in Chapter 1 produce fear
of the impending cost of caring for the growing population of people with dementia.
Such cost can be counted financially, for the economy, and emotionally, for informal
carers at home (Wilkinson 2002). This perception is enhanced by the more visible
presence of people with dementia in settings where they were not previously seen, for
example, in general hospital wards rather than in long stay institutions.
Unlike depression and delirium, issues around dementia and dementia care have received a great deal of attention. Although medically it continues to inhabit the paradigm of old age psychiatry, there is some evidence of a shift towards a position of social disability. Non-psychiatric care readily occurs for people with dementia both at home and in the care home sector, as reflected in the broad literature (e.g. Cantley 2001, Killick and Allen 2001, Adams and Manthorpe 2003). My purpose in exploring and targeting the literature on dementia is to begin to consider how it relates and may influence perceptions within the general hospital setting, an area that has received little research attention to date.

In this section I consider dementia and the experience of dementia first from the biomedical perspective and then by looking at psychosocial approaches. I concentrate my examination on that which may be transferable to the general hospital setting and consider how dementia is perceived.

4.6.1 Dementia - the Medical Context

In medical terms dementia describes a group of illnesses, predominantly occurring in old age, characterised by deterioration in intellectual function alongside changes in personal and social functioning (McKeith and Fairbairn 2001) in the absence of a diagnosis of delirium. There are many different types of dementia, defined by differing causes and variation in symptomology, with Alzheimer's Disease being the most prevalent, followed by Vascular Dementia and Lewy Body Disease. Although medically defined discretely I use the generic term both in this chapter and throughout in the thesis. However, it should be noted that, in some contexts, the term dementia is seen as interchangeable with Alzheimer's Disease.

Alongside the increased attention, arguably fuelled by social and political interests, dementia has become increasingly medicalised since the 1980s. Post mortems more readily show the presence of plaques and tangles within brain tissue, those neurological features that Alois Alzheimer noted in identifying the disease early in the twentieth century. The ongoing development of the use of brain scanning is also cited as
fundamental in medicalisation (Adams and Bartlett 2003). Prior to the 1980s, a
generalised diagnostic term of senile dementia had been attributed to older people with
failing cognition and, in line with the Latin definition of *demens*, people with dementia
were accepted as beings without minds. In the past three decades specificity in diagnosis
has increased. Although some aspects of presentation apply across diagnoses, memory
changes, disorientation, emotional, behavioural and functional and intellectual change,
they do so in differing intensity and degree. Alongside the increased identification of
dementia as a medical phenomenon has been an increase in research examining causal
factors, genetics and possible pharmacological intervention (McKieth and Fairbairn
2001).

The focus of medical and health service intervention for people with dementia is
threefold. Firstly early identification of problems is encouraged in order that differential
diagnosis can be considered before introducing cognitive enhancing medication, aimed at
slowing and deferring the disease process (Adams and Bartlett 2003). This form of
intervention is not without ongoing controversy with dementia champions advocating for
widespread use and politicians more reticent in accepting the cost efficacy of these drugs
(Alzheimers Society 2006, NICE 2006). Early intervention for people with dementia,
and their families, is also favoured in order to assist all those involved in coming to terms
with the issues and receiving timely information about options open to them. Such early
identification rarely occurs in the general hospital setting (RCP 2005).

The second medical focus is on control of behaviour. Medication is often prescribed in
order to counteract behaviour and emotion perceived as challenging to those who provide
care. Such behaviour may exhibit in agitation, changes in sleep pattern, frustration or
aggression. Thirdly focus concentrates on how and where future care should be
provided, with professionals offering advice and making judgements on the person’s
ongoing ability to live independently or with the support of their family or other
supporters. The ability of the person with dementia to express their own view on such
issues has become an issue with the growth of consumerism, the Capacity Act (OPSI
Despite this latter emerging field of attention, health care for people with dementia is generally paternalistic and disempowering. People with dementia are done unto rather than involved in their care or their future. Several authors consider why people with dementia are so socially excluded, even from involvement in issues that directly affect their health and well being, and conclude that the exclusion is evidence of intolerance within an "ultra cognitive world" (Adams and Bartlett 2003 p5) where those with lesser thinking capacity are discarded and seen as valueless. Because they have lost their mind, they have lost their place in the social world (Gilleard 1992). In such a world the role of a service becomes one of control and curtailment whereby people with dementia are removed from society literally in institutions and socially through lost interaction (Spicker 2000).

The view of family carers, about whether they perceived their loved ones to be socially dead was considered by Sweeting and Gilhooly (1997). They found that perceptions were dependent upon the nature of the relationship between the carer and the cared for, with those with closer relationships less likely to perceive social death. Perception was also noted to vary dependent on the ability to conduct a social conversation, recognise significant people and retain good physical health.

A picture is emerging of a medical condition that renders one socially inept, except possibly in the eyes of one's nearest and dearest. I now move on to examine the non medical literature to uncover a parallel view of the condition.

4.6.2 Psychosocial Perspectives

Coupled with the assumption of intellectual inability and social ineptitude as features of biological disease, dementia is often viewed in terms of behaviour, with a focus on a need for control as described in treatment with medication above (Stokes 2000, Wills and
Dewing 2001, Adams and Bartlett 2003). People with dementia are often seen as a problem due to adverse impact on others in the way they interact and demand attention, repeat questions, use bad language, display vulgar habits, are noisy, aggressive, rude and disruptive (Spicker 2000).

In the 1980s, with the advent of Community Care, much attention was given to the needs of informal carers who were now caring for their family member, with dementia, at home. The focus was on the burden of the role particularly in the presence of, what was described as, challenging behaviour on the part of the person with dementia (see for example Nolan and Keady 2001, Soliman 2003). The impact of the behaviour of the person with dementia is viewed differently dependent on the setting. In less specialist places Middleton et al (1999) discovered a greater tendency to negatively label the behaviour, and the person exhibiting the behaviour, and to term it as inappropriate. This research took place in dementia specialist and non-specialist care homes with results similar to a study that Rachel Norman (2003) undertook in the general hospital setting.

Much of the recent psycho-sociological work on dementia seeks to move the agenda away from classifying people with dementia as either bad, due to their behaviour, or diseased and socially inept, due to their medical diagnosis. Tom Kitwood and his colleagues in the Bradford Dementia Group focused on the problems associated with viewing those with dementia as diseased objects, incapable of thought and badly behaved, rather than seeing them as people with problems. The focus of “The New Culture of Dementia Care” (Kitwood 1997) and much subsequent literature advocating for improvements in dementia care, is to view, and hear about, dementia as a subjective experience. The developing view is that dementia is a social disability as much as it is a biological illness. People with dementia, it is claimed, are able to retain entity whatever their cognitive state, dementia may destroy the brain but it does not destroy the person (Hughes 2001) or their ability to integrate from a psychological or social point of view (Brooker 1995). This approach can be viewed as attempt to shift power from the “clinical gaze” (Foucault 1976) of clinicians who objectify people with dementia, towards a position of entity for the people with dementia themselves.
Tom Kitwood wrote extensively on his theories of dementia and dementia care asserting that how a person manages their life with dementia depends on their nature, their social support and their ability to cope with adversity. Interestingly these are the same phenomena as Brown (1978) and Murphy (1982) emphasised as protective against depression (p83). However, whereas research on depression, particularly in old age, has not moved on from these works, dementia research continues in examining how the nature and the quality of interaction can assist or detract from helping people with dementia to live with their condition. Those interactions that may detract from positive experience are what Kitwood terms as the prevailing social psychology as it impacts on the experience of the person with dementia. The ways in which others act and interact is core to the philosophy that focuses on valuing the person with dementia as a unique and resourceful person. While acknowledging that neurological brain changes are a feature of dementia, Kitwood (1993) suggested that experience is based on a combination of factors. He documented his theory using an apparent mathematical formula:

\[
D \text{ (dementia)} = P \text{ (personality)} + B \text{ (biography)} + H \text{ (health)} + N_I \text{ (neurological impairment)} + SP \text{ (social psychology)}
\]

He also provides detailed documentation of *malignant social psychology* through which care givers can undermine the basic rights and needs of people with dementia, for example, by ignoring them in their presence or by treating them as objects on whom tasks are undertaken.

The work of Tom Kitwood has been highly influential in raising the profile of dementia and dementia care, and has led to much further investigation. However, it has been criticised for its lack of academic evidence and rigour (Adams 1996). Others are concerned that the sole focus on the person with dementia excludes others, such as formal and informal carers (McKee 1999, Nolan et al 2004, Adams 2005). Indeed it is a criticism of much research around dementia over the years that the perspective of one key group of player has been examined to the exclusion of others. Early research took the
view of medicine and of formal carers. In the 1980s informal carers took centre stage. At present there is a danger that the voice of the person with dementia is heard to the exclusion of others intricately involved in the person’s life. There is also a lack of evidence about how the lay public perceive dementia.

In reflection of this concern, current thinking around models of dementia care and research focus needs to consider all those involved, with all views considered to be valid and not interchangeable (McKee 1999, Adams 1998). In the work on *Relationship Centred Care* (Box 4.3) Mike Nolan and his colleagues (2004) describe the prerequisites for appropriate care as being founded in attention to the needs of people with dementia as well as those of their formal and informal carers, arguing that if the needs of one party are not met, the rest of the relationship will be off kilter. For example, Nolan argues that people with dementia and their formal and informal carers all need to feel a sense of purpose in their relationship. It is not solely for the person with dementia to feel satisfied in this respect, but also for those who support him/her. There are suggestions that the care triad of the person with dementia, formal and informal carer, described by Trevor Adams (1998) needs to be further expanded in order to consider the broader needs and demands of communities and society as a whole, with particular focus on the politics of dementia care (Adams 2005), but this work has yet to be fully explored and articulated. My own methodology, whereby I seek opinion from older people, relatives and staff members, as well as considering the organisational influence, may serve to develop this school of thought.

As I have suggested, there is an emerging philosophy of dementia as a social disability. Social gerontologists believe that the over-medicalisation of dementia, and the perception of it as a social problem, would be better addressed if it became viewed as a disability rather than an illness (Kitwood 1997, Manthorpe 2001, Gilliard 2002, Adams and Bartlett 2003). In this way the oppression and social disengagement bestowed on people with dementia could be challenged on a disability rights platform. In the same way that independence is not seen as equivalent to self care and autonomy for many people with disability, people with dementia, by being seen as disabled, could regain feelings of
control in their lives. This correlates with the similar recent change in focus for people with learning disabilities, which has moved from an illness to a disability model of service arguably creating greater degrees of social empowerment.

Box 4.3 Requisites for Relationship Centred Care

❖ A sense of security of feeling safe and receiving or delivering competent and sensitive care.
❖ A sense of continuity - the recognition of biography using the past to contextualise the present.
❖ A sense of belonging – opportunities to form meaningful relationships or feel part of the team.
❖ A sense of purpose – opportunities to engage in purposeful activities or to have a clear set of goals to aspire to.
❖ A sense of fulfilment. Achieving meaningful or or valued goals and feeling satisfied with one’s efforts.
❖ A sense of significance to feel that you matter and that you are valued as a person.

Nolan et al 2004

This move from an illness to a disability model is reflected in the current political guidance with regard to the care and treatment of people with long term conditions (DoH 2001b) as it seeks to empower people with other long term conditions, such as chronic breathing difficulties, diabetes and arthritis, with moves aimed at ensuring that the person with the condition is accepted as the expert and at the centre of discussions in ensuring how their needs will best be met. However, as I have already noted (p70) dementia does not feature as one such long term condition. The exclusion seems to suggest a lack of political and policy clarity about where dementia fits in with health and social care provision, as I have noted with depression and delirium above. With regard to dementia the confusion may be perpetuated by the presence of two clear and potentially opposing views; dementia as an illness versus dementia as a disability.

Before I conclude this section I explore the limited literature on dementia as it exists in the general hospital setting. It is interesting to note that although there is a large and growing literature on dementia and dementia care, other than bio-medical research, little focus is given to the needs of people with dementia as they exist in the bio-medical
world, either within mental health or general services. Again this demonstrates division and, in the case of dementia, two diverse paradigms with little examination of how the two worlds may meet when they converge in one setting.

4.6.3 Dementia in the General Hospital

People with dementia are frequent occupiers of acute hospital beds with figures suggesting that, in 2000 in the United Kingdom, in an average hospital of 500 beds, 330 occupants are over 65 and 31% of them (103) have dementia (RCP 2005). The care and treatment of people with dementia is dependent upon the dominant culture and the social construction of the place in which they find themselves (Adams and Bartlett 2003). If this is the case it follows that care in the general hospital, a bio-medical, clinical environment, will differ from that found elsewhere.

Although there have been various concerns raised, notably by the Health Advisory Service (1998), in the popular health press (Dewing 2003, Armstrong 2002, Burgess 2003, Bush 2003) and by voluntary organisations (Alzheimers Society 2006), very little formal research has taken place in the general hospital setting other than bio-medical examination of prevalence and missed medical attention (Holmes and House 2000b, Holmes et al 2002). Published material on dementia care focuses on how to handle the problems associated with care for people with dementia in the acute setting based upon scant empirical data (Archibald 2003, Harrison 2006a). Many generic texts on dementia care do not provide focus for staff working in this setting, for example, Caroline Cantley (2001) provides a chapter on care settings for people with dementia (Marshall 2001) in which acute hospitals barely feature.

Rachel Norman (2003) reports on her research findings conducted in the general hospital setting. She sought to examine the experience of people with dementia and subsequently developed practice guidance for nursing staff. Using a combined methodology involving observation of and interview with people with dementia and staff focus groups, she concluded that nurses do not readily connect with these patients and thus do not achieve
understanding of them. In line with the earlier findings in care homes (Middleton et al 1999), Norman found that staff define dementia in terms of the presenting behaviour, seeing it as non-directed, irrational and purposeless and as such staff seek to override and/or constrain it. The research discovered that when nurses could attribute meaning to actions, both levels of engagement and quality of care improved. The subsequently developed practice guidance encourages engagement through which people with dementia and their actions can be better understood.

4.6.4 Discussion on Dementia

In this section I have examined the literature around dementia and the understanding of dementia as a medical and psychosocial entity. Research has been undertaken, over the last thirty years, from differing angles. Historically, like other medical diseases, research has concentrated on bio-medical positivist science with opinions and views on the condition and its management sought from health care professionals. With the advent of community care, the focus of attention moved to examine the perspective and needs of informal carers, with much research conducted in this field in the 1980s and 1990s. More recently, arguably in line with consumerism, attention has become more focussed on to the person with dementia, hearing the voice (Goldsmith 1996) of the person experiencing the problems and attempting to see the world through their experience. The most recent opinion suggests that dementia should be viewed as a social disability rather than a medical illness.

Although there is a wealth of literature on dementia, like depression and delirium its place within the scope of health services is unclear. Currently dementia appears to inhabit two parallel paradigms as both an illness and a social disability. Arguably this mirrors the developments in mental health services for younger adults towards a recovery model (Anthony 1993 p21) but in dementia such focus does not both sit clearly within psychiatric service provision. I am interested in considering how these potentially opposing views are evident in the perceptions of people in the general hospital setting.
4.7 Conclusion

In this chapter I have examined perspectives on mental health problems in old age from political, bio-medical and social perspectives and compared these perceptions with the broad perspectives discussed in the previous chapter.

It is clear that mental health problems are perceived differently when they are experienced by older, rather than younger, adults. Politically and organisationally definitions of what qualifies as a mental health problem is clearly defined for adults of working age (DoH 1999) yet not explicit for older adults. Similarly medical services for older people with long term conditions have received specific government focus without consideration of those with long term mental health conditions. This appears to leave the older person with mental health problems out in the cold, with attention lacking both in service requirements and in research attention, particularly when such issues arise within the health service. Where older people with mental health problems present in the general hospital setting, little research has occurred examining their experience or the impact of the service they receive. There is supposition that consultation/liaison services are preferable to a traditional model, but without any clear evidence of support.

In examining the literature on depression, delirium and dementia, the evidence suggests that each sits outside the core mental health agenda, each in a different way. Depression has become a medical rather than an every day word. It is accepted as a common ailment among the general population and has moved from the realms of psychiatry into that of general medicine. In old age however, depression has received little attention. It is less frequently recognised and treated.

Delirium also is under recognised and under researched. It is unclear where delirium sits within the medical world, and therefore in terms of service provision. Lastly in this chapter I looked at dementia and its possible positioning as either a biological illness or as a social disability.
In the course of this work I have sought to discover where people in the general hospital setting position mental health problems in old age. I do so against a literature, little of which is specific to the setting, which emphasises a nebulous position due to differences between political, medical, psychiatric and social views.

I am interested in the broad perceptions about mental health problems as they are perceived by those in the general hospital setting. I have noted that, in such a rigid setting, power relations are highly influential and will affect how people perceive phenomena therein. As well as comparing views with those described in the literature I want to specifically address the gaps in the research about depression in old age, particularly as it impacts on very old and ill people. Lastly I seek to consider the health service needs of this group of people; not only in consideration of whether different models of mental health service impact on the way that people perceive mental health problems in old age, but also on the place of mental health problems in old age within services generally.

I argue that mental health service is currently provided in answer to the constructs as perceived by the professions of medicine and psychiatry, and due to political and organisational demands, rather than in consideration of how mental health and mental illness in old age is perceived by those directly involved in the general hospital setting.

I now move on to consider the methodology used in achieving the data through which to consider these issues.
Chapter 5

Methodology

5.1 Introduction

In the previous chapters I have outlined the background to this research and explored the available literature that informs the subject of perceptions of older people with mental health problems in the general hospital setting and the services provided for them. I have highlighted the following particular strands of research interest in the absence of current evidence.

I am interested in the broad perceptions about mental health problems as they are perceived by those in the general hospital setting. I have noted that, in such a rigid setting, power relations are highly influential and will affect how people construct phenomena therein. As well as comparing constructions with those described in the literature, I want to specifically address the gaps in the research about depression in old age, particularly as it impacts on very old people who are chronically physically ill. Lastly I seek to consider the health service needs of this group of people; not only in consideration of whether different models of mental health service impact on the way that people perceive mental health problems in old age, but also on the place of mental health problems in old age within services generally. As I have highlighted in Chapter 4, this position is currently unclear.

The presence of older people with mental health problems in general hospital settings impacts upon many people and groups: the older people themselves, other hospital patients, relatives and friends, health and social care workers and service managers. The social actors all have thoughts, feelings, behaviours, beliefs, communication methods and memories associated with, and influenced by their experience (Williams and May 1996). As well as the personal and experiential influences carried by each person, further
influence occurs due to the setting itself, an institution carrying history, administrative structures and mechanisms.

Within this research I have sought to hear the voice of people with mental health problems who are not usually given the opportunity to be heard. I have encouraged people to speak on the subject of mental illness which, potentially, they may not have wished to consider. I conducted the data collection within the structure of powerful institutions which have long been driven by a perception that those with mental illness and those in old age do not have a valid voice. The parallel tradition is that the medical voice holds implicit power and validity, yet this too is now challenged by political and bureaucratic power. These vying challenges emphasise the need for stringent attention to methodology in order that voices are heard and that vulnerability is not exploited.

Within this chapter I explain, explore and discuss my chosen methodology and the associated challenges, building from the information gained through my literature review. Initially I return to my research questions and revisit the underlying theoretical principals employed. I go on to explain the nature of the data and how it was collected. I explore the research design, the research sites and the issues and challenges considered in achieving a sample. I then examine the potentially contentious issue of consent, given that some of the sample group had diagnoses of dementia. I examine both the nature and content of the qualitative interviews, and the method of analysis employed. The process of conducting this research brought many challenges as I discuss throughout the chapter. I focus specifically on that of achieving ethical approval and suggest that the favoured concept that necessitates the use of informed consent requires challenge. I finish the chapter by again focusing on power, this time within research relationships, as it is pertinent to the methodology.

Before moving on to future chapters, in which I analyse and interpret the data, I provide detail of the research participants again noting that participants names, as well as the setting names, have been anonymised
My research questions ask:

- What are the social constructions that are drawn upon and that generate perspectives on mental health problems in old age in the general hospital setting and
- Does the nature of mental health services provision affect and/or influence the social constructions?

5.2 Theoretical Framework

I asked these questions in order to inform debate around the future provision of mental health care for older people in general hospital settings. I argue that service is currently provided in answer to the constructs as perceived by the professions of medicine and psychiatry, and due to political and organisational demands, rather than in consideration of how mental health and mental illness in old age is perceived by those directly involved in the general hospital setting.

As I set out in the introductory chapter of this thesis, my epistemological position is that the way in which one conceptualises phenomena within the world is the result of how we interpret data from within it. Thus different people will make different interpretations of a thing, dependent on their current and past experience and the context in which they experience the thing. Theory about the world is thus interpreted rather than deduced. With regard to these phenomena, mental health problems in old age in the general hospital setting, one person's view will differ from another's particularly if they are playing a different role within the setting. Differences are also likely in different hospitals. I hold that no one view has more credibility or validity than another.

I draw particularly on the theories of Interpretive Interactionism and Social Constructionism, as I now explain.
5.2.1 Interpretive Interactionism

My research methodology draws on a Grounded Theory approach (Glaser and Strauss 1967) which suggests that theory is developed from observation of the world. Using this premise, theories about the world are built inductively from the data itself rather than by testing a hypothesis against data, as in the positivist model. Whereas empiricism in positivist approaches emphasises the collection of facts and observations, an inductive approach focuses instead on conceptual reflection and theoretical enquiry (Marshall 1999). In order to understand a social situation the researcher needs to see the world from the perspective of those within it, to consider their actions and interactions in order to discover how concepts are sustained (Porter 1998). Or, as Howard Becker (1963) suggests in his work examining concepts of deviance, the meaning that we give to an object is not the result of its innate qualities but of our active interpretation of it.

I draw also on the work of Denzin (1989) in his description of Interpretive Interactionism. This places focus on the relationship between “personal troubles” and the policies and institutions created to address those troubles. As he states:

> In social life there is only interpretation. That is, everyday life revolves around interpreting and making judgements about their own and others' behaviour and experiences. Many times these interpretations and judgements are based on faulty or incorrect understandings. Persons, for instance, mistake their own experiences for those of others. These interpretations are then formulated into social programmes intended to alter and shape the lives of troubled people, for example community services for the mentally ill...But often the understanding that these programmes are based upon bears little relation to the meanings, interpretations and experiences of the persons they are intended to serve.

(Denzin 1989 p11)

I am examining mental health and illness, as a “personal trouble”, within an institution able or not to address the issues arising. I look to uncover underlying assumptions in order to interpret the phenomena and to consider how service may best be provided.
5.2.2 Social Constructionism

In this research I am seeking to discover the taken-for-granted perceptions about what constitutes a mental health problem in the general hospital setting. By conducting the research in two sites, each using a different model of mental health service provision, and by interviewing people from across the range of social actors, I seek to compare those perceptions and consider any differences. In doing so I am mindful that the social construction of a concept, such as mental health problems, is affected by all sorts of influences such as differing power relationships, local practices as well as internal and external cultural, political and legal positions.

The ontological position that I adopt for this research is basically described within the following assertion from Peter Berger and Thomas Luckmann, who developed the theory of Social Constructionism. However, notably I do not exclude the biochemical existence of mental illnesses as defined within the biomedical literature (see Chapters 3 & 4).

> It is our contention, then, that the sociology of knowledge must concern itself with whatever passes for “knowledge” in the society, regardless of the ultimate validity or invalidity (by whatever criteria) of such “knowledge”. And in so far as all human “knowledge” is developed, transmitted and maintained in social situations, the sociology of knowledge must seek to understand the processes by which this is done in such a way that a taken-for-granted “reality” congeals for the man in the street. In other words, we contend that the sociology of knowledge is concerned with the analysis of the social construction of reality.

> (Berger and Luckmann 1991 p15).

The theory of Social Constructionism was born out of Symbolic Interactionalist theory and focuses on uncovering the ways in which individuals and groups participate in the creation of their perceived reality. Social Constructionists suggest that society, and concepts within society, are actively and creatively produced by human beings and that the social world is made up of the product of such constructions. Such knowledge is not static and is influenced by the culture and history of the micro setting and the macro environment (Burr 1995). It is appropriate to use this position for research that is conducted within an environment of varying and conflicting power relationships, as discussed in Chapter 2.
Social Constructionism was adopted in the 1960s and is fundamentally based on the Weberian suggestion that the task of sociology is to try and gain interpretive understanding of social action in order to understand why such action happens and what the effects are. This is achieved by understanding the subjective meaning held by the people involved. Sam Porter (1998 p112) describes how such approaches draw significantly on the work of Alfred Schultz and his descriptions of social phenomenology. Schultz suggests that from our varying experiences we construct the objects, and our common sense knowledge of those objects, that we take for granted in our everyday life. We see the world through typifications or conceptual frameworks, which he calls "recipes", and slot events and activities that we experience into a "recipe" in order to make sense of them. We take these typifications for granted, assuming that they are objective reality and that others share the same concepts, not always realising that different people have different realities.

It is important to note that, while I am working from a social constructionalist position, I do not adopt an extreme standpoint and assume that no material definition of mental illness exists. In approaching the work from a softer or contextual constructionalist position, I acknowledge the existence of the phenomena of depression, dementia and delirium as having material biochemical basis, and also the definition of mental illness within the legal framework of the Mental Health Act. The ability of social constructionalist researchers to embrace some elements of a critical realist approach (Connelly 2001) is defended by Burningham and Cooper (1999). They demonstrate that constructionalists often acknowledge that socially problematic phenomena exist, before moving on to explore perceptions around that subject by certain social actors in specific circumstances.

In his work "The Social Construction of What?" Stephen Hacking (1999) cautions social constructionist researchers against being critical of certain perceptions of knowledge, particularly those that may be seen as the status quo, while attempting to discover alternative ways of describing the phenomenon. He describes six grades of Social
Constructionism (Box 5.1) ranging from historical to revolutionary construction. In this research therefore I do not discard the historical positivist view of mental illness as held within psychiatric circles. Hacking’s work points towards the importance of reflexivity in research process, as I discuss below.

In guarding against potential bias, I note the perspective of social realists (Bhaskar 1989, Pilgrim and Rogers 1999) who argue that it is inappropriate to claim that mental illness is a purely a product of society or the intent of those within it. Examination of constructs of mental health and illness must, Bhaskar asserts, include reference to both natural and social sciences: the biology of conditions, the delivery of mental health care, the history and geography of mental health. Thus concepts change with time and changing influences with the importance of one perspective holding no more “reality” than the others, as I have already demonstrated within the literature review. An appropriate model for mental illness therefore lies in a combination of the medical, psychological and social (Goldsmith 1996). The person with depression, for example, has biological brain changes that combine with elements of personal and social history, personality and current physical, psychological and social factors, internal and external to the person, to culminate how s/he thinks, feels and behaves (p83). How the person reacts to the depression depends on the impact and action from oneself, professionals, relatives and friends and the wider society.

A social model approach argues that social relations between people and within society are fundamental to the experience of disabled people. Rather than focussing on medical problems or deficits, this approach highlights the impact of social and environmental barriers, cultural processes and policy frameworks that actively and systematically disable people.

Wilkinson 2002 p11

The methodology employed therefore needs to elicit the perceptions of the social actors, not only about mental health problems in old age and their experiences thereof, but also about the social setting and the influences within it.
In considering how to gather and examine the relevant data, I have also noted the literature concerned with evaluation research in using two sites, each using a different mode of service, in order to make some comparison about the potential influences of the differing modes of service provision. The aim of evaluation research is to contribute "to the best possible knowledge designed to help people make wise decisions about future programming" (Clarke 1999a p20). As well as being useful in comparing two modes of intervention, the use of two sites helps "to overcome the idiosyncratic characteristics of a given institution and of particular case mix" (Strain et al 1991). Using more than one site also allows comparison of social structures whereby one may look at the range of generality and pin down conditions under which the findings will occur thus providing greater explanatory power (Miles and Huberman 1984).

I now explore the essential process of reflexivity as fundamental to the methodology.

**Box 5.1 Six grades of Constructionism.**

1. historical – X has been constructed out of social processes
2. ironic – X is here, not a lot I can do about it / cannot escape it
3. reformist – it’s bad, let’s do something about it
4. unmasking – stripping of false appeal, uncovering other interests/ functions it serves. 3 & 4 may go together
5. rebellious – such as those who say there is no such thing a schizophrenia
6. revolutionary – such as RD Laing and the anti psychiatrists

Hacking 1999

5.2.3 Reflexivity

As discussed above, social constructionist theory is based on the premise that knowledge about the social world is formulated through ones interactions with the social world. Perceptions are influenced by culture, history and politics and the meaning that one attaches to the experience. In the research context, the presence of a researcher and the occurrence of a research interview itself may have an effect on the phenomena under
scrutiny. It is therefore implicit within the research process to consider, reflexively, what
the impact of such presence may be. Tim May (1998 p157) describes this process as
referential reflexivity, whereby the researcher considers the consequence of the meeting
of the social actors in the setting and the researcher "as part of the scientific community".

Such referential reflexivity is particularly pertinent in this work due to my dual existences
as a mental health nurse and a researcher. These two diverse positions within the general
hospital setting potentially rendered me at risk of influence due to each role and also
because of the dominant positivist framework within which mental health problems are
largely viewed in psychiatry.

The purpose of reflexivity is also key in considering how research material is interpreted.
This May (1998) describes as "endogenous reflexivity". This process enables the
researcher to check and counter check the typifications drawn from the data by
considering patterns and the justification of those patterns.

In this section I have explained my ontological position as framed within the
epistemology of Social Constructionism, whereby knowledge is seen as structurally
designed, socially learned and fluid. I have considered how the nature of my enquiry,
to mental health problems in old age in the general hospital setting, can be examined by
eliciting the views held by the various social actors and considering how those concepts
converge and diverge, given the influence of local and wider contexts. I have also
touched upon the importance of reflexivity in research. I now move on to provide detail
of the research design.

5.3 Research Design

As discussed, the ontological starting point for my research generally follows the views
of Berger and Luckmann (1991 p13) who suggest that knowledge is "developed,
transmitted and maintained in social situations" and that social reality is that which is
taken for granted by people within specific social settings. My research methodology
therefore needed to access that taken-for-granted knowledge and, from it, generate understanding of the social constructions in play. I assume that all expressed values beliefs and knowledge systems have equal importance and validity (Stacey 1986).

In order to capture this complex phenomenon I gathered data from a sample of all those involved within the setting in order to compare how the concepts converge and diverge. As Weber suggests, in his description of "verstehen" (German for - to understand), we can only hope to explain people's actions by knowing the meanings that are attached to them (Williams and May 1996 p60), and we can only understand how a phenomenon exists within a social setting by knowing the attached meanings of the variety of people involved. Too often services are shaped around what those not in receipt of the service perceive service users to need, without reference to the views of the users themselves. This has particularly been the case for those who have not readily been given the opportunity to be heard.

The beliefs and views that I sought could not be accessed through observing the setting in which they take place, as they are not overtly expressed. I needed to hear how people attribute meaning and, therefore required verbal data. I chose the method of qualitative interview for several reasons. As stated I want a broad perspective of thoughts, feelings and beliefs, and to encourage people to self-express freely. Through a qualitative interview I used strategies for discovery (Fielding and Thomas 2001). This could not be achieved within the confines of closed questioning, for example in structured questionnaire, which preclude disclosure (Lee 1993a). I wanted to allow the person to choose where to take the conversation, without being prescriptive, thus giving greater power to the participant than is possible within a survey, where direction is clearly defined and confined. Dougall et al (2000) sought to compare questionnaire and interview methodology when examining patient experience of a service providing an invasive clinical intimate investigation. They found that while patients reported satisfaction within the questionnaire data, interviews revealed richer data and particularly uncovered negatively perceived aspects of their experience. The authors claim that this differential is due to the explorative and flowing nature of the conversational interview.
which allowed respondents to move beyond a general perception of satisfaction to a closer scrutiny of less satisfying elements within it.

Other reasons for the choice of interview methodology centred on the sample group and on the sensitivity of the subject under examination. As discussed above, mental health and illness are taboo subjects and carry social stigma as discussed in Chapter 3. Older participants may be particularly troubled by the subject matter. The cohort of older people here may recall experiences or family stories about the workhouse and asylums as images of insanity. Also people with mental health problems may have difficulty sustaining concentration and focus. Within an interview, adjustments and time can be given to facilitate response. It has been my experience, working as a mental health nurse, that disclosure on sensitive topics takes place more readily in a situation perceived to be non-censorious, such as a conversational interview. Using such methodology, emphasising privacy, confidentiality and a non-judgmental attitude, I could access sensitive material (Lee 1993a). Indeed Lee (1993b) suggests that, especially when concerned with subjects which may provoke high emotion, complexity and contradiction, data cannot be achieved other than through explorative interview.

As discussed, I needed to gather data from a variety of social actors in order to examine the perspectives of all those involved in the service. Although there is a wealth of research examining health service/care provision, data is often collected from one section of the population involved in the particular activity. For example, Wiles and Higgins (1996) examined doctors' relationships with private patients solely from the patient's perspective and McKevitt and Morgan (1997) looked at doctors' experience when they are patients and did not seek the perspective of the doctors providing the treatment. Thus comparison of compatibility and conflict in perspective is not considered. One qualitative study (Boyle and Chambers 2000) was concerned with medication compliance, and sought the views of seven family carers rather than asking the people with depression. No explanation is given as to why those involved were defined as carers or why the people with depression were not asked to participate. Such exclusion appears
to suggest that the authors perceive those with depression as invalid, without a valid voice.

Recent literature focuses heavily on the need to engage service users in research and to hear their views (DoH 1999, McClymont 1999, Clarke 1999b, DoH 2000, DoH 2001a). Nevertheless there is a danger of hearing the user view to the exclusion of other influential voices. The view of the insider expert does not replace that of the outsider (Brown et al 2001). As suggested within the literature on Relationship Centred Care Nolan et al (2004), to take the service users context to the exclusion of that of his/her family and of those who are providing the care could be said to be as negligent and exclusive as it has previously been to exclude the service user. Adams (1998) notes that views may notably differ, between user and carer, but that both are valid.

In gathering data from older people, relatives and staff members, I draw also on the work of Kevin McKee (1999) who suggests that, in dementia, there exists a care triad (Figure 5.1). One's perspective of a given situation is dominated by where one fits into the picture. In the community the carer perspective has predominated; in institutions the professional carer perspective dominates. For example, the National Consumer Council (1990) sought to examine services for older people with dementia living at home. While they included both people with dementia and their carers in the sample, the results published refer solely to the views of the carers. Although this can be seen as a move towards inclusion, exclusion remains the result.

Similarly I argue that Dementia Care Mapping (Kitwood and Bredin 1992), developed as an observational tool for measuring the well-being of people with dementia, focuses on care staff practices to the exclusion of the person with dementia, who is passively involved only as the peripheral article of scrutiny. Well-being, or ill-being, is interpreted from how a person with dementia expresses how they feel, non-verbally, without the additional validity of hearing the person with dementia verbally express their feelings.
While I welcome the will to improve patient care through such examination, I suggest that the methodology could be said to marginalise people with dementia.

More recently two studies have used three sample groups in dementia research (Cohen-Manfield et al 2000). The findings suggest that using three sample groups enriches the quantity and scope of data achieved and also highlights both consensus and lack of agreement among the groups. Particularly the people with dementia placed emphasis on the need for aesthetic quality of life, enjoyment, creativity and appreciation of surrounding, and on the importance of interactional capability, social participation, whereas carers and professionals did not feel these to be so pertinent for the person with dementia.

Having considered the research design, I now move on to consider its application.

![The Care Triad](image)

**Fig. 5.1 The Care Triad**

**Older person**

**Relative**

**Staff Member**

5.4 The Sites

The research took place within two sites, both district general hospitals, where the local population is provided with medical services for all within the same premises. The hospitals are both in the south of England and serve equivalent population groups, covering both rural and urban population groups. Three comparable medical wards have
been selected on each site, where the patient population was largely made up of people over 65. Staff members refer patients to psychiatric/mental health services using one of two modes of service, as set out in Chapter 4. I use pseudonyms to ensure anonymity.

- **Chapley Hospital**
  Uses a mental health consultation/liaison nursing service whereby any member of the staff team could refer for an opinion and/or advice. Response involves an assessment, discussion and, often, ongoing intervention with the patient, family and team.

- **Glimster General**
  Uses traditional psychiatric consultation, whereby physicians seek formal diagnostic assessment and advice from a psychiatrist. Consultation is followed by a formal written report and is a single event.

### 5.5 Inclusion and Exclusion

Engaging people with mental health problems in research produces challenges in both ethical and pragmatic terms (Clarke 1999b, Hubbard et al 2003). Not to overcome the challenges would negate the purpose of the research. Some authors have suggested that people with dementia have “lost their mind” and are unable to comment on subjective states (Wilkinson 2002); others have sought to define ability to respond through cognitive measures such as MMSE (Mini Mental State Examination. See Box 5.2), usually excluding those who score under 17/30. Mozely et al (1999) cited these anomalies and sought to discover whether people with dementia can answer questions about their quality of life. Using a combination of cognitive scoring and subjective interviewer view on confidence ratings on the face value of the interview, the findings suggested that over 75% of those older people with MMSE scores of 10 could provide effective information. Interestingly the research design was such that those who scored less than ten were excluded from interview, without a clear and apparent rationale. Cohen-Manfield et al (2000) felt that “the MMSE score is not always a good predictor of ability to participate
in research. Therefore, given evidence that people with dementia have a lot to say, if only we listen to them (e.g. Goldsmith 1996), I did not use a cognitive measurement tool.

I excluded only those who, I ascertained through conversation around potential research participation could not engage either due to attention, hearing or language deficit. Although it is possible to communicate with people, other than verbally, such is not suitable for research involving taped interview. In practice exclusion on these grounds occurred only once, for a woman whose speech was barely discernable. Unfortunately

<table>
<thead>
<tr>
<th>Box 5.2</th>
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<tbody>
<tr>
<td><strong>Folstein's Mini Mental State Examination</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>What year is this?</td>
<td>1</td>
</tr>
<tr>
<td>1b</td>
<td>What season is it?</td>
<td>1</td>
</tr>
<tr>
<td>1c</td>
<td>What month of the year is it?</td>
<td>1</td>
</tr>
<tr>
<td>1d</td>
<td>What is today's date?</td>
<td>1</td>
</tr>
<tr>
<td>1e</td>
<td>What day of the week is this?</td>
<td>1</td>
</tr>
<tr>
<td>2a</td>
<td>What County are we in?</td>
<td>1</td>
</tr>
<tr>
<td>2b</td>
<td>What Country are we in?</td>
<td>1</td>
</tr>
<tr>
<td>2c</td>
<td>What city/town are we in?</td>
<td>1</td>
</tr>
<tr>
<td>2d</td>
<td>What is the name of this building/the address of this house?</td>
<td>1</td>
</tr>
<tr>
<td>2e</td>
<td>What floor are we on/room are we in?</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>I am going to name three objects. After I've said them please repeat them to me, Remember them because I will ask you to name them again in a few minutes. (repeat up to five times) BALL, CAR, MAN</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Spell WORLD backwards, or subtract 7 from 100 and keep subtracting 7</td>
<td>Max 5</td>
</tr>
<tr>
<td>5</td>
<td>Recall the three objects from 3 above</td>
<td>3</td>
</tr>
<tr>
<td>6a</td>
<td>What is this called? (show a pen)</td>
<td>1</td>
</tr>
<tr>
<td>6b</td>
<td>What is this called? (show a watch)</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Please repeat this phrase after me &quot;no ifs, ands or buts&quot;</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Read the words on the page and do what it says, &quot;CLOSE YOUR EYES&quot;</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Take this paper in your (non-dominant) right/left hand, fold it in half and place it on the floor.</td>
<td>Max 3</td>
</tr>
<tr>
<td>10</td>
<td>Please write a complete sentence.</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Please copy this drawing (of two interlinking pentagons)</td>
<td>1</td>
</tr>
</tbody>
</table>

Maximum score 30

Adapted from Kennedy (2002 p53)
two of the interviews that I did conduct were difficult to comprehend on communication grounds. One man was inaudible and one woman was very hard of hearing. No exclusions were made due to gender or ethnicity. My intention was to exclude non English speakers but, in practice, such exclusion was not an issue.

The potential problems with attention and language are not, of course, exclusive to the potential participants with dementia. Although recently much research has focused on accessing the experience of people with dementia, similar emphasis has not been placed on hearing the voice of older people with depression. Its presence often leads to the person becoming withdrawn, uncommunicative and of low self-esteem. My experience suggests that people, at Chapley Hospital with identified depression were more likely to decline involvement in the research. In Chapley Hospital, seven people, who I knew to be depressed, declined involvement when approached by the gatekeeper (see below p 119). One woman later voluntarily told me “I don’t know why you want to talk to me; I haven’t got anything interesting to say.” Another woman diagnosed with depression initially agreed to participate in the research. When, having gained permission, I telephoned her relative to ask whether she too would consent to participate, she declined participation and also said that her mother had told her that she didn’t really wish to participate but was doing so because she wanted to please and could not assert herself. This, the woman confirmed when I returned to her. My clinical knowledge suggests that declining involvement was, at least partially, due to depression and an associated sense that their view was unworthy of attention. Without negotiation, which may have been viewed as coercion or the inappropriate use of our clinical relationship, I could not engage many people with identified depression in research. This may explain, to an extent, the dearth of research in this area, as discussed in Chapters 4 and 7.

In contradiction to my experience achieving participation from people with depression in Chapley Hospital, the converse seem to be the case in Glimster. Although I was not aware whether the participants had been diagnosed as having depression I knew that they had not received attention from mental health services. Yet, I found six of them to show signs of depression. This brings into question issues of the effect of diagnosis of
depression on esteem, which of course, due to lack of participation, I can merely speculate about. I go on to explore this further in Chapter 7.

It is also interesting to note that, whilst much of the concern within the methodology of this work centred on the need to protect the vulnerability of people with dementia who may not be able to give fully informed consent, as I go on to explore, it is the people with depression who remain unheard.

5.6 Sampling

The proposed sample size for interview was sixty: twenty service users, twenty relatives/informal carers and twenty health care professionals, with ten of each group from each site. This size of sample was chosen in order to provide sufficient comparable data using the principle, laid down by Lofland and Lofland (1995), which suggests that one must have a reasonable sample size in order to enable a “range of versions” of the phenomena to be captured. Had saturation not been achieved with these sample numbers I would have sought further participants. By this I mean that, had I not been able to generally predict what themes would arise within interviews 9 and 10 from each cluster group, I would have sought more participants. This did not occur.

Prior to, and during the data collection process posters detailing the nature of the research project were exhibited on each ward (Appendix 7)

The criterion and rationale for inclusion in the research sample was as follows. The research subject gave consent or assent, as discussed below. Subjects were able to communicate verbally reasonably audibly and to hear conversation. The patient participants were over 65 and in hospital and on one of the wards involved in the study. In order to minimise the effect of any previous experience subjects were asked to confirm that they have no previous experience with mental health services. In addition the staff sample excluded those with a specific mental health qualification.

Purposive sampling was used. In Chapley Hospital the patient sample was identified from those who met the inclusion criteria and who have received mental health intervention during their hospital stay. A gatekeeper was used in order to minimise any
risk of feeling an obligation to participate, particularly as they have met me in my clinical role before. The gate keeper approached potential participants and provided them with the relevant information sheet (Appendix 1) and returned later for a decision on whether or not the person wished to participate. If s/he agreed to do so I subsequently met the potential respondent for further discussion. The timescale for this process was necessarily short in order that data related to experience may be readily recalled and the person would not go home prior to the interview being conducted.

In Glimster General, a similar process occurred, except that referral to mental health service was not required. A gatekeeper approached the person most recently admitted and provided the information sheet. Only when agreement was achieved was I given the person’s name and enabled to meet with them.

My initial intention was that the samples of relatives/carers and associated staff would be generated following the agreement of a patient to participate. Permission would be sought to approach a relative, and the subject would pick an unseen card to indicate
which professional would join that cluster (Figure 5.2). The professional sample comprised doctors, nurses, occupational therapists, physiotherapists, service managers and social workers. The aim of this approach to generate samples is to keep the patient at the centre of the research. Although this process sometimes worked, it became apparent that some patients wished to participate but either had no relative or a relative who did not wish to participate. The formation of clusters of three, comprising a patient, their relative and an associated staff member therefore was not uniformly achievable. Reflecting on this finding I noted also a possibility that the relatives of those patients excluded from participation due to communication difficulties may wish to contribute. Thus I achieved equality in sample group sizes. Although clusters were being used for the purpose of sampling, there was no intention to analyze by cluster; therefore introducing unassociated participants did not affect results.

5.7 Consent/Assent

Considering the ethical dilemmas around achieving consent or assent, in as informed a way as possible, from people who are vulnerable to being misled or used for research without their knowledge, was a major challenge. My focus on this issue, although initially focused on the older people sample groups, expands to all participants. In many research studies ongoing consent and grasp of information are assumed, though possibly not present, throughout the data gathering process merely because the subject is assumed competent and is implying consent through participation. The presence of disability or illness, or being within an alien environment where one may feel disempowered, surely impinges on decision making and the ability to give informed consent for anyone. Such rigour, as I now describe, should be afforded to all research candidates.

There has been a recent increase in involving people with dementia in research. However, often little or no attention is evident on how consent from participants is achieved and sustained (e.g. Berlowitz et al 1995, Spector et al 1999). For example, within a report on an action research project examining the efficacy of a home support scheme for people with dementia, Askham and Thomson (1990) detail interviews with clients with dementia making no reference to the issue of consent. Consent, in this context then appears to be
taken as implicit in that the person is speaking with the researcher and not objecting. Such assumptions could be seen as exploitative given the vulnerability and powerlessness of the sample group. Some researchers have used proxy consent in accessing people with dementia in studies (Berghams and Ter Meulen 1995). I rejected this approach as being disempowering to the person with dementia.

It is recognised that competence and capacity are context and time specific (British Medical Association, BMA 1995, Office of Public Sector Information (OPSI) 2005, Harrison and Williams 2006), for example, a person may be able to make decisions about what to eat for lunch but not about how to organise the purchase of the ingredients one day, but be able to achieve both the next day. Capacity can fluctuate with time of day, medication, physical health and stress (Moody 1992, OPSI 2005). However, protocols in place for research participants tend to assume an all or nothing concept of capacity to give informed consent. To make a competent decision a person must be able to comprehend and recall the information, consider the potential risks and benefits, and subsequently to weigh up the options before making their choice voluntarily (Lord Chancellors Office 1997, Gilhooly 2002, OPSI 2005, Harrison and Williams 2006). If a research participant is fully informed s/he knows that s/he can withdraw at any time, how the data will be used, that they are being interviewed, interpreted and analysed with intent to publish (Mason 1996).

I have already said that historically, those who have been perceived as unable to give informed consent have been excluded from gold standard research. However this is changing. If one cannot be sure that consent is informed, the bio-ethical model suggests that the research can progress if, in the utilitarian tradition, it is for the greater good. If potential benefits exist without risk this is termed as “non-therapeutic research” (Box 5.3) and may proceed, if the person expresses willingness to participate and a proxy for them agrees (Melnick et al 1984, Resau 1995). This research fulfils the described criteria. Because of the elements of forgetfulness and difficulties with judgement, I suggest that people with dementia cannot give consistent and ongoing informed consent. I therefore do not claim to have achieved informed consent from any participant who has cognitive impairment, or memory change caused by another problem, such as depression and who,
Box 5.3

Non therapeutic Research

- The principal intention is to extend knowledge to benefit future patients (British Medical Association 1995)
- Such research... is concerned with the condition from which the person without capacity suffered and the procedures involve minimal risk and invasiveness... (Lord Chancellors Office 1997 5.35.)
- ... it is desirable to provide knowledge of... the care of people affected by the incapacitating condition with which the participant is affected,
- The object of the research cannot be effectively achieved without the participation of persons who are without the capacity to consent,
- The research will not expose the participant to more than negligible risk, will not be unduly invasive or restrictive... and will not unduly interfere with the participant's freedom of action or privacy (Lord Chancellors Office 1997 5.36.)
- "The person concerned does not object"

(Lord Chancellors Office 1997 5.37.)

at the time of my second appointment, could not recall the content of our first meeting. Rather I sought ongoing agreement to participate and considered the assertion that “Testing the competency of a person with dementia is ultimately a test of our own competency as thoughtful, judicious humane human beings” (Sabat 1992 p334). I adopted an assent, and significant other assent, approach with those people who could not give fully informed consent. I judged assent to be present when the person verbally agrees to participate in an interview. Withdrawal of assent was to be taken verbally or by non-verbal evidence of unwillingness to participate/continue, although in practice this did not occur.

In practice I effectively used this approach on five occasions in Chapley Hospital. This model of assent complements the views of Jan Dewing (2002) who considers person centred approaches for achieving consent in her study into the meaning of wandering for people with dementia. She describes “inclusional consent” as a process, rather than a single bureaucratic act, achieved through the ongoing research relationship.
5.8.1 Interviews

Through the consent/assent process, participants were asked to permit interviews to be taped, in order to ensure the accurate recording of data. The interviews generally lasted between half an hour and an hour but there was no time limit. I anticipated that people who had dementia may take longer (Goldsmith 1997). Interviews were loosely structured around key topics (Mason 1996) (Appendix 5). With the participant’s agreement, interviews took place in a confidential area of the ward, an office or therapy room. I largely conducted the interviews within the institutional setting of the general hospital sites. This was done for practical reasons given the feasibility of gathering the amount of data required within a time scale. I also felt that the potency of the hospital experience may be more validly expressed as it occurs, rather than in retrospect.

While I tried to make the interviews as informal as possible by conducting them away from the ward area the subject could be perceived as disempowered, being out of his/her own environment. Pinkney (2001), writing about children’s ability to participate in decision making, suggests that participation is not truly achieved when a person is invited to comment whilst in an environment and with “experts”, alien to their normality. What is said may be differently articulated dependent on the setting (Goldsmith 1999). Several authors have reported a more assertive and authentic response when hospital patients are visited and interviewed after their discharge from hospital (e.g. McClymott 1999). However, the hospital setting is the focus of this research, thus I argue that was both pertinent and practical to keep within the presenting context. Three of the Glimster relative interviews took place in private homes as the older person had been discharged from hospital and this venue was preferred. The timescale was limited to within three days of the experience and did not appear to influence the content of the data.

I aimed to make the interview process comfortable by being conversational, thus achieving rich data (Oakley 1981). The power dynamics (p133) of interviews could not be wholly overcome and, no doubt, judgements were made on what the interviewee believed that I wanted to hear (Koch et al 1995). There is no magical device for
dissolving such inequalities. Whilst Oakley (1981) suggests that women can share power in interviews because of shared gender, this rather suggests that no other power dynamics exist, such as professional/lay person, class, knowledge etc. The most effective way to overcome issues around power is found in the skill of the interviewer in using personal style and adjusting to the position required by each interviewee as well as being non-judgmental even in the face of offensive material (Lee 1993a).

As described above, I sought to uncover thoughts, feelings, behaviours, beliefs, communication methods and memories associated with mental health provision in general hospitals. I also needed to access participants interpretations associated with old age and hospitalisation generally as influencing concepts. My guide covers the areas I wanted to explore (Appendix 5). I encouraged focus on perception of mental illness and on how service may best be provided. I also looked for interpretation of any experience they have had in hospital, direct or indirect, and the extent of their involvement and power within any such involvement. For the staff sample I also sought information on what and how they learn about mental health problems in old age. Analysis of the content of the early interviews demonstrated that interviewees often did not identify depression as a mental health issue. Whilst this was interesting and worthy of further comment alongside overall findings, I wanted the subjects to discuss their views on depression even if they had not identified it. Thus I decided to introduce the topic myself, if necessary.

Throughout the data collection process I kept concurrent field notes. As well as detailing my immediate perceptions of the “gut” feel and content, verbal and non-verbal, of interviews, the notes ensured that I remain focused on the importance and risks involved in using myself as the tool with which to access information (Hedelin and Strandmark 2001). I considered how I performed in the interview and whether I exerted any undue influence on response. Inevitably, as a nurse and as a post graduate student, I carry various agendas and history which influence the way I conduct interviews, which questions I choose to ask, how I, verbally and non verbally, attribute importance to
particular questions and responses. In persistently reflecting on my own performance and the potential rationale for it, I sought to maximise objectivity.

5.8.2 Interview Content

Although I had considered my interview technique, with particular attention to my dual role as clinician and researcher and the associated power issues, I had anticipated a relative ease in interview style given my clinical ability to rapidly achieve therapeutic rapport. In theory I was aware that research interviews are “different”, due to the changed power dynamic (Hockey and James 1993, Oakley 1999), particularly given the sensitive topic under discussion (Lee 1993a). In practice it took a few interviews for me to adjust to a more personal interaction. Particularly I had to allow more time and effort in easing people into information giving by initially asking general questions allowing the topic of the research to emerge as the interview progresses (Brannen 1988).

Part of considering methodology for research is to contemplate the foreseeable “what ifs”, particularly so when potentially distressing the person with a mental health problem has been cited as rationale for not involving them in research (Moyle 2002).

Prior to starting the field work I considered that, during the course of an interview, a participant may become distressed due to the nature of the content, for example by focusing on the feelings of depression, hospitalisation or by highlighting the presence of a mental health problem. Lee (1993b) suggests that both interviewers and interviewees are likely to feel discomfort about sensitive topics. Therefore researchers should be trained and experienced in managing distress (Froggatt 1988, Gilhooly 2002). I felt that as I am a skilled clinician risk was minimised. The ability to handle distress and elicit information on sensitive issues from those who may not readily engage in conversation is central to my expert clinical role and transferable to the research interview situation. Similarly, the ability to manage emotion in the presence of distress can be transferred. Of course an interview could have been terminated due to distress. In practice this did not occur. There was an occasion when a woman became physiologically distressed.
Although she declined termination of the interview, I am aware that I shortened the length of it.

I also considered that during an interview, information may come up that has not been shared with any member of the care team and which causes concern for the safety and/or the well being of the participant. I planned to seek agreement to act on such information, only if the person is unwilling to share the information with others him/herself, and if I feel there is significant risk to the person, her/his health or others. In considering the action to take, I relied on the British Sociology Association Statement of Ethical Practice (1994) and on the Code of Professional Conduct (Nursing and Midwifery Council 2002). For example, if a participant had expressed that s/he was hoarding medication with a view to future overdose, and was unwilling to share the information outside the research interview, I would divulge the information. If a person informed me that s/he was not taking medication as prescribed, but with no intent to self-harm, I would encourage the sharing of the information but not do so myself. In practice such a situation occurred just once. I felt that Selina, a patient in Glimster General, was depressed and that her depression was potentially adversely affecting her ability to progress in rehabilitation. She had not shared her feeling with the staff and did not wish to do so, despite my suggestion. In absence of significant risk, I respected her wish.

5.9 Patient Confidentiality/anonymity

I have taken various steps to ensure that the confidentiality and the anonymity of participants are protected. I have a safe in which I store interview tapes and data upon which “real names” appear for example consent forms. In transcribing data any information that could make the information attributable, either through names or places, is removed prior to being saved on pass-worded floppy discs. Pseudonyms are used in transcripts, in research papers and in this thesis.

In analysing and reporting on data I ensure that material is written up in such a way that participants will not be able to identify any specific individual.
5.10 Analysis

For qualitative analysis I transcribe each interview verbatim, with any names used being substituted with the participant’s research number or, in the case of a third party name, by a pseudonym. The data is then analysed using N Vivo, a computer package, allowing rigorous and systematic retrieval in order to test relationships. Thus varying experiences can be constructed into meaningful social structures and become typifications (Williams and May 1996) and theory can emerge.

Before closing this chapter, I now spend some time contemplating my experiences in achieving the necessary ethical approval in order to carry out the research. Lastly I return to issues associated with power, particularly as they pertain to the research relationship and my dual roles.

5.11 The Challenge of Achieving Ethical Approval

While considering the ethical issues within this methodology, I became aware that my view was, by procedural necessity, being influenced by the demands of the bioethical model that surrounds clinical research. In seeking approval to proceed, from the Local Regional Ethics Committees, I had to become involved in a power possessing procedure in order to access and empower the vulnerable society members within the sample groups. The whole process was both personally and theoretically challenging. Although I agree that achieving the approval of ethics committees is necessary in order to safeguard those being researched, I became frustrated by the process and on several occasions could have disempowered the potential sample by giving up the research. I will explain my experience of the process before arguing that changes could appropriately be made without compromising the need to protect the vulnerable.

The system for achieving ethical approval for research is steeped within the traditional bureaucratic hierarchical systems that typify the National Health Service. Due to the inability of such systems, at the time, to talk to each other I had to overcome two committees, as the two research sites were in different NHS regions. This process has
now changed. Each Local Regional Ethics Committee (LREC) has its particular quirks that I had to learn, through trial and error.

The first task was completion of the LREC form, itself designed with positivist randomised control trials in mind. To achieve completion of the form I had to gain the agreement, often including a signature, of a number of representatives from the involved hospital trusts. I had to seek out these people and explain my plans to them, thereafter gaining their consent to proceed. Some were interested and readily engaged and several seemed to view me as an unnecessary chore that could readily be delayed. I came across a couple of people who I perceived as actually hostile to my intent. I left one meeting feeling battered, belittled and ridiculed by someone who, on reflection I felt, could not fully grasp the concepts I was trying to explain.

The role of an ethics committee is to prevent exploitation, consider scientific merit and ensure voluntariness (Gilhooly 2002). I discovered that there was a tendency to prevent exploitation through exclusion of the vulnerable, a perception that scientific merit is present only in quantifiable data, and wanting participants to be able to consent. Both committees had a predominant medical presence. Each demonstrated limited understanding of grounded theory and theory development through induction. More than once I was asked how I could numerically validate my findings, how I would prove my hypothesis and why I couldn’t perform the research without involving vulnerable people. In contradiction, given the desire for valid data, I felt that too much concern was expressed about my sample size and how I could hope to achieve it. On a positive note, the experience facilitated close scrutiny of my methodology and therefore met the objectives of the committees as well as ensuring my confidence that ethical standards were being met.

As I have described, the process for achieving ethical approval is based on positivist medical methodology. The principles of bio ethics emerged in the 1960s and 70s with consumerism and the developing new technologies e.g. heart transplants. A system was required to address maximising benefit, minimising risk and involving people in decision making, while being just and fair. Bio ethics is driven around the principles of autonomy,
beneficence and justice; it is concerned with legal principles and the power of the law. This process, that is now inappropriately generalised for all research, was designed for a perceived need for an individual to make one off decisions, for example whether to have an operation, and assumes competence in giving informed consent.

Such principles are of questionable value for older people in hospital with chronic health problems, and particularly for older people with mental health problems. Moody (1992 p21) describes the approach as one of “academia and professions removed from everyday politics and culture”. He argues that it is not fair to exclude anyone from involvement in decision making on the grounds of being unable to give wholly informed consent. In old age, autonomy is not an absolute. People are often co-dependent and choose to make shared decisions or, indeed, to defer to another. This interdependence, paired with a belief that consent is not a once and for all event (British Sociological Association 1994) but a subject for negotiation, suggests that alternatives to the bio-ethical model are needed. This particularly in research aimed at including those who cannot meet the definitions in achieving autonomy, yet need to be heard and not exploited.

To move from the bio-ethical model, old age and mental health problems in old age need to be seen in a context separate from that of acute medicine and rather as disability, as discussed in Chapter 4. Within disability forums user involvement and credibility is established, shifting power from medicine to the person in the situation. Ethical principles can thus be developed from the historical “virtue ethics” perspective which centre on moral obligation. Moody (1992 p37) talks of negotiated consent (Box 5.4) as informal justice, involving the person in communication with all those involved in order to reach decisions. The ethical principle of social justice is seen as more pertinent than autonomy or beneficence.

Although Moody describes the subject of negotiated consent in the context of decision making around care and treatment and end of life decisions, I suggest it is applicable in considering research participation in using models of assent described above and by Dewing (2002). In attempting to achieve my sample, I have come across specific problems that could potentially be overcome using this approach. Firstly, due to the
demand for absolute confidentiality and risk of coercion, at the request of the ethics committees, I had to use a gatekeeper to make initial approach to potential participants. Given that those who make the approach are not skilled in communicating with people with mental health problems, I suspect that some potential participants are lost particularly those with the most subdued voice.

Bartlett and Martin (2002) describe similar concerns in using a gatekeeper. They felt that candidates were selected using the gatekeepers' personal judgements about the ability of people with dementia to participate rather than their potential against the research criteria. Secondly, there have been occasions when a proxy has declined to allow a relative to participate despite the person's initial will to do so (see p119). Using a negotiating approach I could explore the issue, with both parties. Of course such a communicative ethics approach does not obliterate the risk of paternalism either from staff members or from a relative; however, it does give scope to explore and challenge such positions.

If we are to move forward with the philosophy of hearing and responding to the view of the service user, the power and the assumed generic applicability of the bio-ethical model in considering research participation requires challenge. However, I feel somewhat ambivalent in making this argument as, despite my concerns about the hierarchical structure and process of Local Regional Ethics Committees, I know that the discipline has enabled me to find an appropriate path between not involving those who cannot consent and merely assuming consent through compliance. There is a balance to be achieved between the health service model of LRECs and the less stringent concern for attention to ethics evidenced elsewhere. To not give due attention to ethical concerns around involvement, especially with a vulnerable group, is to abuse vulnerability by unknowing inclusion rather than by unknowing exclusion.

5.12 Power

As discussed in the previous chapter, the relevance of power is apparent in many guises throughout this research, and indeed within the process of ethical approval just described. The interviews themselves as well as each participant's position within the general hospital setting, involve power dynamics associated with age, health status, competence,
professional status, expertise, gender, class and environment. Here I specifically address issues of power within the research relationship.

Although inequalities in power are "politically unacceptable", in a research relationship (Oakley 1999), they are inevitable. In holding the purpose of the interview, setting the date and venue and sometimes even physically assisting the person to the appropriate room, the researcher holds power (Hey 1999). Inequalities also occur due to any number of social differences between the parties involved, such as gender, ethnicity, age and professional status. Feminist discourse suggests that women are more effectively interviewed by women and the majority of subjects in this research were women, in each cluster group (Oakley 1981, Wolf 1996). In contrast Hockey and James (1993 p167) suggest that the research interview potentiates the use of "liminal" power in the participant (see Chapter 2 p38). Contrary to their submissive position within the hospital setting, the interview afforded participants the opportunity to be powerful, to critique the dominant order. This may have been exhibited through refusal to participate, by being controversially outspoken, overtly frank or subversive.

Box 5.4

NEGOITIATED CONSENT IS CHARECTERISED BY

1. The clash and balancing of competing interests: there are multiple, legitimate views to consider with compromise a typical result.
2. Shared or dispersed authority for decision making: no single party has exclusive power of decision and specific attention must be given, for example, to the structure of team decision making, or conflict or concensus among family members.
3. Negotiation is not governed by strict deductive rules; it is heuristic [uses trial and error] in its cognitive style, implying less reliance on codes of ethics and more attention for opportunities for discussion and discovery.
4. Negotiation is appropriate for situations where the ideal outcome is not attainable and making the best of a bad situation is the most that can be reasonably expected.

Moody 1992 p37
Interestingly in practice I found no such exhibition of liminal power from within clusters of older people. Rather it occurred among the relatives who were often critical of the system in ways that they had not overtly expressed elsewhere. This particularly occurred in Glimster General where I, the interviewer, sat wholly outside the powerful and rigid organisational structure (see also Chapter 6).

In examining the power dynamics within research participation I give particular attention to my role in Chapley Hospital where I performed the dual roles of clinician and researcher, and met research subjects in both capacities. Ideally I should have used independent hospitals, however, as I have explained in Chapter 1, when I commenced my research this was not possible due to realistic geographical consideration. Provision of established mental health service for older people in general hospitals using models other than medical referral was rare when this work was started in 2001, the nearest known site with a similar service being some 200 miles away. As with the issue of consent, described above, I have found that the necessary scrutiny, because of the challenge of being a clinician and researcher, has led to the development of approaches that can readily and appropriately be used in other situations.

Although within the realms of evaluation research the skills of the internal evaluator, a technical expert in the field, are acknowledged as being of value (Clarke 1999a) there is potential influence from the insider. Due to our clinical relationship potential participants may have been over-influenced to become involved in the research. Literature on service satisfaction data recognises that when users evaluate a service in which they are/have been involved, their response is likely to be falsely positive if they need to continue using the service or they know and like the staff working within it (Edwards and Staniszewska 2000). I had to minimise the risks of appearing to empower people by virtue of my position in the health hierarchy and by my knowledge of them and of the system. Older people may be particularly vulnerable to agreeing to participate in research, through paternalistic influences (Barraclough and Fleming 1991). In achieving a sample, undue
influence has been eliminated through the use of gatekeepers, as described, and indeed criticised, above (p121).

Within the research interview, I adopted various techniques aimed at minimising the "clinical" influence. Interviews were never conducted on a day when I was also working clinically on a ward. I emphasised that the research was about mental health problems and mental health service generally, not about my ability or their specific issues. I conducted interviews as conversations, adapting to the needs and timescale of the subject, attempting to take on the role of the "interested stranger" (Hey 1999), or therapeutic listener (Oakley 1981) who can achieve intimacy and then vanish. Professional language was avoided in line with Foucault's theories on the power of discourse. On the two occasions when a relative referred, during interview, to clinical issues unrelated to the research, I answered direct questions and confirmed that we would address the issue later (Clark and Keady 1996). Alongside these strategies I made concurrent field notes in which I reflect on any perceived influence or role conflict.

In practice, although I made conscious attempts to personally feel different on the days when I was a researcher rather than a clinician for example in my dress, my work colleagues failed to notice my changed attire and continued to ask clinical questions. As a fellow practitioner I continued to be viewed as an ally (Bloor 1997). Usually I could swiftly respond and return to role but on one occasion, I had to remove my research "hat", for a clinical emergency, and simultaneously lost a research subject. Indeed such role conflict also occurred at Glimster General where I was known to be a clinician as well as a researcher. This raised concern as I did not want to contaminate the data by providing mental health liaison clinical expertise to potential participants. I therefore avoided any such professional discussions until after any research interview had occurred.

Once within the interview situation clashes of role with clinical colleagues become unproblematic. The staff I have interviewed do not discuss "cases" at all, apparently
using a professional role boundary to do so. In the extreme one nurse referred to me, in the third person on several occasions:

Nurse Fiona: I refer to Gwyn Grout for advice...

My conflicting roles were often the subject of my field notes and reflections. In relation to interaction with colleagues, particularly fellow nurses, the presence of two, potentially conflicting role categorisations (Baker 1997) was again apparent when they, during interview, extolled the perceived advantages in having a nurse mental health expert rather than one of other professional discipline, notably medicine. Within analysis I had to consider how much of this was a message of solidarity between allies and how much was due to other factors such as approachability and scope of practical functional expertise (see Chapter 8). I found myself constantly on my guard to remain within the, less familiar, researcher role, while not becoming so distant as to lose the conversational interview style fundamental to my methodology.

In considering my dual roles in relation to the older people and relative clusters, my reflections centred on my clinical versus my research eye. Due to my years of experience I am embedded within my membership category (Baker 1997) of mental health nursing, and as such work within the dominant culture of bio-medicine. Moving from a stance of listening followed by action to listening alone was a challenge. For the majority of interviews focus and insight into the potential pitfalls was effective. However, particularly for those older people in Glimster Hospital who I felt to be depressed yet to have had this unnoticed, was a major challenge (see Chapter 7). As I write about it I continue to feel the conflict between listening and not acting.

In terms of role conflict issues on the part of older people and relatives I had met before I found that the older people did not stray from the research topic to seek clinical intervention. In most cases this is due to memory impairment such that our previous encounters are not recalled. Relatives, however, return repeatedly to the specificity of their relative's situation, often lacking an ability to generalise, maybe because of their current stress within the hospital situation. This latter occurred in both Chapley and
Glimster indicating that it was not my role that caused this focus. I will explore this more fully in Chapter 8 and consider whether relatives had more difficulty conceptualising the whole setting because they are not embroiled within it in the same way that patients and staff are. Older people in hospital take on the expected role as hospital patient and become part of a social world that their relatives view solely as outsiders focused on the piece of interest to them, i.e. their relative.

In considering the ethical issues surrounding this research I have contemplated my own position in conducting this research as a relatively younger person who, in our ageist society, may hold more power than the older participants. Such focus, by the powerful on the less powerful, could itself been construed as pejorative and ageist. Such arguments are often aimed at Gerontology particularly when researchers are examining their subjects from a “job” perspective with a potentially political agenda. I counter such a possibility by emphasising the inclusion of all the social actors in the setting and by asserting that to exclude older people would certainly be unjust.

5.12 Participant Detail

Before concluding this chapter and moving into analysis and discussion, appendix 6 provides detail of the anonymised research participants, by site, cluster group and, for staff, profession. I provide each participant with an imaginary name. I found potential relatives very challenging to recruit and eventually, in the knowledge that saturation of data had been achieved and in absence of further time, I remained with the sample as detailed. The majority were of white British origin with the exceptions having lived in the UK for many years.

In quoting responses I will detail my speech, as “Int”. Respondents are given a pseudonym, their cluster status (if not an older person in hospital) and a “C” for Chapley or “G” for Glimster, Chapley being the consultation liaison method site and Glimster the hospital using the traditional model of mental health service provision. For example,
Selina is a patient in Glimster General; therefore she is quoted with G. Selina. Fiona is a nurse in Chapley Hospital and is quoted with C. Nurse Fiona.

5.14 Conclusion

In this chapter I have described and explored my chosen methodology. The use of qualitative interviews across six cluster groups from two hospital sites ensures an adequate and diverse range of views of the social world; the general hospital. Such scope of data is required in order to utilize the theories of Interpretive Interactionalism and Social Constructionism and to interpret the data, in considering how mental health problems in old age are socially constructed in the setting.

I have examined the ethical challenges involved in the research. I discuss my rationale for not excluding people using arbitrary test scores, rather on their communicative ability. Maybe surprisingly it was more difficult to recruit people with depression than dementia. I also explain my rationale for not insisting on informed consent. In using an accent process I both facilitate participation and avoid the risk of exploitation. I afford much attention to the process of achieving ethical approval, challenging the methodology of bio-ethical committees in favour of a process involving negotiation.

Lastly I explored the concepts of power, influential in many guises, both empowering and disempowering, in the research. Particularly I explain the strategies used to minimise risks associated with my dual role as clinician and researcher.

I conclude that all research subjects should be afforded the same scrutiny to detail and that my attention is to the potential benefit of all potential subjects, all of whom hold a place within the complicated power dynamics of a general hospital setting.
Chapter 6

The Visible

In this, the first of three analysis and discussion chapters, I address the question: “How are mental health problems in old age conceptualised in the general hospital setting?” This chapter forms a foundation upon which the subsequent chapters and theories are built.

Here I examine the power dynamics that dominate each site and, through their presence, impact on the formation of perceptions of mental health problems in old age as overtly visible and socially bad behaviour. I suggest that this construction is an emphasis of the popular perception of mental illness described in Chapter 3.

In Chapters 7 and 8 respectively, I examine those mental health problems that are invisible in the setting and the nature of service provision. Although I have divided these chapters, the subject matter and discussion within each is not mutually exclusive and much of it is cross influential, particularly given the impact of the power dynamics that affect perceptions. In concluding the thesis, Chapter 9 brings together for further argument and discussion the issues as they converge.

Throughout the examination, interpretation and discussion, in this and future chapters, I particularly examine the language people use to define the issues. Evidence from each site and cluster group is examined for comparability and difference. In quoting data, participants are identified by a pseudonym and the site and cluster group, as explained in Chapter 5 (p138).

6.1 Introduction

As discussed in Chapter 2, various forms of power impinge on the social actors, the social settings and inevitably on the research matter within this work. Given that Social
Constructions arise out of local practices and beliefs as well as from wider cultural and social contexts, it is necessary to explore the influences that impact upon those practices and beliefs before delving into the generated data.

The power dynamics that might typify the setting became apparent during my experience with the ethics committees (p130). I became increasingly aware that I was entering a world of positivist, bio-medical dominance within which people with mental health problems were not seen as capable of engagement with any decision making. The imbalance between the vying powers of medical knowledge and organisational politics became increasingly evident as I progressed through data collection to analysis and exploration. These competing powers serve to ensure the exclusion of the consumer voice, particularly when the consumer is not readily warranted a valid voice.

As I was collecting data, meeting people, seeking research subjects and conducting interviews it became apparent that, although the sites are comparable in demographic make up, they were different in culture and organisation. In his study of a psychiatric hospital Lindsay Prior (1993) points out that each ward is different in culture, supporting Foucault’s suggestion that power flows through systems and that it can move differently between groups and within systems (Hey 1986, Lupton 1994). It is therefore unsurprising that Chapley and Glimster hospitals differ. The wards in Glimster General, where the traditional model of psychiatric consultation was used, seemed calmer and quieter, with more order than those in Chapley Hospital. I began to consider that there were differences in the understandings of the norms and expectations that govern being a patient in each site and also in the organisational goals and agendas that concern the staff. This feeling was emphasised as I became immersed in the interview data. While it is not the subject of this research to scrutinise these aspects of the settings, such differences potentially affect how those with mental health problems are defined and responded to.

As I discussed in Chapter 2, traditionally, patients have been expected to defer to those seen to have legitimate power, the health care professionals, and this renders them invisible as individuals and merely part of the group (Hockey and James 1993).
However, since the 1980s with the bureaucratisation of the NHS and the subsequent drive towards maximising consumer involvement and choice the direction of the flow of power is changing.

In examining the organisational differences I explore these three potential areas of difference traditional, organisational and consumer power before going on to consider how they may affect the perceptions of mental health and illness. In considering the differences between Chapley and Glimster Hospitals, in terms of power and influence, I conclude that there exists traditional bio-medical power in both sites with Chapley Hospital showing signs of movement towards a more consumer, person centred focus while Glimster General exhibits strong organisational power. Such differences do appear to influence the view of mental health problems in old age by the staff working in the hospital.

Having scrutinised the data around power, this chapter moves on to explore how the participants describe and view those older people in the general hospital thought to have mental health problems. I note that references almost exclusively define mental health problems in old age as being characterised by confusion and a presentation that does not fit in with the demands and anticipated norms of the social setting. Deviations from perceived normality are described in various ways, generally emphasising the nature of behaviour that does not fit in.

Before exploring the specific descriptors I examine the use of diagnostic terminology around confusion, concluding that this is not generally how mental health problems in this setting are defined. For the remainder of the chapter I scrutinise and discuss data suggesting that people with mental health problems do not fit into, and indeed are a threat to, the social world generally and specifically to that of the highly structured general hospital setting.

In concluding the chapter I argue that mental health problems in old age in the general hospital setting are defined, across sites and cluster groups, by the extent to which the
confused person fits into the social setting. The person seen to have a mental health problem does not fit in by virtue of their socially unacceptable behaviour. The divisions between normality and abnormality in this setting are emphasised by the power dynamics, the stringent organisational structures and the bio-medical focus that exist. It is to these issues of power that I now turn my attention.

6.2.1 Traditional Medical Power

In concurrence with the literature (Morgan 1997, Pilgrim and Rogers 1999, Vincent 1999) among the older people in both sites there is an expectation that, when in hospital, one must behave in certain ways and defer to the routines and direction of those in power. Carolyn Baker (1997 p130; see p39) explains how people attribute themselves and others with “membership categorisation” dependent upon specific role. In this way deference to professional power is readily accepted as the required state of mind and body for a patient in hospital. Selina, a patient at Glimster Hospital, comments on the perceived need to conform and disappear in to the group. She is aware that she has lost her individuality to the hospital routine, yet appears powerless to assert her uniqueness from within the prescribed patient role. She whispers her response that she dislikes being in this position, apparently signifying that she dare not contravene her expected position for fear of being found to be rebelling.

G. Selina: You're given a new life; you know what I mean...You're leading your life under a new name. It's all I can say
Int: Is it completely different to what you are used to then?
G. Selina: Yes, yes. In fact I don't like it... (whispered) Doing things differently; you know what I mean, getting up at funny times and going to bed at funny times, that's terrible. Quarter past eight, that lot that I am with. Sound asleep and I'm wide awake wondering what to do.

The expectation of conformity is also strong among the relatives with only Malcolm expressing that he dares to challenge the view of the hospital. He insisted that his wife, who has Alzheimers disease, would go home despite contrary advice. Here he speaks of another family in an extremely sad situation who feel powerless against the medical recommendation that she should go into a nursing home. Like others, particularly in
Glimster General, the family do not feel able to “stand up” and express their will to take their mother home. As Lesley, another relative asserts: “You feel very much in their power, a lay person can’t argue with them. They are the experts, they ought to know, they do know what is best, I can’t argue with that.” Such exclusion from decision making, around the future care needs for someone with dementia, correlates with the assertion of Cotter et al (1998) who discussed the lack of consultation with people with dementia about long term placement.

G. Husband Malcolm: Now I found out from a patient opposite, she had two daughters and they came and said to me one day “Mum’s got to go in a home” I said “why?” [they said] “because they’ve told me she’s got to go in a home” and they said to me “we wish we could be like you and stand up for Mum, but we’re not built that way” and it’s very sad.

Among the staff group at Glimster evidence of a historically based traditional service expectation is seen in several staff members who suggest that there are people in their wards who should never have been admitted. They feel that those seen to have mental health problems, in perceived absence of a “bad enough” physical illness, do not meet their expectation of category membership for a general hospital patient. Such a view, suggesting that problems with physical and mental health are mutually exclusive, was challenged back in 1924 in the Macmillan Report that suggested that demarcation between “ordinary parlance and derangement of conduct” was inappropriate (Jones 1993 p131, (p7), and is recently emphasised in “Everybody’s Business” (CSIP 2005).
However it appears that in Glimster General the Cartesian psych/soma division remains clearly defined with the entry of inappropriate patients seen to disturb the traditional equilibrium.

In the following quote Nurse Trish clearly separates physical from mental illness, seeing the latter as not hospital business. In his quote Consultant Peter suggests that those who are a challenge within the setting may be physically contained, to retain social order, using medication and cot sides (rails on the bedside that prevent a person from getting up). This may explain why Glimster General appears to be so ordered and why the staff there are less troubled by extremes of challenge in behaviour than their Chapley Hospital
counterparts as I explore as the chapter progresses. While there is evidence of a lack of willingness to accept caring for older people with mental health problems as core to the general hospital role among other cluster groups, and indeed the Chapley Hospital staff, there is not the emphasis on a clear definition about what conditions are proper to the setting. In Glimster General there appears to be a stronger belief that medicine and psychiatry are mutually exclusive specialities.

G. Nurse Trish: Often they don’t have medical problems. Often with the elderly we get patients; they don’t come in because they are ill, they come in because they are not looking after themselves... I think there are a lot of people who come to us because they are depressed because they have got mental health problems, not medical problems.

G. Consultant Peter: Dementia has always been at the bottom of the pile and it would be expensive to change it, for example to provide one to one nursing, rather than putting the cot sides up or increasing medication.

Coupled with this concept of bio-medical power from the general medical perspective is the macro power that psychiatric services hold in being the experts in the field of mental health and illness. Each group of professionals has a vested interest in sustaining the exclusivity of their knowledge and thus their power (Foucault 1974). I go on to explore this perpetuation of division further in the next two chapters noting here that it is highly influential in the way that mental health problems in old age are perceived in the general hospital setting. In both sites, issues of mental health and illness are seen as the business of external experts and not within the tradition of general medical knowledge.

6.2.2 Organisational Goals

As discussed in Chapter 2, the power within the NHS is shifting from medical to political/bureaucratic power (Pilgrim and Rogers 1999) with government targets focussing on waiting times and delays in hospital discharges. There is some suggestion within the data that the staff at Glimster General are more politically process focussed than their colleagues at Chapley Hospital, implying that Glimster has a power base within management whereby older people, who do not follow the expectation of the system to
come into hospital: receive treatment and go home; are more likely to be deemed as medically untreatable; in need of nursing care only and "not the responsibility of their budgets" (Vincent 1999 p52). The person with mental health problems therefore meets neither the traditional expectation of a patient (above) nor the organisational expectation that they will get better and be discharged. It becomes evident, as we move through the data, that such inability to fit in with general hospital expectation actually becomes the definition of a mental health problem.

Referral to mental health services, in Glimster, is more driven by the organisational agenda to move people through the system than that of their counterparts in Chapley Hospital, where referral appears to be more focused on the needs of the individual patient using a more person centred approach (Kitwood 1993). Although Val suggests that a psychiatrist is called to consider a person's safety, her emphasis is that the decision about whether or not this person requires specialist care underlines her perception that the person is socially inept (p95) and unsafe to go home.

G. OT Val: We have one [psycho geriatrician] who comes, basically if she is requested to. She doesn't come all the time. It's basically for people who come in, come in with a mental health diagnosis and the query is whether they are safe to go home or not. She'll get involved then to see whether they need EMI [elderly mentally ill] placement or whether they'll be fine in an ordinary placement.

As discussed above, Val defines the person as not being proper for hospital business due to the mental health problem and therefore in need of being systematically moved on. I go on to explore the definition of such older people as "poor things", who are perceived as incapable and not attributed with a voice, in Chapter 7.

The apparent organisational positioning of Glimster General appears to mirror the description from Gilleurad and Hill (2000 p101) who suggest that older people are seen as a sub class of consumers unable to exercise choice, even though they are the ones who most often use the services.
Old people are hurried in and out, their physical and social status assessed and their frailties noted and attended to as efficiently as possible within the law: or they lie, waiting to be claimed by some citizen consumer, a.k.a. carer, where the health service can discharge its responsibilities...And yet ironically at the point where the body becomes the defining element in a person’s life, the health care professionals re-orientate themselves. They construct disembodied packages of care in which the fourth ager becomes a series of categories of response, a new cultural text of met or unmet need.

Within structured organisations there are expected standards of behaviour, monitored and controlled by panoptic surveillance (Foucault 1979 p34). The general hospital setting, apparently particularly Glimster General, is a tightly controlled system whereby any observed deviation from the rules is either extremely apparent and frowned upon, or subdued, as Consultant Peter, above, suspects to be the case.

The relatives of older people with dementia in both sites are aware when their relative has moved beyond the boundary of the hospital’s organisational purpose. They know that those termed as “bed blockers” do not fit in, with Daughter Lesley using the organisation’s language that defines those who are “medically fit” as no longer having a rightful place. Malcolm suggests a political driver for such action in saying “possibly it is league tables”. The use of hospital colloquial language is evidence of the power exerted by professional staff whereby they control the agenda (Hewison 1995) ensuring that what they perceive as excessive and inappropriate length of stay is interpreted in the same way, and acted upon, by the relatives who are left feeling guilty.

Int: So, is this the right place for people like your Mum, who are ill?

G. Daughter Lesley: No. In a way it is because we've taken too long, trying to get her out. When she was stable, medically, as they said, then we should have been starting to move her out but, I mean, that's 5 weeks ago.

6.2.3 Consumer Power

With the Governments of New Labour in the 1990s and 2000s, emphasis is currently placed on the agenda of consumer choice (DoH 2000) with the recommendation of a shift in power from the traditional and organisational to that of the NHS service user. There is some evidence of movement in this direction within responses at Chapley Hospital.
Cathy, like her counterparts in Glimster General expects to have her future determined by the “powers that be” irrespective of her wish to return home. The nature of the power dynamic for an older person in hospital, render her, in her perception, inevitably subservient. She believes that, by courtesy of their powerful position, they have the right to take her house away from her if they deem it necessary. However, Cathy was due to go home shortly after the interview, but had forgotten that it was happening.

Int: So who did you think would make the decision about you going into a home then?

C. Cathy: Well, the powers that be...the sort of people ...who are people that knew all about that. I am not making that up ...that is the one thing that worries me so you know that they will say I can’t go home... well I have got my own house that I live in I mean, well they can take it from me of course they can, but I mean it is my house.

Among the staff sample from Chapley Hospital, unlike their counterparts at Glimster, there is no suggestion that any older people are inappropriately occupying hospital beds. Contrary to Consultant Peter’s suggestion above (p145), Fiona explains the explorative efforts she makes in trying to avoid using restraint. Many, like Dianne, describe their role in addressing complicated presentations. The Chapley Hospital staff seem less inclined to make traditional differentials between issues of the mind and body, while they establish “what’s going on” and how best to provide care.

C. Nurse Fiona: I have had several experiences of very disturbed people...
...Yes, and how to deal with them. The basic stuff, keeping them quiet, talking one to one, for any confused patient, we have absorbed and we can do it but we don’t always know what triggers them back up. I mean it might be a single word, or it might be an action. In one case it was a blue dress [that triggered the agitation] but it took us about 3 or 4 days to figure it was a blue dress....if we can’t find it we have really got to do something more constructive than one to one.

Int: And what would that be?

C. Nurse Fiona: Well unfortunately the duty doctors usually suggest drugs to sedate them or to put them in bed asleep for a few hours which I think is counter-productive, it doesn’t solve the problem, it just alleviates an immediate crisis.

C. Dr Dianne: Well, confusion is a big problem and then that could be just because of infections or, you know, simple things causing it,
but it then also can be gradual confusion from dementia or that kind of thing. We have had a number of psychotic patients as well that have obviously had problems throughout their lives that are just exacerbated further by them being elderly or then having other infections on top of that and then again that can be acute psychosis. We have to find out what's going on.

Such examples may suggest an organisation which focuses more on hearing the voice of people in hospital. Equally such differing focus, particularly towards those who traditionally do not belong, may result from differing modes of mental health service. It will not be possible to wholly untangle the route of these differences, in absence of comprehensive exploration of the organisations, but I further the analysis and discussion in Chapter 8.

Although there may be some evidence of a more person centred approach in Chapley Hospital, consumer power has a long way to go before it truly influences the power structures that exist in these settings. As becomes evident as we progress through the data, there is more visible assertive consumer behaviour from the relative clusters, who focus on the needs of their loved one rather than on the whole system, particularly in Chapley Hospital. I suggest that this may be because the relatives do not, so readily, become embroiled within the organisational system and the subservient role expected of patients. Equally, however, it could be because the relatives are mostly of a different age group who have existed in the world as consumerism has developed.

6.2.4 Site Comparison

Examination of the data suggests that there is little difference in the perception of power structures and hospital organisation among the older people and some of the relatives across the sites. However, differences in staff views are clear. The variety and instability of power influences in these two hospitals reflects the current power struggles within the NHS between clinicians, who traditionally held the reins, managers, politicians and the growing power of the patients themselves, as consumers.
In Glimster a traditional model of hospital care exists, with problems outside the perceived boundaries of the organisation, for example mental health problems, "overlooked, ignored and assumed not to exist" (Parker and Penhale 1999 p203) except when they affect the environmental order and organisational goals. There also appears to be a high focus on the current political drive to move people through the acute hospital system. Chapley Hospital feels more chaotic and is possibly moving towards a more consumerist and person centred approach with greater emphasis on individual choice.

Due to the more rigid organisation structure at Glimster General, mental health problems are potentially more readily described in terms of those who do not fit in with the perceived service criteria and focus on rehabilitating people who are able to conform. In Chapley a more fluid response is apparent. It is only those with extremes of deviant behaviour that are perceived as out of place. I continue to explore these apparent differences further in this chapter and also in Chapter 8 where I look at the impact of differing models of mental health service.

6.3 Perceptions of Mental Health Problems in Old Age

I now move on to consider perceptions of mental health problems in old age in the general hospital setting as described by the research participants. I consider the impact of the power differentials just described, as well as considering other influential factors.

I explore how the participants describe and view those older people in the general hospital thought to have mental health problems. I note that references almost exclusively define mental health problems in old age as being characterised by confusion and a presentation that does not fit in with the demands and anticipated norms of the social setting. Deviations from perceived normality are described in various ways, generally emphasising the nature of behaviour that does not fit in.

Before exploring these descriptors, however, I examine the use of diagnostic terminology around confusion concluding that this is not generally how mental health problems in this
setting are defined. For the remainder of the chapter I scrutinise and discuss data suggesting that people with mental health problems do not fit into, and indeed are a threat to, the social world generally and specifically to that of the highly structured general hospital setting.

I argue that mental health problems in old age in the general hospital setting are defined, across sites and cluster groups, by the extent to which the confused person fits into the social setting. The person seen to have a mental health problem does not fit in by virtue of their socially unacceptable behaviour. The divisions between normality and abnormality in this setting are emphasised by the power dynamics, the stringent organisational structures and the bio-medical focus that exist as explored above. The presence of such rigidity in organisation serves to exaggerate the presence of socially abnormal behaviour. Constructions of mental health problems in this setting are, I suggest, an exaggeration of those of the wider lay public, as examined in Chapter 3.

All participants were introduced to the research subject in the following way:

Int: This research is about mental health problems in old age in the general hospital setting. What do you think I'm talking about?

Going on to use the further probe if necessary:

Int: What would you see as a mental health problem here? How could you tell?

6.3.1 Defined by Medical Diagnosis

I explained in Chapter 1 that the underlying question which led to me undertaking this research was that I suspected that people in the general hospital setting do not use the language and definitions of psychiatry in conceptualizing mental health problems in old age. As discussed in Chapter 3 both literature and psychiatric service provision around mental health and illness have long been dominated by the perspective of psychiatric medicine, this despite significant advances in sociological and psychological study of
mental health problems in old age, particularly dementia as discussed in Chapter 4. Given this historical and dominant model, alongside the dominance of the bio-medical perspective in this setting, I here consider whether this position, taken for granted in psychiatry, is replicated by those in the general hospital setting.

In this section I first examine the responses as they appear to pertain to dementia. I go on to examine any differentials made between dementia and delirium. The diagnostic category of depression is notable in its absence. I explore this apparent omission in Chapter 7. Lastly, in this section, I explore any possible influence due to my position as a researcher whose professional background is within the field of medical psychiatry.

6.3.1.1 Confusion

In concurrence with the literature that suggests that professionals use diagnostic categories (Pilgrim and Rogers 1993, Prior 1993) all the staff from Chapley Hospital and the majority from Glimster General assert that mental health problems in old age are defined by the words dementia, cognitive impairment, cognitive problems or chronic confusion, used as medical diagnoses. They demonstrate a construction of dementia as the mental health problem in old age that they encounter, and are challenged by, day-to-day. Few use other diagnostic descriptions.

C. Nurse Fiona: Onset early dementia, dementia, Alzheimer's, cognitive problems, perceptual problems - the whole range.

G Discharge Nurse Ruth: Well I guess, short-term memory loss, you know, as we say, perhaps Alzheimers, those sorts of conditions really.

Interestingly although most of the staff members made reference to diagnostic identifiers, to describe dementia, as the interview progressed they all moved on to describe mental health problems in old age in terms of the impact of those perceived to have such conditions, have on the social setting. They did not use the diagnostic language of psychiatry. Such lack of sustained focus on the medical categories of psychiatry begins to suggest a lack of concurrence between the medical and the psychiatric position. It is as though the practitioners know, and can reel off, the language that is anticipated of their
professional position yet do not buy into the whole concept as it is defined by psychiatry. Using the terminology of Carolyn Baker (1997; see p39), they use the diagnostic language that becomes their status as members of the health professional category, yet they readily stray from it.

The patient and relative groups broadly do not use diagnostic terminology. Mary is the only patient participant to suggest that “senile dementia” is a mental health problem of old age. Mary is the youngest of the “older people” at 65, and clearly does not define herself as old in any way making no association to her own cognitive abilities. Olive and Pru are typical of the older old participants who define their own memory changes in terms of a phenomenon of normal ageing. Indeed consideration about whether or not memory problems constitute a mental health problem brought general consensus that some deterioration in cognition is to be expected as one grows older.

G. Olive: I know forgetful is a thing of old people, I mean I forget things, people younger than me forget things don't they?...And especially words. Oh and it comes instantly after a few seconds doesn't it? When you're not trying.... I've got all my marbles, but they get moved around sometimes.

G. Pru: Some people in old age get problems with their memory, don't they?
Int: So. Is that mental illness?
G. Pru: No, no, that's old age.
Int: That's normal old age?
G. Pru: Yes, I mean I forget things at times.

Such definition of relative normality, in the presence of ageing, suggests that older people themselves support the positioning of dementia, or at least memory loss, as a disability rather than a disease, in line with the suggestion of Jane Gilliard (2001) and others (Beresford 2002, Kitwood 1997, Manthorpe 2001, Adams and Bartlett 2003). The difference here however is that Olive and Pru are not using the word dementia to define their memory changes. They do not wish to tag anything that smacks of abnormality to their own experience. Here we begin to encounter some of the difficulties experienced in differentiating age related memory loss from dementia, a disease. As I go on to explore in this chapter it seems that the lay view, including the view of staff who do not work in
psychiatry, is that the attribution of the mental illness, dementia, only occurs in the presence of exhibited unusual behaviour. I also go on to explore in the next chapter the power of stigma in preventing people from acknowledging the presence of anything that may be construed as a mental health problem.

There is however something of a contradiction arising once a person has been given a medical diagnosis. Lesley, who has recently been told that her mother has dementia, demonstrates differentiation between disease and ageing, deferring to the knowledge of the superior medical standpoint. Vera too suggests that the attribution of a diagnosis turns an age related memory problem into a mental health problem.

**G. Daughter Lesley**  I thought, you know, that this was old age, that my mother was getting forgetful sometimes, said strange things and lied, but...but it didn’t occur to me that it was mental illness, as such.

**Int:** What about people with memory problems, would you call that a mental health problem?

**G. Vera:** I’m all right. I remember too well, that’s my trouble.

**Int:** Oh yes, I’m not suggesting that you have a memory problem, but some older people do have a memory problem. Would you call that a mental illness or not?

**G Vera:** No, I wouldn’t, I think it’s all part of growing old.

**Int:** You mentioned Alzheimer’s disease earlier?

**G Vera:** Oh yes. I’ve known several people who’ve had it.

**Int:** And would you call that a mental illness or a mental health problem?

**G Vera:** It is really isn’t it, because they seem to get worse, not better.

**Int:** In what way?

**G Vera:** More confused, more and more confused.

The attribution of the diagnostic labels appears to exaggerate the confusion and make it worse. This differentiation may demonstrate the power and influence of medicine over the lay view and indeed the medicalisation of old age and dementia (Vincent 1999, Adams and Bartlett 2003, Redfern and Ross 2005). Alternatively Vera’s differential perceptions, characterised by medical diagnosis of Alzheimer’s disease, may suggest that in her eyes, mental illness is present when one is “worse” and “more and more confused”
than one is in normal old age. Such presentation is evidenced by the behaviours I explore below.

In Chapley Hospital all of the relatives had had contact with mental health services and spoke of the diagnosis of dementia. As John Keady and Jane Gilliard (1999 p248) found in their study on experiences in Alzheimer's disease, they seem to find that being given a diagnosis and information about the condition helps “to place retrospective and current events in context”. Angela appears to find support in having a diagnostic tag with which to associate her mother’s problems. Helen however demonstrates her preference to minimise the impact of the dementia diagnosis by adding “age” to the diagnosis, therefore somehow cushioning the blow. This distinction between old and ill again underlines the societal power of bio-medical diagnosis and the “Alzheimerisation” of dementia (Gilleard 2000). Older people who have memory problems that may be seen as usual in old age become something different, and potentially something more frightening, as I go on to explore, when a diagnostic label is attributed.

C Daughter Helen: Their brain capacity has diminished. They have got older. That's how I understand it. It's an illness isn’t it, dementia or Alzheimer’s or however you like to label it.... it seems to be mostly dementia. It seems to me that they are that sort of age group that you could put it down to age dementia really.

Int: And when you had an [mental health] assessment, what do you think was the value for you and for your Mum, or was there any?

C Daughter Angela: Well I think it was good for me because I am now aware of her condition and how it is labelled in some way and it is treated and in what way it can't be treated. You need to be aware of it so that if she goes back home, you need to adjust maybe her home environment to accommodate that.

The older people in both sites and the relatives from Glimster, who have either had no contact with mental health services or do not recall their contact, did not tend to use diagnostic terminology. Rather, as I go on to explore, they describe what they see and what they hear as defining their understanding of mental health problems. As with the attribution of a diagnostic label, what they see, hear and experience changes their acceptance of diminishing memory in old age.
However, before I go on to consider the non-diagnostic descriptions of people with mental health problems I consider the diagnostic category of delirium.

### 6.3.1.2 Delirium

As discussed in Chapter 4, delirium is a medical diagnosis describing temporary signs of confusion due to reversible medical cause(s). It is estimated that up to 50% of older people entering a general hospital setting will experience an episode of acute confusion (Phair 1999) either at the point of admission or during their hospital stay. Many of the behaviours and assumptions discussed below could be attributed to someone with diagnoses of delirium and/or dementia, particularly those of aggression, noisiness and sleep disturbance yet few participants made any differentiation in diagnostic terms.

In comparing the interview data from the staff samples in Glimster General and Chapley Hospitals it is notable that the majority of staff at Chapley, the liaison site, consider the potential presence of a diagnosis of delirium, whereas there is minimal such emphasis from within the Glimster cluster.

C OT Elizabeth: When I get somebody referred who is confused, the first thing I do is ask why? Have they got a UTI [urinary tract infection] ...and ask questions that are suitable that might explain the reason for it. ...Why are they confused? Can we have a look? Is it something physical? Is it that they are deaf?

C Dr Dianne: Confusion is a big problem and then that could be just because of infections or, you know, simple things causing it?

That Glimster staff do not readily differentiate could be seen to concur with the limited medical literature (Inouye 1993, Fick and Foreman 2000, Milisen et al 2005) and Irene Schofield’s (1997) discovery, among her sample of older people who had experienced delirium, that staff interact with people with delirium as if their brain damage was permanent. The ability of some of the Chapley staff to make the separation between delirium and dementia as psychiatric differential diagnoses may be an indicator of an
educative effect of the consultation/liaison model of mental health service (see Chapter 8). However, it could equally be argued that in Glimster General, where there seems to be a clear focus on medical categorisation, delirium is seen as a biological medical condition and thus not categorised as a mental health problem. Sue’s comments appear to suggest this to be the case.

G Service Manager Sue: I think there are actually patients with dementia but also, which aren’t strictly mental health problems but who are a problem on the wards, acute confusional states.

As the rationale behind the perceptions of participants was not explored in relation to delirium, it is not possible to fully explore the reasons for these differences in response. I concur with others in suggesting that much more research is needed into the subject of delirium. This is required both in examining recognition and appropriate attention, and also in considering perceptions of the condition and responses to it, from the view of the sufferer. All that I can infer from the data here is that it is possible that the style of mental health consultation liaison provision has influenced the Chapley Hospital staff into excluding delirium before dementia is assumed.

Among the non-staff cluster groups, only Rose alludes to her delirium at the time of the trauma of her fracture.

G Rose: It's all a lot of sudden shocks you know as, in a way, it was to me when I broke the femur. I wasn't quite there either for a day or two. My mind was gone.

As with the differentiation of delirium and dementia, among staff there is no evidence of specificity with regard to differential dementia diagnoses, such as Alzheimer’s disease or Vascular Dementia as readily occurs among mental health professionals. Nor is there any emphasis on early diagnosis and therapeutic treatment options in line with the political drivers at the time of data collection (DoH 2001a). Indeed, nobody mentions any possibility of medical treatment for older people with dementia, other than to suppress the behaviours I explore below.
6.3.1.3 The Biomedical Position of the Researcher

In examining perspectives on mental health problems in old age from a biomedical perspective, I have considered how my position as a researcher may have affected the nature of the response with regard to diagnostic categorisation. Some of the participants were aware of my dual role. As discussed above there is evidence that the staff in the Chapley site were more likely to consider differentiation between delirium and dementia. However, given that the staff in Glimster Hospital also knew of my professional role I do not feel that the difference can be attributed to any Hawthorne Effect, whereby a research participant is said to respond in the way that s/he feels that the researcher would desire him/her to. In terms of diagnosis of depression and dementia, there are few site differences with regard to diagnostic terminology used, indeed the staff at Glimster hospital mention depression more readily, as I note in the next chapter.

The relatives cluster group at Chapley hospital use diagnostic terminology readily, due to information that they have received during mental health intervention. Although they knew me, the researcher, from our clinical encounters I did not feel that they were giving the diagnostic answers because they thought they were the right answers. Rather I felt that they reflected the knowledge achieved through a clinical mental health encounter, irrespective of who that was with. The older people’s cluster groups are comparable in that all but one of the Chapley older people had no recall of having met the interviewer in any context other than as a researcher.

In this section I have considered how the participants conceptualise mental health problems in old age in the general hospital setting in terms of medical diagnosis and note that such usage varies between the cluster and site groups. The staff tend to list diagnoses, but not necessarily elaborate further on their medical meaning and any associated medical actions. There is some difference in perceptions about delirium, whether it is noted or whether it is defined as outside the boundaries of mental illness. Relatives and older people do not generally use diagnosis to define mental illness until a condition has been thus defined by a health practitioner.
Already it appears that the language of medical psychiatry, as definition of what constitutes a mental health problem in old age, is not shared by those within the general hospital setting. I now go on to explore how the social actors explain their perceptions in terms of what they see and hear from those who they determine to be mentally unwell.

6.3.2 They Don’t Fit In

In this section I explore how the respondents perceive mental health problems to be present, in older people in the general hospital setting, by virtue of some aspect(s) of overtly visible behaviour which is seen as not appropriate, and not fitting in, within the environment. As discussed in Chapter 3, mental illness has long been defined, in lay terms, by behaviour outside the realms of social normality within the dominant culture (Pilgrim and Rogers 1999). Unsurprisingly this view is reflected in the perceptions of the older people and relatives in the general hospital setting. Maybe more surprisingly is that this lay view, rather than a bio-medical view, also dominates the perceptions of the staff members in both Chapley and Glimster Hospitals. Older people with mental health problems in this setting are seen as inauthentic, insincere and abnormal and a threat to the social order of the setting (Crossley 2000). Here we again note the power of the social setting from both professional and organisational perspectives, as it indeed becomes more and more apparent as we move through the data. The tight professional and organisational regime of a general hospital makes those who deviate from expectation all the more noticeable.

Before looking at some of the ways in which inappropriate and deviant behaviour is described, I examine the use of some nouns to describe people with mental health problems and reflect the detachment of these people from the broader “normal” society members. The use of such language defines the person as morally different, deficient and deviant. I go on to explore how mental health problems, in this setting, are defined by the way in which a person speaks before looking at aspects of perceived adverse behaviour.
6.3.2.1 Derogatory Descriptors

Several participants, though few staff members, used specific derogatory societal descriptors to define people as having mental health problems. This reflects a view, as discussed in Chapter 3 as emphasised in the media, that focuses on difference and depicts those with mental health problems as being socially bad, dangerous (Ward 1997, Philo 2001, Clarke 2004) and morally weak. The use of disparaging language, such as that used by The Sun (2003) when describing Frank Bruno, a boxer who became mentally unwell, as “bonkers”, serves to belittle the person with the mental health problem, rendering them powerless. They become insignificant and disabled in a social world where there is an expectation for conformity and control. I suggest that, in the powerful, ultra-controlled environment of a general hospital ward, deviation from expected behaviour may be even more stringently noted and frowned upon.

Nora’s remarks encapsulate many aspects of her perception of mental ill health by attaching both behaviour and a derogatory descriptor in the following quote. She sees people with mental health problems as behaving strangely because they are “barmy”. She suggests that such people are not up to the anticipated moral strength of a “normal” member of society and nor are they able to perform meaningful, sensible activity. Such definition is in line with Graham Scrambler’s (1997 p173) suggestion that people who behave badly become “unacceptable or inferior beings”.

Int: So when I say problems with mental health, what do you think I’m talking about?

G. Nora: Well, a bit barmy in many ways.

Int: And how can you tell if somebody’s a bit barmy? What would they be doing, what would they be saying?

G. Nora: Well they wouldn’t be up to the strong strength would they? ...They’d be flicking about with one thing and another

Int: flicking about?

G. Nora: um, yeah

Int: what walking about or...

G. Nora: no, sort of doing different things

Int: unusual things?

G. Nora: I’d say.
The use of derogatory terms is further demonstrated with references to people with mental health problems suggesting a faulty personality and badness. Janet describes this in terms of “weakness” and being “naughty” on purpose due to a “wicked streak” in them. Felicity suggests that people with mental health problems are “in trouble”, making clear links with perceived unlawfulness. Olive sees herself as having been extremely fortunate not to have come across anybody characterised by these alien, and potentially dangerous, qualities while Pat confirms that if you are not displaying any of these negative attributes, such as losing your marbles, you are “good”, clearly implying that those with mental health problems are “bad”.

C. Felicity: Well I don’t think I know many people with mental problems. Not really I haven’t known anybody that was in trouble.

G. Olive: I don’t know. Fortunately I’ve never met it. ... Fortunately, I’ve not met anyone like that. You know.

G. Daughter Pat: Her short term memory, and in fact, she and the lady sitting next to her, she was a lovely lady, and she was 91 but she had all her marbles, she was very good.

Presentation that is defined as morally inappropriate is further mentioned, by some of the relatives at Glimster general, in terms of stealing. The dementia care literature defines such behaviour as rummaging (Armstrong 2002) yet here it is clearly seen as indefensible with the use of strong negative language associated with fear. As Bender and Wainwright (2004) suggest, behaviours that are not actually under the control of the person are perceived as “deliberate, obstinate and bloody minded.”

G. Daughter Rachel: My mum is constantly worried because she thinks that [the woman in the next bed] will steal her things from her locker.

Others use derogatory descriptors such as “daft”, “dotty”, “doollally”, “mad” to define those who do not fit in, with Christine defining those with “behavioural problems” as “dumps” because she feels that her ward is seen as a repository where such people are “batched together” (Prior 1993 p151). Not only does this description depict a notion that
people with mental health problems are the rubbish of society, or in this case the rubbish within the hospital system, but also that Christine does not feel it appropriate that she, and her colleagues, are dumped upon in this way.

C. Nurse Christine: Yes. I think the majority of people that we get have got ... behavioural problems. I think we are the repository for people that other wards find difficult to manage ... I think generally they come to us because the rest of the hospital have this perception that we take the dumps and if you don't know what to do with this person, put them [on this ward]. ... Yes, well we don't get young, well we have had a few people who have been younger than we wouldn't traditionally take and you hear "oh we are going to get someone in their 60's" and you automatically think "well what's wrong with them then, what mental health problems have they got?" and 9 times out of 10 they have got one.

The data explored in this section emphatically describes older people with mental health problems as a breed apart from the majority of older people in hospital. They are constructed, through the language of the derogatory descriptors used, as outside the expectation of the setting. The perceived attribution of a mental health problem creates judgements about their morality and their existence as a valid entity in this social world.

I now go on to explore how those with mental health problems in the general hospital setting are noted by the research respondents by their overt behaviour. I divide this into descriptions about speech and perceived threat.

6.3.2.2 Abnormal speech

Several of the older people and relatives in both hospitals suggest that not using appropriate language is a sign of "being doollally", as Helen, the daughter of a woman in Chapley hospital, terms it. Those with mental health problems "talk silly nonsense" and "go off on a tangent." Lesley describes how her mother "lives in a dream" thus underlining that, as someone with a mental health problem, she does not exist in the same world as the rest of us. Oliver, the husband of a patient in Glimster General, suggests that the staff treat his wife differently, and as if she were mentally ill, because
she has difficulty with verbal communication following a stroke, even though Oliver does not perceive her to have a mental health problem.

G. Daughter Lesley: Now she spends a lot of time in imaginary dreams, dreaming away. And she'll say strange things. The other day I came in and she was obviously preparing for some sort of church fete, well, school fete it might have been, and "go and get that bench from over there and we'll put these two together and make an angle, and then we stack these tins up on them" you know, and getting annoyed if I didn't do as I was asked.

G. Husband Oliver: My wife has had a stroke and can't express herself properly. Some of the nurses treat her as though she is daft.

6.3.2.3 Threat to Social Order

I will now explore further how conclusions are drawn, through the presenting behaviour, that someone is mentally unwell. As discussed in Chapter 3, mental illness has long been associated with demeanor and abnormal, unusual behaviour which does not fit in, and which may be socially harmful (Szasz 1963, Scheff 1966, Prior 1993, Pilgrim and Rogers 1997, Crossley 2000). Most of the older people interviewed describe mental health problems in terms of the behaviour that they observe. They ascribe the behaviours to people who are confused, without (with the exception of Mary above, p151) terming the mental illness as dementia. This broad definition of dementia as "behavioural disturbance" concurs with Adams and Barletts' (2003) assertion that because dementia does not fit in with the general medical paradigm of disease, it can be defined through behaviour. Descriptions of dementia as challenging behaviour also correlates with the findings of Rachel Norman (2003) who found that staff working with people with dementia in a general hospital setting defined dementia as a thing that impacted on behaviour, and is particularly characterised by behaviour that is seen as meaningless, as Nora (p160) noted in talking of "flicking about".

Paul Spicker (2000) suggested that people with dementia "are seen as a problem due to adverse impact on others in the way they interact and demand attention, repeat questions, use bad language, display vulgar habits, are noisy, aggressive, rude and disruptive". It is
also noted in the literature that definitions of behaviour, in dementia, as troublesome, occurs more readily outside of specialist settings (Middleton et al 1999). This view is reflected across the cluster groups and by almost all of the participants, to a greater or lesser extent.

The combination of the medical and organisational vying power bases in this setting serve to emphasise boundaries between what is acceptable and not acceptable in this social world. Again I suggest that the very controlled nature of the general hospital setting makes deviation from a strict norm highly noticeable and all the more intolerable and as a threat to the smooth running of the system. Those who are perceived to have mental health problems are thus potentially more visible in this environment than elsewhere.

A variety of behaviours and perceptions which have an adverse effect on the cultural expectation of the clinical environment are described. Those who impact on staff time, those who do not follow advice, who are seen as causing risk and those who are thought, through their presence, to adversely affect the health prospects of others, are all cited as having mental health problems. All these can be defined as a threat to the social order of the setting.

The issue of the time spent providing care for people with mental health problems in this setting, is a particular concern of the relatives at Chapley hospital, whose relatives have mental health problems. Their responses suggest feelings of guilt that their relative should take up time inappropriately, stopping staff from performing their “real” nursing duties. While they do not overtly suggest that their relative does not belong and is undeserving of a place in the hospital, the implication is present.

C. DiL. Ellen: Yes and I don't think it is fair to expect the nurses to have eyes in the back of their head thinking oh I wonder where so and so's got to and apart from anything else if they have got to keep running and bringing them back, running and bringing them back it is detracting from the nursing isn't it?
The risk of older people wandering, that Ellen alludes to, is an issue noted by members of each group with the exception of the patients from Glimster General. The language used, particularly by staff members, emphasises the anxiety that this behaviour causes due to the perceived risk that the older person may get lost. However, as with the Chapley Hospital relatives, this is overlaid by a message that the presence of people who wander, and who thus require additional nursing time, prevents staff from attending to the proper general hospital business. Christine stresses that she is “trying to go in and do things for other people” and both she and Linda emphasise the strain that nurses feel at being diverted from their real work.

C. Nurse Christine: I mean we have our lady at the moment who is just wandering all the time and we are trying to go in and do things with other people and we are having the same conversation over and over again, I mean she can’t help it at all, it's just really not a great environment for her, there are people rushing around and she wants reassurance and things explained to her. You start thinking, “Oh I've told you, I've told you!”

G. Nurse Linda: You do hear in people's voices the strain of caring for them sometimes. “Oh please, sit down”.

As well as taking up inappropriate amounts of time, participants across the cluster groups and sites mention that those who have mental health problems do not behave as they are expected to and do not do as they are asked. This tendency is often perceived as purposefully bad. Powerful words and terms such as “refuses” “non-compliant” and “unco-operative” emphasise an assumed intent at disruption of the equilibrium of this environment. Tom is particularly emphatic in describing his belief that the man in the next bed to his “ought” to behave in the expected way, and do as he is told. He described how he argues and tries to fight when nurses are trying to assist him to have a wash and get dressed in the morning.

G Tom: well, [it's his] attitude to staff really, you know, he doesn't co-operate and all that sort of thing. In my opinion anyway. I don't know, maybe he can't help it. I don't understand...You can listen to it all and it's um, to me he's very unco-operative and puts on this stuff. I would never be able to; I would never have done that. He doesn't co-
operate with them, as he ought to be. That's my personal opinion.

Similarly Olive and Malcolm suggest that people with mental health problems perform certain acts in order to achieve undeserved attention. Such attention seeking behaviour could be described as the exhibition of liminal power, as described by Turner (1974, see p38), that is the exhibition of power from ones subordinate and transient traditionally disempowered position. It is already clear that people with mental health problems in the general hospital are not viewed as having equal validity to those not perceived to have such problems. They are generally seen in terms of a derogatory descriptor and/or in terms of the behaviour they present, a wanderer, talks rubbish etc. Thus they are not afforded a voice with which to have their needs heard, and possibly receive no attention unless they exhibit that very behaviour, powerful deviant behaviour, that defines them as mentally unwell. This is something of a Catch 22, but, as Olive describes it does achieve recognition.

G. Olive: I think it's about attention...probably, well that's my opinion...I think a lot of it is to get attention. Rather like the lady in the ward who keeps pulling her skirt up. She did it this morning and nurse said "don't keep pulling your skirt up".

Int: And, you think she did that for attention?

G. Olive: I think so.

A further way, in which people with mental health problems are seen, is through the attribution of negative impact from them upon the well-being of other older people in the setting. In both sites relatives anticipate that they will "fiddle with things and be dangerous" "because they are not aware of what actions they are doing, they are not responsible for their own actions and therefore they could touch something...."

Noisiness is, according to older people and relatives at Glimster General, a clear indication that mental health is a problem, particularly when it occurs at the wrong time of day, is seen as inappropriate, sounds distressed or is demanding. Although Louisa attributes meaning, pain, to the behaviour she still classifies it as a sign of mental ill health because it is disruptive to her sleep and to social order.
This attribution of a mental health problem, even when another explanation is possible, correlates with Oliver’s assertion above that his wife is seen as having such a problem. Because she exhibits an abnormal behaviour, inability to communicate verbally, she is seen as mentally ill even though the reason for her lack of speech lies in her physical illness. This tendency to define mental illness as opposed to physical illness, particularly at Glimster General, mirrors the comments made by some of the staff members, reported earlier (p145), suggesting that older people were inappropriately being admitted to a general hospital in the presence of a mental health problem. This suggests that the presence of a perceived mental health problem obliterates the possibility of any other concurrent health problem, wholly overshadowing it. The person becomes the problem.

Others, particularly older people in Glimster General, feel distressed that they have to share their experience with those who cause them distress. Mary asserts “It is just so sad to listen to...it’s horrible, how does anyone cope with that?” Selina’s distress is such that the presence of people with mental health problems makes her fear for her own sanity. She wonders if she will become tainted by them if her exposure to them continues. Ellen talks of how some family members avoid visiting the hospital for fear of observing the behaviour of those who are mentally ill.

G. Selina: I don’t agree that they should be in with other people. Because it makes other people think that they are the same. It actually makes you worry about your own sanity does it? Yes, you do worry about what’s going on and are you thinking like they are...um...you know... because it’s playing on your mind like that?

C. DiL Ellen: Well no I think that is off putting. I mean, I know for a fact that my son they will come up but they will find it very, very hard to cope with that as a visitor. I mean I can sit there and I can steel myself to it but I know they won’t they will be in and out in 5 minutes; they just can’t cope with it.
These expressed worries provide powerful messages about the fear associated with mental illness, a phenomenon that people do not want to see, for fear of being contaminated by the stigma that it would bring to them. In the next chapters I explore further the potential drive for an "out of sight, out of mind" approach to mental health problems which seems to be attractive in order to distance oneself from any contact with people with mental health problems.

Several participants from the older people and relative clusters at Glimster General believe that the presence of people with mental health problems disrupts the progress of other patients. Natalie feels that this is particularly so when one is at a low ebb due to the effects of illness.

G. Daughter Natalie: But it feels a bit unfair that, you know, their problems and that are impacting on the other patients. Because, you know, they're not getting any sleep... Obviously everyone on the ward has their own problems, that's why they are there. It's not like normally when you are more tolerant aren't you, of things, but if you are not well, or whatever, your tolerance levels are going to be low.

The views and perceptions of both relative cohorts differ from the other groups in that they are more influenced by and focused upon their own experience, and its perceived influence on their loved one, than on the perceptions as influenced by the nature of the powerful social setting that is a general hospital. It is noticeable that the relatives from Glimster General noted noise and distressing behaviours that would disrupt their relative's progress, much more than their counterparts at Chapley Hospital. Throughout the analysis I noted that while older people and staff were able to generalise about the issues under discussion and explore possible potential solutions, the members of the relative cohorts rarely did so. It seems that they are less embroiled within the power struggles that exist in the social setting. Unlike the staff and the older people they do not have such a fixed hospital membership category to fulfil (Baker 1997), although they are expected, as demonstrated by Malcolm above (p144) to conform to medical and organisational recommendation. Their focus, and probably their anxiety, is centred round their relative, to the exclusion of generalities. Despite this difference in focus however,
they concur with members of all the other cluster groups that mental health problems in old age in this setting are characterised in extremes of behaviour.

So far in this chapter I have explored the data as it presents that mental health problems in old age in the general hospital setting are noted in the presence of behaviour that disrupts the equilibrium of the environment. There is however evidence that those broader influences, from wider society and the media (Philo 2001, Clarke 2004) impinge on these perceptions. Participants from across cluster and site groups see aggression as a potential indicator of a mental health problem. There is some suggestion that violence is viewed differently by the staff groups, with potentially greater understanding and tolerance at Chapley Hospital where Christine feels that they “handle it fairly well” and refers to mental health services only when problems are “huge”, whereas in Glimster General “people don’t like it”. The assertion from Christine appears to be in contradiction of her earlier reference to the “dumps” (p162). I will explore this apparent ambivalence towards her role in caring for these people, and general difference in approaches to care and treatment, further in Chapter 8.

C. Daughter Geraldine: mental health would be very much um er aggression ...; it may be but not always. Aggression and frustration. I think those are the headings I would put mental health under.

G OT Val: Memory wise it is easy but not if they have end stage dementia and are a bit aggressive to the staff, people don’t like it.

C Dr Hannah - I prioritise some [referrals to mental health services] as particular urgent and that is usually when there are huge features of aggression say and my strategies have failed.

### 6.4 Discussion

As recognised in the literature (Schofield 1997, Fick and Freeman 2000) there is an assumption that deviant behaviour in old age in the general hospital setting is characterised by confusion, and moreover by a confusion that is permanent. Although some of the staff at Chapley Hospital elude to the possibility of delirium this is not the focus of much attention. Dementia, as exhibited in challenging behaviour, is the mental health problem of old age in this setting.
The data presented and explored clearly suggests that perceptions of mental health problems in old age in the general hospital setting are similar to, and exaggerated from, the perceptions of the wider lay society, concurring with the literature (Prior 1997, Pilgrim and Rogers 1999, Crossley 2000). The view is arguably magnified within this rigid microcosm of the wider society where any deviation from “normality” is perceived as more extreme.

Scheff used labelling theory to explain mental illness as violations of social norms (Porter 1998, see p48). Those who do not follow societal norms, which he calls “residual norms”, are labelled as mentally ill. The older people defined here as having mental health problems are those who do not follow the residual norm of being a hospital patient. Older people in hospital are expected to behave in a defined and subservient way. They are expected to conform to the organisation of care and treatment and not to disrupt the focus of the system. They are thus categorised as “patients” who should conform (Baker 1997). Those who do not meet the expectation of their category, through behaving unusually or by being out of line from expectation, are assumed to be mentally ill. Along a similar line of argument, the societal categorisation of mental illness, as explored in Chapter 3, is that mental ill health is associated with badness and violence. It appears that for some there is a double categorisation leap from older person in hospital who does not conform, to mental health problem, to potential risk and intentional badness. Older people with mental health problems are not seen as “good” patients as becomes further evident in Chapter 8 when I examine the service that is sought for these people.

As discussed in Chapter 4, the current focus among those who study and work with people with dementia is that care needs to focus on a belief that dementia destroys the brain but not the person (Brooker 1995, Kitwood 1997, Hughes 2001). It appears that the broad general hospital perception is that mental illness, dementia, does produce a damaged and disruptive person. It may also be argued that, because of the ageist invisibility of old age as I explore further in the next chapter, abnormal behaviour in older people is less readily tolerated than in their younger counterparts. Older people in
particular may, through their perceived social uselessness be expected to be even more compliant than the younger hospitalised person, thus when they are perceived as abnormal it is seen as even more extreme.

It is interesting that the staff groups, in both Glimster General and Chapley Hospitals, concur with patients and relatives in their images of mental illness. They are able to come up with a list of mental illnesses, that they have learnt along the way, yet, as non-psychiatric specialists, defer to their lay perceptions in describing how they define mental health problems. As has been discussed in Chapter 3, this is evidence of the ongoing chasm of the Cartesian division between medicine and psychiatry. Mental illnesses, although known through the terms of medical diagnostics, are not categorised in the same way by those who work within the field of pure medicine. None of the staff consider “dementia” in terms of signs and symptoms, or indicators of a disease state as they would a diagnosis of “stroke”, for example. As I move through the thesis I will further consider the stigmatized power of the psychiatric label and how this may impact on perception and avoidance of involvement.

Also of interest is that the older people at Chapley Hospital, who had all been seen by mental health services and had, except for one, diagnosed dementia, did not perceive themselves as having mental health problems. They do not feel socially deviant or different from their fellow patients yet they can perceive such differences in others who are exhibiting unusual or disruptive behaviour. This suggests that mental health problems in old age in hospital are constructed only by those outside of the experience. However, as I explore in the next chapter, this is not the case in depression.

6.5 Conclusion

This chapter has explored the differences between Chapley and Glimster Hospitals in terms of their power structures and organisational goals, as they influence perceptions of mental health problems in old age in each setting. I note that the older people and relative clusters did not significantly differ in their perception of the organisation, tending
towards a perception of traditional medical power. Responses from the staff, however, suggest a differing organisational focus with Glimster General more geared towards the organisational goal of moving people through the system and Chapley Hospital potentially moving towards a greater person centred, consumer focus.

I have demonstrated, through the data, that people with mental health problems in old age in the general hospital setting are seen as confused people who are morally different, deficient and deviant. When an attributable behaviour is present, any other potential cause including the presence of a biological illness, even if considered, seems to become secondary to the predominant deviant presentation. I have outlined the various ways in which the social deviance is described and suggest that the constraints of the setting, both in terms of organisational and bio-medical culture, render levels of tolerance lower. Given the perception of what constitutes a mental health problem in this setting, that is somebody who does not comply with the social norms, it appears that any older person who exerts personal power is in danger of being so labelled. Not to conform with service expectation is unacceptable.

I suggest that the social construction of mental health problems in old age in the general hospital setting is an emphatic exaggeration of the lay perceptions within wider society as discussed in Chapter 3 of the literature review supporting this thesis. Despite the medical nature of the setting, psychiatric, bio-medical constructions are not used, even by the staff members, to describe the phenomenon of mental illness.

I have noted that almost all of the data around mental health problems in old age, as constructed here, refers to the potential medical diagnoses of dementia or delirium, to the exclusion of depression. In the next chapter we will examine this further as I explore the invisibility of mental health problems in old age in the general hospital setting.
Chapter 7

The Invisible

7.1 Introduction

As seen in the previous chapter, the respondents describe mental health problems in terms of socially deviant behaviour and focus on older people who are confused. In this chapter I explore mental health problems in old age that would, using psychiatric biomedical construction, be termed as mental illnesses and yet are not visible as such to the participants in this study.

In the exploration of the literature, Chapter 4, the most prevalent mental illnesses of old age are bio-medically defined as delirium, depression and dementia (Holmes et al 2002, Royal College of Psychiatry 2005). In the previous chapter I noted a lack of distinction made here between delirium and dementia. It is also apparent that dementia is only visible in the presence of adverse behaviour and confusion, such that it disturbs the equilibrium of the controlled setting. Dementia is not defined by diagnostic category and characteristics as expected in the psychiatric medical model. Such perception potentially leaves other mental health problems in old age invisible, unrecognised and unaddressed. It is this potential that I explore within this chapter.

Here I examine the data around people with cognitive problems who are not defined as mentally ill but rather by a category of social incompetence that Louisa, an older woman in Glimster General, calls “poor things”. The loss of faculties is attributed, by the participants, to a natural part of the ageing process, when memory loss is not accompanied by any socially disruptive element. As the chapter progresses, I move on to look at the apparent effect of stigmatization on perceptions of mental health problems in the general hospital setting. It transpires that the presence of ongoing stigma is evidenced through the participants’ emphasis on their own exclusion from association with the phenomenon.
Lastly I look at the phenomenon of depression and how it is conceptualised in old age in the general hospital setting and compare that with a more general view. I argue that older people and their relatives, and indeed many staff members, do not see depression as a mental health problem but rather as a normative expectation given old age and the circumstance of ill health and hospitalisation. I consider whether this may indeed be so, particularly for older people in the fourth age and nearing the end of their life. I also explore reasons for the invisibility of depression for this cohort of women, as compared with their younger counterparts.

As the chapter progresses it becomes more and more apparent, in concurrence with the last chapter, that the nature of the setting and the influences within it are key in the perceptions of mental health problems.

In conclusion I bring together the discussions from this and the previous chapter to consider that mental health problems are only noted through overt visibility or social inadequacy. Depression is invisible as it lacks impact within the social setting. I begin to examine the potential impact of these findings on how service is delivered. First I return to the category that I call "poor things".

7.2 Poor Things

Alongside, and contradictory to, the attribution of deviance and badness to older people with mental health problems in this setting, there exists a parallel yet distinct assumption of social weakness and vulnerability. Those who are not "misbehaving", but who are seen not to belong to the normal social world, are pitied. There is a desire among the participants, particularly those from Glimster General, to protect these "poor things" from the world, with which it is thought, they cannot cope. This assumption is in line with theories on ageism whereby older people are seen to be in need of protection from able bodied and able minded, adults.
Louisa describes a fellow patient as a “poor thing”. She suggests that in having lost her memory she has lost her social status and, as a “lost soul” is without a role in society. She thus defines her as disempowered and socially excluded (Goffman 1961). Mary calls this type of person “a different breed”, implying a need for nurture as well as a distinct separation from herself. Pat’s contribution is particularly powerful and in line with the supposition that people with mental health problems hold no place in society. She perceives those who are mentally unwell as dead, although in body they are present.

G. Louisa: Poor thing, I’m terribly sorry for her....I feel sorry for somebody who’s like that, ...poor thing, she’s obviously lost her memory... It comes back, because she knows her daughter, and that sort of thing, but she’s a lost soul.

G. Daughter Pat: Well, poor soul, this man or woman, I don’t know, was counting up to a hundred and then shouting out, and I just felt possibly that was not the place for them....you don’t need, I mean these poor souls can’t help it, but you do not need to be exposed when you are trying to recover from a stroke. I just don’t think you need it, you really don’t. I mean, I’m going to use a term now that will probably horrify you, but I came home, and I said to my husband and my sons that they are either dying, don’t know they’re dead or think they are dead, in that ward.

These descriptions can be seen to define the confused older person as being “mentally dead”, thus concurring with the bio-medical model of dementia (Adams and Bartlett 2003 p6). Alongside the behaviour that does not fit in with the organisational rules, as I discussed in the previous chapter, this difference may also provide explanation as to why older people with mental health problems are so alien in this environment. The business of a hospital is to focus on curing the living. If a person is seen as no longer wholly alive, s/he ceases to fit into the necessary criteria and thus does not belong. The person with dementia, who is socially inept, is thus to be marginalised. S/he has no category within the setting.

The social exclusion of people defined to have mental health problems is in line also with Sweeting and Gilhoolys’ (1997) examination of the definition of “socially dead”. In their study, only the relatives of people with dementia who had a particularly strong and close relationship perceived social life in the person with dementia. Those whose relationship
was not strong perceived social death in the same way as we see here. Social death implies dependence and inability to engage at all in the social world. As Pat describes, they have lost their place in the world (Gilleard 1992) and need somewhere else to go (Spicker 2000) away from those who continue to engage in life. Kitwood (1997) defined this way of ignoring the personhood of someone with dementia, excluding them by treating them as a diseased object, although what Pat actually describes is a deceased object.

Goffman (1964) described discreditable and discrediting stigma whereby ones perceived weaknesses may be visible or invisible to the world (see p47). These “poor things”, through their perceived inability to engage in society, have a discrediting stigma, and are assumed to have no social role, due to their presentation. This compares with those in the previous chapter, whose behaviour is overt, who have a visible discreditable stigma. Geraldine’s response is very reminiscent of Goffman (1964). She talks of visible vulnerability (discreditable stigma) and invisible vulnerability (discrediting stigma). Geraldine suggests that one may appear able, outwardly, when inwardly you are not. Once the weakness of mental illness is uncovered, in the presence of old age, the assumption that one cannot cope is made. Angela, the daughter of a woman in Chapley Hospital, concurs, saying that “they are not capable of looking after themselves and that obviously is associated with a mental illness.”

C. Daughter Geraldine: I take mental health as being a vulnerability; we are not easily visible to be vulnerable. Let me start again. I take a mental health problem to be where you are vulnerable and sometimes not to be visibly vulnerable.... It hasn’t been detected your level of vulnerability and inability, right. And so therefore you are a bit prey to being in a world ...for any number of reasons. ... Well, I suppose that the end result is that they all have to be moved out into homes.

In her work examining how nurses in a general hospital view people with dementia Rachel Norman (2003) found that people with dementia were constrained because they were seen to be dependent. All but one of the staff at Glimster General agree that older people with mental health problems cannot cope with the world and that their main staff role, as I explore further in Chapter 8, is in finding them an appropriate place to be cared
for. As with the disruptive behaviour, discussed in Chapter 6, this inability to fit in with normal hospital business, defines the “poor things” as mentally unwell. They do not fulfil the required expectation of a patient within the organisational and medical purpose of the setting, particularly in the more ordered setting of Glimster General. The “poor things” are noticed in Glimster General only when they challenge the system by not getting better and going home.

G. Physio Maggie: [people with mental health problems have] difficulty with coping with life generally. People not being able to live on their own through it.

G. Consultant Peter: cognitive impairment to the extent that they can’t look after themselves.... [it] is such a problem that they are likely to require a higher level of service.

This “poor thing” category is common to both relative clusters and to the older people and staff in Glimster General. The older people at Chapley hospital, diagnosed with mental health problems, did not indicate inability to cope with the world as suggestive of mental health problems.

The other cluster group that use the “poor thing” category less readily are the staff from Chapley General. All but one of the Glimster staff, and less than half of those at Chapley, describe this perceived social incompetence as an indicator of mental illness in old age. As I go on to explore further in Chapter 8, Chapley Hospital staff appear less readily to perceive people with dementia, whether this is characterised through their overt behaviour or through passivity and social withdrawal, as wholly incapable. This is notable particularly in their consideration of whether or not a person with dementia can go home.

In this section I have highlighted a difference in perception between confusion that causes people to become disruptive within the setting and confusion that is seen to render an older person as a sad and worthless waste product of society and socially dead. Such definition can readily be seen alongside the discussion on ageing in Chapter 1, whereby the old are discarded and seen as of little use to society. Foucault (1967) described
mental illness in terms of unreason and irrationality, here it appears, only the latter is applicable in that irrational behaviour is the definition used. If one is solely without reason in old age, society accepts this as normal.

It is interesting to consider how the category of “poor things” could correlate with a disability model of dementia as advocated by Jane Gilliard (2002, see p57). I suggest that older people with dementia in general hospitals, especially in highly regulated organisations such as Glimster General, are not seen as disabled, rather they are seen as unable.

My exploration so far suggests that people who have cognitive impairment in old age in the general hospital setting are defined as having a mental health problem either due to their overtly visible behaviour or because they are poor things and socially inept. This latter group are, in general terms, viewed as old rather than mentally ill. However, if they challenge the system, particularly the more rigid system, age related problems become mental health problems. Such dual definition potentially leaves a third group, those who have memory loss but do not challenge the setting, invisible and disregarded.

Whatever the definition of a mental health problem in old age any perceived attributes are not readily attached to oneself or to one’s nearest and dearest, as I now explore under the heading of “stigma”. All of the participants seek to distance themselves from the phenomena of mental illness and old age by various means.

7.3 Stigma

Examination of the data to this point has already demonstrated the presence of stigma. In this section I explore, more specifically, the data and how it underlines the power of ongoing stigma towards issues of mental ill health. Within all the cluster groups there is evidence of intent to distance oneself from the potential of being tarnished by that stigma. I have already demonstrated the power of stigma in exaggerating the presence of mental health problems in that, in the presence of any deviation from normal behaviour or any
perceived loss of social competence, total mental incapability is assumed. There does not seem to be a perception of a bit of a mental health problem, the perceived sufferer is either wholly deviant and bad, or wholly inadequate and socially inept.

Mental illness has long been stigmatized and, given the long history of social exclusion and fear, as explored in Chapters 1 and 3, its effect on perceptions of mental health and illness cannot be under estimated. Lindsay Prior, in his study within a psychiatric hospital suggests that:

"Perhaps it is a result of the stigma associated with mental illness, that psychiatric patients rarely describe themselves as being mentally ill (even though they recognise other patients as being so). So patients will readily say, for example, that they suffer with their nerves, that they come from a nervous family, that they are constantly bothered with their nerves, that they feel unwell or just not themselves or more likely refer to some general notion of dis-ease."

Prior 1983 p161

Alongside the stigma associated with mental illness, for older people there is also stigma associated with ageing (Bytheway 1995) and dependency. Therefore, in line with Golander and Raz (1996), older people and their families disassociate from any condition that may define them as either mentally ill or as old and burdensome. Such distancing seems also be linked to the desire to not be negatively judged as either bad or incompetent, in line with the attributes of mental health problems, of bad behaviour or social inadequacy, already discussed. Pru, a patient at Glimster General, powerfully suggests that the possibility of having a mental illness is terrifying.

G. Pru: I've only been depressed on and off, lightly like nothing sort of bad but...
Int: So, if you did have to see somebody and it was thought that you might have depression, how would you feel about being told that you might have a mental illness?
G. Pru: That would hurt wouldn't it?
Int: Why would that be?
G. Pru: You wouldn't expect it. The terror of it.

Some older people describe never having noticed any person with a mental health problem, either in hospital or elsewhere, Both Olive and Daphne noting that they have
been very "fortunate" not to do so, suggesting that it is unlucky even to meet someone with mental health problems. As Selina suggested above (p167) it is as if ones persona can be stained through being in the presence of such people.

Cathy sees herself as a normal person going into hospital for normal things; she acknowledges that there may have been people around her with mental health problems but that she chooses to blot them out of the sphere of recall. She, like many others, particularly in Chapley Hospital, has memory problems but attributes her own idiosyncrasies to the normalities of old age and/or a physical illness rather than to a mental health problem. She explains her memory problems as having been caused by a fall, painting an elaborate picture in an attempt to ensure that she is not seen as being out of the ordinary permanently. In his work on stigma, Goffman (1964) describes this behaviour as "impression management". Such avoidance of the stigmatized condition renders one as commendable, and not stigmatized, to oneself and others. Thus something, Cathy says, has been temporarily moved out of place. She is sure that things will return to normal, given time, when she is stronger.

C. Cathy: I don't really know, because I have never come up against it. I have gone into hospital on various occasions but it has been for quite normal things you know what I mean.

Int: And have you ever noticed any other patients around you who may have mental health problems?

C. Cathy: I expect they were there but you see at this time that is all blotted out. It never happened.

C. Cathy: Oh I do try to remember but I am sure I will as I get stronger...Yes, well I am not in that state by any manner of means and I won't be as I get stronger in myself. I don't know why I had a fall...

Int: And your memory was OK before that was it?

C. Cathy: Oh well yes I had a very good memory, so I, you know, I really wondered if it was something I jolted out of place when I had the fall, because I did go quite heavy and can remember again catching hold of the rhododendron tree to pull myself up and you will think this is funny, but by the side of it there was a shrub with a small sort of stem a sort of a forsythia thing and I could remember thinking, no you mustn't pull yourself up with that because it is not strong enough to take your weight but I mean I had quite...I was sort of sensible if you know what I mean. So I got on my hands and knees and crawled across the lawn until I came...
to a clothes post and pulled myself up you see. Whether that was anything to do with starting this I don't know.

Some of the older people at Glimster hospital are adamant in their self exclusion from mental health problems. Louisa believes it impossible that such problems could affect her although she has suggested that mental health problems, in hospital, are driven by pain and poor health. She sees herself as removed from these risks despite her severe arthritis.

Int: So you think that their mental health problem, if you like, has been brought on by their illness?
G. Louisa: I think so
Int: So in that case do you see yourself as at risk of falling into that hole?
G. Louisa: Oh no, I definitely won't!

In examining the responses from relatives, those people whose relatives have a recognised mental health problem tend to powerfully disassociate their relative because they are somehow not as bad as others. This may help them to preserve their impression of their relative as a person and as their loved one rather than as an ill, or indeed bad, person. The attribution of a stigma renders one as something less than human (Goffman 1964), it is thus understandable not to perceive a relative as such. Alternatively such disassociation may be demonstration that the media image of mental illness outweighs and is more powerful than any personal experience (Philo 1999). Both Angela and Lesley’s mothers have diagnosed dementia yet they cite others who they can see as worse. Angela suggests that her mother does not have real confusion, and Lesley feels that her mother is well behaved and therefore less mentally ill than someone who shouts and swears at nurses. This again, as is the case for the Chapley older people cluster (p180), suggests that it may not be possible for people to correlate what mental health problems are through their personal experience. Perceptions of mental health problems remains removed from personal experience.

C. Daughter Angela: She got confused but it was logical confusion, if I can kind of categorise it in that way
G. Daughter Lesley: I mean, I suppose I thought she might be going that way, you think those things won't happen to you....She likes the nurses. When I was here, that day, she was saying how clever they are and how accomplished they are, whereas the lady in the end bed was shouting and swearing at them saying that they were hurting her.

Relatives who have had no personal contact with mental health problems, in contrast, are more likely to not want to consider the subject at all. Steven provided an extreme construction finding it very difficult to bring himself to consider such issues at all, finally settling for the media image of violence and social deviance (Philo 2001).

G. Son Steven: Well, I'm not sure what you mean really, have you noted anyone with mental health problems in the hospital?

G. Son Steven: No, no I haven't...

G. Son Steven: You have no idea what mental health problems some older people here may have?

G. Son Steven: No, I'm sorry, but no

G. Son Steven: What about not in hospital

G. Son Steven: Um, well, um...there are people who molest children and kill them, alcoholics, that sort of thing.

I asked the staff members how, or whether, they would inform an older person that someone from mental health services had been asked to come and see them. Most of the professionals acknowledge that, if they do talk with the older person about mental health issues, they do not use the terminology of psychiatry because of the negative connotations that they perceive it will evoke. Linda suggests that staff seek to distance themselves from mental health problems by avoiding reference to them and thus minimise their own discomfort. This underlines that the stigma of mental illness is felt by staff as well as by those they care for.

C. Discharge Nurse Kate: I think there is quite a stigma attached to it. I think if I was an elderly person and someone came up to me and said, we're going to refer you to the mental health services, I'd probably freak out. You'd be thinking "Oh, am I going mad, what have I been doing, what have I been saying" you know. "What will everyone think of me?" All that...
G. Nurse Linda: I think there's a lot of stigma, in terms of talking to a psychiatrist, particularly with older people. Um, maybe culturally it's been seen as a sign of weakness... I suppose, in a way it's [not telling] a means of causing minimum distress to them, but maybe it's easier for the staff not to have to deal with somebody that's facing something that they're not happy to face.

As well as disassociation by avoiding talking of mental health issues in conversation with patients and relatives, some of the staff members distance themselves from mental health problems by claiming that to be involved is beyond the remit of their job.

G. Discharge Nurse Ruth: Well, that's general, because I'm not dealing with mental health, we'd see that there could possibly be a mental health problems, I'm no expert.

Several of the staff from Glimster General, as mentioned in Chapter 6 (p145), suggest that inappropriate admissions to hospital occur for people with mental health problems and no, or what are seen as negligible, medical problems. Naomi suggests that mental health problems are not her job. She, like Nurse Trish (p145) does not see it as the business of the general hospital to provide care and treatment for people who are not looking after themselves, that is the “poor things” discussed above (p174).

G. Dr Naomi: I don't think I've seen anybody who's not had medical needs as well as only mental needs. Urr no, that's not true. There is somebody on the ward at the moment whose needs are not being met here.

Possibly what is most noticeable about this section of the chapter, examining how stigma is apparent within the data, is that all of the research subjects demonstrated its presence, in one way or another. Older people and relatives all distanced themselves from mental health problems by denying any connection with the virtual social identity of a person with mental health problems. Even the relatives from Chapley, who know that their relative had a defined mental illness, seek to minimise it by describing their loved one as not as bad as others. Staff, in both sites, tend to demonstrate their disassociation either, predominantly in Chapley, by claiming that this type of thing is not their job, or, in Glimster, by emphasising that it is inappropriate for such people to be in this setting in
the first place. There is a tendency, particularly among the Glimster relatives, to avoid even entering into conversation about mental health issues.

Crawford and Brown (2002) suggest that the stigma of mental illness is perpetuated by the continued divisions in health service between general medicine and psychiatry. I continue to explore this theme as the thesis progresses.

In this chapter so far I examined how mental health problems in old age may be rendered invisible in the general hospital setting either because they are termed as the normal debility of failing mental ability in line with old age, or because reference to them is avoided because of stigma. I now move on to explore the phenomenon of depression which rarely features in the data as a term of description for a mental health problem in old age.

7.4 Depression

There is both professional and political acknowledgement that depression in old age is under-recognised and under-treated (DoH 2001, Holmes et al 2002, NICE 2004, Godfrey and Denby 2004, CSIP 2005). Manthorpe and Iliffe (2005) suggest that the complexity of presentation make under-diagnosis inevitable. It is said that 25% of older people in general hospitals are depressed (Anderson 2001, RCP 2005).

Depression is considered as a common condition within the life course with 20% of the population experiencing it at some point (Depression Learning Path 2006). Indeed the word “depression” has moved within language use. One can no longer use this word to describe feelings of misery and sadness; rather it has become a medical diagnosis and the property of medical psychiatry. In general language phrases such as “I was depressed” now readily conjure up an image of a problem for which one has received professional intervention.
The figures for incidence of depression and the acceptance of it as a treatable phenomenon may lead to a supposition that it would readily be recognised as a mental health condition in old age. There has also been a marked increase in lay literature (e.g. Cembrowicz and Kingham 2002, Massey 2004) and media coverage (e.g. BBC 2005). However, an anticipation that depression would immediately spring to mind for anyone asked to consider mental health problems in old age was unfounded. Depression in old age, it emerges, is not defined as a mental health problem; rather it is seen as normal and inevitable for older people in the general hospital setting. This raises questions about how, and whether, depression in old age, in this population, exists at all or whether it is part of a general categorised societal assumption attributed to older people in hospital. I argue that the psychiatric definition of depression, now readily accepted as the acceptable face of mental illness for younger people, has not been applied for older adults in hospital.

As in the previous chapter I first examine responses around the medical diagnosis of depression noting that, like dementia, such attribution almost only occurs among staff members. I go on to again consider the staff ambivalence before looking at how depression is characterised by the older people and relative cluster groups. In conclusion I suggest that depression is seen as a bi-product of ageing rather than as a mental illness and as such it is invisible. Such invisibility may be even more evident in this setting where mental ill health is defined through negative impact on the smooth running of the hospital system as already discussed. The presence of depression does not negatively affect the power structures that govern the setting and as such is not seen. This invisibility poses major challenges in considering how to address the issues.

During early interviews it became apparent that people did not always specifically mention depression unless encouraged. Therefore if subjects did not make reference to depression they were prompted to the effect of:

Int: Is there any other mental health problem, in this setting, that you can think of?

Going further as necessary to ask: -
What about depression, have you heard of depression?

In analysing and discussing data elicited after such an intervention on my part, I am mindful that through my emphasis I highlighted my position in expecting depression to feature as a mental health problem in old age. This will have inevitably influenced how the research participants responded thereafter. The content and comparability of the data is also influenced by differences within the cluster groups, particularly the older peoples' clusters. As discussed and explored in Chapter 6 I had difficulty recruiting people diagnosed with depression to participate in Chapley hospital and interviewed only one such older person. In Glimster Hospital I considered that six of the older people I interviewed were depressed or potentially depressed, although none of them had, as far as I was aware, been diagnosed or received targeted care or treatment. This difference is reflected in the data, notably in that the older people from Chapley Hospital, and the relatives, rarely dwell on issues around depression whereas their counterparts in Glimster were more likely to.

7.4.1 Staff Perceptions

Paradoxically, given the apparent lack of recognition of depression in those older people I interviewed, the staff at Glimster General identified depression as a mental health problem in old age more readily, and with less encouragement, than their colleagues at Chapley Hospital. It was mentioned by the medical practitioners in both sites. However, as with dementia, the majority cite it briefly as a diagnostic label within a list, before returning to their more predominant concerns about those who do not fit in, as discussed in the previous chapter and within the “poor thing” category above.

Of those staff who did not readily come up with depression, some were clearly embarrassed at their perceived omission. This feeling may be associated with knowledge of the recent focus and attention on depression in professional journals (e.g. Peveler et al 2002, Minardi and Hayes 2003, Schofield 2004) and in the National Service Framework
for Older People (DoH 2001) which was much heralded at around the time of the interviews. Sue was clearly taken back at her failure to note depression as a mental illness. Her embarrassment can be explored in terms of “membership categorization” (Baker 1997). In not readily coming up with the term, she sees herself as not fulfilling the expectation of her role as a health care professional who should readily identify diagnostic labels. Her discomfort is potentially fuelled by her categorization of me as a mental health nurse, rather than a research interviewer, who she places within the biomedical model of psychiatry. She therefore feels that she has given an incorrect response. The embarrassment may also be seen in relation to the organisation structure within Glimster, as I explored in Chapter 6, which encourages systematic categorization, in which she has just failed by missing out depression.

Int: So you haven’t mentioned depression
G. Manager Sue: Oh yes, depression, yes depression, I mustn’t forget depression.

In contrast to the listing of depression in old age, albeit transiently, in Glimster, the staff in Chapley Hospital arrived at depression more often as an afterthought to dementia and confusion, defining it in terms that suggest that it is less important than other diagnoses. For Fiona, although she tries to cover what she perceives to be a mistake, it is just depression. Ann sees depression as being much less serious than other mental health problems correlating with the definitions of severe mental illnesses according to the National Service Framework for Mental Health (DoH 1999, see p12).

C Nurse Fiona: and just [my emphasis] - I don’t say just - depression in varying degrees of depression.

C Physio Ann: Well, I think there are many degrees of different mental problems that can go to, I don’t know, a depression, to something bigger [my emphasis] like schizophrenia or you know, something like this…. Serious, really serious, more than a depression.

The data, examined so far, suggests that depression in old age is seen as an ontological bio-medical reality for medical practitioners and some other staff. However many staff, from both sites are ambivalent, which suggests a lack of clarity in their concept of
depression in this setting. There is an apparent contradiction between how staff are expected to define depression as health care professionals and how they may see it as members of society, as a normal reaction of sadness to circumstance.

There is a suggestion that those who dwell on depression as a diagnosis are those with personal experience of the phenomenon. Nurse Ruth described the social isolation of her own mother and Nurse Trish spoke about a friend's depression. Geraldine was the only relative to immediately mention depression later disclosing that she has herself been depressed in the past. Selina, who has a history of depression, is the only older person to make unsolicited mention of depression.

Highlighting the problems experienced by staff members, Trish is uncomfortable about what she sees as the inadequacy of the treatment given to people with depression. The case that she describes here highlights the apparent lack of clarity both she and her colleagues have about how to see the phenomenon. She feels helpless in her inability to adequately care for a woman whose wish to die is assumed by others to be a rational choice. Yet, earlier in the interview, she doubts the efficacy of the treatment when it is offered. We see the dilemma experienced by those who work with older people, who try to balance the opposing perceptions of depression as a diagnosis or as an inevitability of old age. Trish seems to feel helplessly confused by the opposing possibilities.

G Nurse Trish: And I feel that depression in the elderly isn't addressed properly here. They're just slapped on [an anti-depressant] or something like that......whereas somebody who is inside themselves isn't seen. The person who sits quietly and doesn't speak, with their head in their hands, often isn't treated.

Int: So what happens to them?

G Nurse Trish: They may get put on anti-depressants

Int: And do they get better?

G Nurse Trish: Not really, no. And you know that when they go home they're probably not going to take the tablets anyway...

G. Nurse Trish: [later] There is one lady in there now, I feel helpless. I can't help her. Except try and get her to eat. I say, no you can't go to bed until you've had a drink but that's terrible, I
mean for me to say that to her, dreadful. But when she
 goes to bed she goes in under the cover and she'd die...
 And then people say, "Well that's her right". But I feel that
 it is not her right, that's her illness... she's ill, and that's
 what we've said all along, if somebody wants to do that,
 that's up to them and I've said, but they might not really
 want to do that. I feel helpless.

Val, who listed depression as a mental health problem, also demonstrates ambivalence in
being unsure as to whether depression is appropriately addressed with the use of anti-
depressants. In recognizing that depression is "picked up" she identifies depression as a
medical phenomenon but then suggests that medical intervention may not be appropriate
as low mood is inevitable for someone in hospital.

G. OT Val: It depends on the consultants. One of them is quite good
at picking up depression and one of them isn't. But then
one of them is almost too quick to put them on an anti-
depressant when he hasn't really given them a chance... [It
may be] just because they are fed up with being in
hospital.

In terms of hospitalisation the literature suggests that depression can be seen as either
causative in or resulting from, physical health deterioration (Katz 1996, Kennedy 2000,
Godfrey and Demby 2004). Peter suggests that without the depression there would be no
physical health problem. Gayle also defines depression with the pessimism of
permanence.

G Consultant Peter: Problem wise, I'd say two main things, volume wise, I'd
say the main conditions I see are dementia and
depression...The vast majority are physically unwell
because they are [sic] depression, or its part of their
depression, it's the way their depression runs.

C OT Gayle: Um, could seeing things like the permanent problems not
just say acute confusion, I think? Maybe things like
dementia, depression.

Both these responses suggest that diagnosed mental health problems, in old age, are seen
as an insurmountable barrier in the acute general hospital setting, whether the problem is
related to mood or cognition. The older person becomes the diagnosis, suggesting that
problematic needs in old age in hospital can be seen as equivalent to mental ill health.
Such pessimism is thought to contribute to therapeutic nihilism, lack of treatment due to perceived lack of hope (Godfrey and Demby 2004 p20).

Some Glimster staff members, in line with the organisational focus on throughput, mention depression in pessimism, in terms of its influence on potential to return home. Maggie, a physiotherapist, correlates depression with an inability to concentrate on, and therefore benefit from, her instructions aimed at improving mobility. Dr Naomi focuses on the lack of drive with the same probable outcome, not getting home. Herrman et al (1998) suggest that people with depression are not afforded rehabilitation opportunities; there is suggestion here that this is subtly linked to lack of hope and the social inadequacy attributed to those with mental health problems.

G Dr Naomi: Certainly things like depression. People won't be motivated to go home. It's all right us saying get up and walk, but if you don't feel that actually it's worth getting up and walking it's not going to be any benefit to do that then why bother trying?

Between the two sites there is some apparent difference in the staff actions taken when people are thought to be depressed and what happens when they do not recover. In Chapley Hospital all the staff respondents described referring for a specialist opinion for people with suspected depression, in Glimster General such an action was felt to be rare, as Sue confirms.

Int: At what point would you consider calling somebody in, for somebody who is depressed, or does that not happen?

G. Manager Sue: I don't think that happens. No, I don't think it does. I think that provided that there are signs that, say in a fortnight after they've started the treatment, that things have improved...

Int: And has it?

G. Manager Sue: Not always. I don't think enough is done.

In line with the literature (Rapp et al 1988, Grout 1997, Rothera et al 2002), staff in both sites believe that they readily identify depression in absence of evidence that they do. In Chapley Hospital the lack of older people diagnosed with depression was evident during
the sampling process and the data confirms that staff rarely readily identify depression, in considering mental health problems in old age in their workplace. At Glimster General, although depression was readily mentioned, the older people sample, the majority of whom may have been depressed, suggests lack of recognition and treatment. This seems to demonstrate that the differing models of mental health service in these sites, were not impacting on issues around identifying and addressing depression.

In this section I have examined how staff members conceptualise depression. While many staff members, in both sites and more confidently in Glimster, identify depression diagnostically, there is evidence of ambivalence in all but the medical staff. Contrary to the assertion from Manthorpe and Iliffe (2005 p9) who suggest that describing depression as a psychiatric phenomenon helps differentiate it from sadness, staff appear confused about how to identify it with many describing it as expected misery, understandable in ill health in old age. In mental health circles there is a recipe for depression (Box 3.1) that others do not share. The staff respondents believe that depression exists as a medical condition but they cannot define it in terms of the diagnostic ingredients.

I now go on to explore depression as sadness by examining the data from the older people and relative clusters.

7.4.2 The Views of Older People and Relatives

Among the older people and the relatives, depression in old age in the general hospital setting is generally not seen as an illness. Being unhappy and fed up are seen as normal, within the context of being old and being in hospital, and indeed expected.

G. Son Steven: Depression is normal in old age isn't it?

Several respondents use colloquial articulations of depression, demonstrating its perceived normality in these circumstances. This view concurs with the work of Brown (1996) who describes depression as occurring in response to attacks on ones self esteem.
whereby one is in a subordinate position, with loss of control, events that undermine the person’s value and a perception that escape from the current situation is blocked. All of these can be true for the hospitalised older person, as can the loss of autonomy that Geraldine Boyle (2005), in her study of older people receiving care at home and in residential settings, found to be a key risk factor in the development of depression.

Selina described her fear of loss of control (p167) and goes on to describe her fight against the tide of potential depression brought on by the circumstance of hospitalisation and ill health. She is a relatively young woman, at 67, and unhappy at being in a ward with older people. She demonstrates fluctuating resilience. The depression she expresses, may win over within this environment that encourages dependence and compliance. She wants to behave in the “old” way, to strive to get better, but feels dragged towards the “new” way, the way of the ward, of allowing things to be done for her. The way that Selina talks about her two potential selves, the old me and the new me, epitomizes the potential membership categories (Baker 1997) that she can fulfill. The old her, the Selina that she wishes to hold onto, the one who would go into hospital as a patient who has fractured their hip would strive to get better and get out. However, Selina’s old self is in danger of being overshadowed by the expectation from the social structure in this older peoples’ ward, as defined by the organisational structure discussed in Chapter 6. Here she becomes the “new” me and is drawn into the category of old and ill which she does not want to identify with, but feels forced into. She suggests that it is this overpowering pressure to conform to the category expected of her, which drives her towards depression. She fears but does not want to be bracketed with those whom she sees as distressing and having mental health problems.

Int: Have you had depression yourself?
G. Selina: Yes. It can be nasty... It slows things up, it does. Because you are dealing with the old and the new. You get the old feeling and you get the new feeling about getting better. Let me put it this way, the old feeling was go into hospital, lay in the bed, smile at the world, smile at people, try and get better, but it [mental illness] mustn’t touch you. Then you get the new people, they go into their own world and they want people to come and touch them, get them out, get them doing things, they want them to do it. And sometimes you feel like one of those and sometimes you feel like the other. Is that what you are saying?
G. Selina: Sometimes you want to lie back and...but at other times you want to get on and get out of here. And it's been more like that this time, I'm getting more like them. [Those she calls mentally ill]

Int: So is there a danger, and you have been depressed before, so I think I can ask you this, is there a danger of you getting depressed because of this?

G. Selina: Yes

Tom too appears to be depressed, following his bereavement, but approaches his feelings in a particular way. Like Selina, he sees depression as something that he must not succumb to. He must buckle up and get on with it rather than consider the weakness he associates with being depressed.

Int: So, what about depression. Have you heard anything about depression, do you know anything about that?

G. Tom: Well, not a lot...and I still don't understand what it means really. Why they don't sort of buckle up and say "come on lad, we've got get cracking, we've got to. ...Because somebody told me I was a bit depressed a while ago after my wife died, but I'm certain I wasn't... It is difficult when, especially when you love someone you think how the heck am I going to get over this. In fact now I'm going back to my cottage, I leave it as long as I can at the end of the day...Too many memories

All the participants, who I considered to be potentially depressed, describe their feelings of unhappiness as environmentally and circumstantially inevitable yet not attributable as a mental health problem.

Pru emphasises that her feelings of being fed up are different than having a mental health problem, because a mental illness would be demonstrated through not "thinking right". Here she emphasises the attributes of mental health problems as discussed in Chapter 6 whereby one would have to be physically displaying something abnormal to be classified thus.

Int: What about depression, have you ever met anyone who's had depression?

G. Pru: I have yeah. I can get depressed a bit sometimes...But, I mean, day after day, as I just said to my husband, I just sit here and howl my head off...Especially with the family being away, you know, you think of them then...and it makes you feel worse.
Int: So is there a difference between being depressed like that and being depressed in a mental way, do you think?
G. Pru: Oh, I should think so...That's worse isn't it?
Int: How would that be worse then?
G. Pru: When you really would be awful I think...not quite thinking right or anything like that....I think so. Think I've only been depressed on and off, lightly like nothing sort of bad.

Oliver’s wife had been diagnosed with depression following her admission to hospital due to a stroke that had rendered her unable to speak. He sees her feelings of frustration and sadness as inevitable in the circumstances and does not feel that the pills, anti-depressants, will serve to help in any way. Like Pru, he differentiates depression from “real” mental illness through the attribution of negative behaviour.

G. Husband Oliver: [my wife] is fed up (my emphasis) because she is not herself. Who wouldn’t be? ... I don’t know if she is really depressed, you know, ill depressed (my emphasis) if you know what I mean. I don’t think so. I don’t expect that these pills will change how she feels about what has happened to her [health].
Int: What do you mean? Ill depressed?
G. Husband Oliver: Well, I suppose not being able to stay still, um, wanting attention all the time.

Although the participants expect depression to be present in old age in hospital, as a feature of ageing and ill health rather than as a mental health problem, they generally anticipate no action upon it, perceiving it as futile. Nora demonstrates a belief that nothing can be done, suggesting therefore, that overlooking depression is to be expected as there would be little point in doing anything else.

Int: What do you think happens to them? What do you think the hospital staff do about that [depression]?
G. Nora: Don’t know quite. I think they quite happily overlook it.
Int: you think they overlook it, why would that be?
G. Nora: They can’t do anything about.
Int: Can nobody do anything about it?
G. Nora: Shouldn’t have thought so, perhaps, I don’t know.

This data begins to suggest a differentiation from the popularist, publicised phenomenon of depression in younger people, people with social capital, against a perceived absence of treatable depression in older people who have “disengaged” (Cumming and Henry
1961, Wainwright 2004) and are losing their usefulness to society. Both Oliver and Pru, above, seem to be trying to differentiate between the lay and the medical use of the word depression as it is differentiated from feeling glum, fed up or sad. Clinical depression, they seem to realise requires some sort of treatment before it can be cured. I go on to discuss this possible difference between sadness in extreme old age, and clinical depression in section 7.4.3.2 below.

7.4.3 Discussion on Depression

I have explored the participants' views about depression in old age in the general hospital setting to discover that it is not generally viewed as a mental health problem. Even among staff, who are aware of depression as a medical phenomenon, an expectation of being inevitably fed up, due to age and circumstance, emerges. Such a view has implications for recognition and service response which I will explore further in the final chapters. Of course it also suggests that, in line with the literature, older people in hospital are invisibly suffering a remediable mental health problem to the detriment of their quality of life and their general health potential.

However, I suggest that lack of recognition is not merely due to an inability on the part of clinicians to put the symptoms together to formulate a diagnosis, as has been suggested in the literature (DoH 2001, Godfrey and Denby 2004, Manthorpe and Iliffe 2005, RCP 2005, CSIP 2005). The inability to see depression is due to its lack of existence as a phenomenon for this population group in this setting. If depression in old age in hospital is socially accepted as normal a clinician will not look for an illness. Ironically if the problem was accepted, identified and addressed it would facilitate faster throughput within the organisational system that, when it is not noticed, it challenges.

The under-recognition and acceptance of depression as normal in these circumstances, is out of kilter with a proliferation of lay interest and acceptance of depression as mental health problem for younger people. Recent examination of the effect of media coverage on society's view of mental illness and distress, explored by Clarke (2004) suggests a
raising the profile of experiences such as depression. Some high profile sufferers, with
whom the press sympathised, notably Princess Diana, may, she suggests, have effected a
clear delineation between acceptable mental illness and bad mental illness. The use of
anti-depressants, such as Prozac, is now acceptable and, as Lindsay Prior (1993) noted in
his study of younger people in a mental hospital, depression was the one mental illness
that people were willing to acknowledge that they had.

This apparent acceptability is not apparent for older people in hospital, either in
themselves or by others. Low mood is seen as circumstantially normal once one has
reached that stage in life, and it appears to be believed that any intervention would be
fruitless. Such definition is more in line with the condition formally known as
"melancholia", described by Joan Busfield (1996) as the predecessor of the
medicalisation of depression. Arguably depression in old age in the general hospital
setting has not achieved the same degree of medicalisation as that for other societal
groups and remains as expected and inevitable sadness. Although psychiatry has claimed
the word depression, and its diagnostic use is widespread among younger adults, it only
has focus in the general hospital setting from mental health professionals.

This apparent different perception of depression in old age in the general hospital setting
leads me to explore further in two differing directions. Firstly I consider depression in
old age against the feminist literature already discussed in Chapter 4. I consider why
depression may be different for this group of older people, notably women, who are
actually of the same generational cohort as those originally studied in the mid-twentieth
century. Secondly I speculate about whether there may be a differential between
medically defined depression in the fourth age, in those who are nearing the end of their
life, and depression in younger people.

9.4.3.1 Structured Depression

Firstly then I draw comparison particularly with some feminist writers of the mid-
twentieth century. Friedan (1963), Gavron (1966) and Oakley (1981) all wrote about the
perceived over diagnosis of depression in women the 1960s and 1970s. They suggest that diagnosis and treatment formed a means of social control that enabled disillusioned housewives to be tranquilised into their undesirable social roles. Ironically the cohort that I now study, the majority of who are women, would have potentially been among that group of oppressed women in their younger years. At that time their misery was over-recognised and blunted in order that they could be useful to society as housewives, hostesses and mothers; now it is ignored.

The links that Oakley (1981) made to depression and oppression are applicable in old age but differently. The “fed up” woman who aspired to be the perfect mother (Friedan 1963) were oppressed through the use of “mother’s little helpers” tranquilisers (Rolling Stones 1963); the current older generation who are fed up in their situation are oppressed by their invisibility. The assumption of the normality of their misery precludes action, medical or otherwise. Such exclusion enables society to put them away and allows them to fade away. The general hospital setting perpetuates, through its social forces, the dependency and loss of autonomy (Boyle 2005) of older people and therefore serves to create the depression it does not recognise, as Selina (p193) fears.

Townsend (1981) described the concept of “structured dependency” whereby older people are socially moulded, by state social systems, into dependent beings. The definition of depression as an inevitable consequence of ageing, particularly when in the general hospital setting, can either be seen as either a bi-product of that structured dependency or as a factor that contributes towards it. Older people either become depressed because structured dependency has defined them as of no social use, or they are seen as of no social use because they are perceived to be inevitably depressed. This is in parallel to the bio-medical literature that defines depression as caused by, or causative of, physical health problems (Godfrey and Demby 2004). To extend on Townsend’s theory I suggest that depression in old age in this setting is an artifact of “structured dependency” as structured depression is invisible as it is perceived as the norm.
7.4.3.2  Acceptable Sadness

I now consider that there may exist clear differences between the definitions of both cognitive impairment and depression in the third as opposed to the fourth age. Although it has not been within the remit of this research to consider age cohort related differences in depression, the data have led me to consider such a possibility.

The construction of mental health problems, in this setting, is one of invisibility when it is attributable to normal ageing and circumstance, unless overt adverse behaviour is observed. In the case of dementia this is characterised by behaviour that challenges the staff and others, and the rigid day-to-day organisational requirements of the setting. For depression, and indeed for the “poor things”, particularly in Glimster General, it is noted only when the organisational goal of moving through the system towards discharge is not being met (see Chapter 8). Within the data there is some indication that the younger participants, from the older people’s clusters, Mary and Selina, view depression particularly differently for themselves, without the acceptance and perceived inevitability voiced by others.

More research is necessary in order to consider whether the older old accept depression as an end of life reality when they are getting ready to die. Do older people in ill health philosophically look forward to death, not in a negative way, accepting that it is their time to die? Such a supposition is supported by the stage theory of life described by Joan Erikson as “gerotranscendence” and the “assimilation and accommodation” model of ageing (Coleman and O’Hanlon 2004, see p20). A view that acceptable sadness may be part of the natural journey towards life’s end, is also complementary with the research carried out by Geraldine Boyle (2005) which demonstrated that depression was more common in older people living at home, who felt that their autonomy was being threatened, than for those in institutional care who knew, and possibly accepted, that their autonomy was lost. Both Pru and Oliver (p194) in older old age, describe depression in terms of inevitable acceptance.
Theoretically it is possible that depression and the experience of depression is different once one has reached those last years of life in which one experiences the "compression of morbidity" (Fries 1991, see p18), that is the last eighteen months of life within which one experiences a period of sustained health problems prior to death. Of course it is essential to then ask whether this acceptance of inevitable decline towards death is part of the life course or is a result of the strong influence of societal ageism. The stigma of old age renders those who perceive themselves to be old, and it is only when one is ill that one does so, as useless and dispensable. If depression in the fourth age, in ill health, is found to be a different phenomenon, the arguments that researchers in the field of dementia use for placing dementia within the disability agenda (e.g. Gilliard 2002) rather than health, could be ascribed to depression as a chronic disability.

One could argue that the recent focus on social inclusion for older people (Office of the Deputy Prime Minister 2005) as discussed in Chapter 1, serves to further exclude the old ill and thus render them structured into depression. As Tester et al (2004) noted, the older old are more and more excluded, perpetuating the development of "poor things" arguably in the eyes of the older people themselves as well as wider society. This work is serving to emphasise the enormous extent of the gaps in research on depression in old age (Godfrey and Denby 2004, Manthorpe and Iliffe 2005) creating more further questions than answers on the subject.

The invisibility of depression in this setting displays a major paradigm difference between psychiatry and lay view. I suggest that recent emphases on enabling non-specialists to better recognise, and therefore address the problems of depression in old age (DoH 2001, Godfrey and Denby 2004, Manthorpe and Iliffe 2005, RCP 2005, CSIP 2005) cannot be met. Non-specialists cannot recognise the indicators of a condition that they do not perceive to exist. In the next chapters I go on to explore the apparent lack of impact on perceptions of depression through the presence of either model of mental health service provision. I explore how the needs of older people with depression, in this setting, may better be considered in the future.
7.5 Conclusion

In this chapter I have continued to explore how the research participants perceive mental health problems in old age. With regard to cognitive and memory changes, it appears that there are two types of dementia, the age related, unproblematic “poor things”, described in this chapter, and the people whose behaviour is unacceptable in the general hospital setting, as discussed in the previous chapter. Each group brings challenges to the organisational management as I explore further in Chapter 8 and neither is seen being the proper business of the general hospital. There also may exist a third group who are invisible as they are not challenging to the system in any way.

It is clear that perceptions are markedly different from those within the field of psychiatry with a general conclusion that mental ill health is defined through behaviour, or absence of behaviour, rather than any other diagnostic symptomology. There exists a dilemma between the constituents of mental health problems as opposed to the expectation of old age. I have demonstrated that the stigmatised position of both mental illness and old age complicates perceptions. The individuals may be seen as bad, yet the group, the older people, are socially inadequate. This dichotomy of definition between bad and in need locking away, and pitied and in need of nurture leads to conflict, particularly in considering how needs can be met as I go on to explore further in Chapter 8.

In considering the construction of depression, exploration of the data leads to the conclusion that depression is not generally seen as a mental health problem in this setting. Rather it is seen as born out of the inevitable social processes of ageing and ill health that people believe they can do nothing about. To the outsider the presence of depression is seen as an intrinsic part of membership categorisation (Baker 1997) for older people in general hospitals and, as such, it is not defined as a mental illness. Sadness, in such circumstance, is seen as inevitable. Such a perception arguably renders depression accepted, intrinsic and invisible. I argue that structured depression exists in this setting.
Further investigation is necessary in order to consider the apparent age related differences in the recognition of depression, a phenomenon which has become the acceptable face of mental illness for younger adults. Also in need of further exploration are possible differences in perceptions of mental health problems in the young old as opposed to the older old, with a potential difference in how the older old express how they feel. As with dementia (Gilliard 2002), there may be a case for defining depression in ill old, old age as a disability rather than an illness. Depression may be different for the, otherwise physically healthy, seventy year old.

Viewed together the exploration and examination of the data in Chapters 6 and 7 suggest that mental health problems in old age in this setting are only perceived when they are a challenge to the organisational structure and obstruct the smooth running of the powerful system. This may be either due to overt and visible behaviour or to an inability to fulfill the normal patient role, in moving through the system, due to passivity or depression. This leaves some mental health problems, as defined by psychiatry, as unseen and unattended. In the culture of a general hospital these mental health problems do not exist.

Whether an older person has a visible and perceived mental health problem and is thus defined as bad, or an invisible memory or mood disturbance, and perceived as inept, they are not afforded a valid voice. They are largely without power in a setting that thrives on the presence of power.

In the next chapter I move on to consider the nature of mental health service provision and the desires of the participants for future service. In doing so I am mindful of the findings detailed within this and the previous chapter; that is that perceptions of mental health problems in old age in the general hospital setting are both influenced and sustained by broad lay perceptions, organisational power and the ongoing stigmas about old age and mental illness. I also seek to answer the second part of my research question, in considering whether the differing nature of service provision, in Chapley Hospital and Glimster General, has any effect on the ways in which mental health problems in old age are perceived.
Chapter 8

Delivering a service

8.1 Introduction

In this chapter I explore responses in relation to the second part of my research question: Does the nature of mental health services provision affect and/or influence the social constructions of mental health problems in old age in the general hospital setting?

In order to explore whether the nature of service provision affects how mental health problems in old age in the general hospital setting are conceptualised, in this chapter I explore firstly the views of the participants about how service is, and should be, provided. I conclude an ongoing will for the exclusion of people with mental health problems, either through physical removal or by providing others to take on the burden of care, with potentially greater such desire in the consultation liaison site of Chapley Hospital. I go on to consider the site differences with regard to knowledge skills and perceptions about mental health issues and note some influence of the mental health consultation/liaison model of service through, what I call, Osmotic Learning. Finally I return to consider the wider implications of the analysis both in terms of the research question and in starting to consider the implications for the future in preparation for Chapter 9.

In Chapter 6 I discussed apparent organisational differences suggesting a possible greater consumer focus in Chapley General with the more traditional model in Glimster General. This latter, as explored in Chapter 7, renders older people with mental health problems less visible unless they do not fulfil their anticipated role as defined by the demands of the organisation. Given these differences it is not possible to exclusively untangle any relationship to construction of mental health problems in old age that may be attributed solely to the model of mental health service in operation.
I conclude that perceptions of mental health problems in the general hospital setting are influenced by the nature of provision but also, and probably more powerfully, by the culture of the setting under examination. While there is some evidence that the presence of a mental health consultation liaison service influences the knowledge and skills of those general practitioners in regular contact with such services, I suggest that the continued provision of an external specialist service perpetuates the traditional Cartesian division and ongoing stigma. Such division enables those in the general hospital setting to be rescued from having to contemplate how to absorb and meet the needs of people with mental health problems in their setting. The division also ensures that the invisible mental health problems of old age, discussed in Chapter 7, remain unseen.

In order to illustrate how I reach such a conclusion, I start by considering what participants expressed as necessary in terms of service provision for older people with mental health problems in the general hospital setting.

8.2 What is Needed?

Having discussed with each participant what they see as mental health problems in old age in this setting, I went on to ask them to talk about service response to such problems. Typically I asked something like “what happens to an older person who is mentally unwell on this ward?” I then asked the respondent how they thought mental health issues could ideally be addressed for those in need.

I have already examined how people predominantly construct mental health problems by identifying those who do not fit in. It is therefore unsurprising that, in looking at care and solutions, respondents tend to focus on older people who they find challenging, in the absence of those who may be depressed or those “poor things” who have memory loss but are passive. Responses can generally be divided between a desire for more mental health external expertise to be brought in to help in the current setting or, alternatively and more emphatically, the removal of older people with mental health problems. I address the latter first.
8.2.1 Take Them Away

The majority of respondents, other than the older people in Chapley Hospital and the staff at Glimster General, suggest that there should be a special place to which older people with mental health problems can be moved to receive their care away from others. Most would prefer a special ward within the general hospital as the people concerned are often not perceived as "bad enough" to require mental hospital care. Although a desire for a specialist ward within the general hospital concurs with limited literature in the United States (Bartels 2003) that suggests the desirability of integrated mental and physical health care for older people, responses emphasise a desire for segregation rather than desire for improved therapeutic value.

This appears to again emphasise a degree of pity about being old, which places one in a different category from the, even more bad, younger people with mental health problems who are perceived to need to inhabit psychiatric in-patient facilities. The difference in definition can also be seen to support the current political position that defines mental health services as necessary only to respond to those with severe mental illness (DoH 1999). People with depression, delirium and dementia do not fall into this category, as explored in Chapter 4.

Of the Chapley older people with memory problems, only Hilda concurs with her counterparts at Glimster in believing that such people should not be in the same place as her.

_C. Hilda:_ I don't think she should be really, I think she should be in a further advanced ward. Somewhere where she can talk to people and find out about things.

_Int:_ Do you mean in a mental institution, or do you mean something else other than that?

_C. Hilda:_ Oh something else other than that...not bad...no, no, not that bad.
Selina alludes to the qualities of a person that render them unsuitable to be among others who may be adversely affected by their presence. This view is clearly linked with the descriptions of mental health problems as discussed in Chapter 6.

Int: So if there is a patient here who has got particular problems, is particularly depressed or is particularly disturbed, do you think they need to call a specialist in?

G. Selina: I think they should go to a different place.

Int: You think they should go to a different place. What sort of place would that be?

G. Selina: A place that deals with that quality of person. um.. get them all in together... Obviously hospitals have got so much on their plates at the time that they don't want the added burden of mental patients as well. ... it's difficult. They've got to be here obviously, but I still say all the time that I've been in, that they should be in separate wards.

Views expressing the desirability of removal are most frequently expressed by relatives, whether or not their nearest and dearest has a mental health problem. The rationale is most often to remove the problem from the presence of their relative, with apparent lack of acceptance that one’s own relative may be perceived as a problem by others. This correlates with the utterances suggesting the stigma of mental illness discussed in the previous chapter. Rachel expresses the views of many in wanting those, who Natalie describes as “the most disruptive ones”, to receive their care elsewhere.

G. Daughter Rachel: She shouldn’t have been in the same room as my Mum. She was really scared that she would steal something from her and I’m sure it didn’t help her to get better, did it? ...I think that all these people, these difficult people, should be on one ward here. There must be enough of them. I’ve heard quite a few. Then they would be with nurses who know what to do with them and they would not worry my Mum.

The majority of staff in Chapley Hospital, would rather there was somewhere else for these people to go. Physio Maggie suggests that this is an “obvious” feeling when considering people with dementia who, it seems she feels do not meet the criteria for being in the ward.

G. Physio Maggie: Well, I see people on this ward that have dementia. Um, which obviously people are not happy with.
Int: Well, where should they go then, in an ideal world what would be... how would you envisage service being provided?

G.Physio Maggie: Well maybe they would get admitted to somewhere that will look after their needs but I don't think it should necessarily be called a mental health unit.

However, Maggie is one of only three staff from Glimster General expressed a will for older people with mental health problems to be removed from their ward, unlike the majority of their counterparts at Chapley Hospital. I will explore this difference further as this chapter develops by considering that the presence of mental health consultation/liaison not only highlights to staff that they need more knowledge and skill but also that it may make mental health problems more overt and therefore less desirable in the setting. Although Gayle is eloquent in her rationale, there is, like the desire for more mental health input (p207) the flavour of a desire to be rescued from dealing with the undesirable. Such discomfort is possibly not felt by those staff at Glimster, who do not so readily perceive that mental health issues are present for their patients. In absence of specialists to highlight need they believe that they are providing an appropriate service and therefore do not perceive any need to change.

C. OT Gayle: It would probably be better for the patient actually if they were having mental health problems and physical problems if they could be seen in a mental health environment where it is more geared towards there problems and solve the physical problems at the same time. Because here we are very much geared towards physical problems but not handling a mental health problem properly could have massive effects. With a physical problem it tends to be very prescriptive, you've got a broken leg you fix it, um, if you've got depression you've got, you know, quite a specific thing. Yeah, but I don't know how that would work practically.

I have already suggested that mental health problems are only readily noted, in these settings, when they are overtly visible. Such visible socially unacceptable behaviour does not fit in to the general hospital setting and nor is it seen as the role of general hospital staff. What is desired therefore is a service that rescues staff from the challenges of caring for those with mental health problems in old age, as perceived by the social actors
within the general hospital setting. Such a rescue service would take them out of the front line of service delivery and problem solving.

Interestingly none of the research participants spoke directly of the rights of older people with mental health problems to be socially included and afforded the same service as other general hospital patients. None of those who suggested a separate ward considered that this may perpetuate stigma though many, like Gayle, alluded to the potential greater expertise. Only Gayle considered the physical health needs that require attention, as they had brought the person into hospital in the first instance. This suggests that the presence of an overt mental health problem, in this setting, leads to the risk of blindness to other health issues, as evidenced elsewhere.

I now examine the responses that suggest a need for an increase in mental health service in-reach to the setting.

8.2.2 Help Us More

In considering the current service provided, it was not possible to elicit detail from the older people and relative cluster group members at Glimster General as they had no such experience. Similarly eliciting detail from the older people at Chapley was a challenge as all but one of them had no recall of the experience, as Cathy demonstrates.

Int: So when you saw a mental health professional here, a specialist, had your doctor told you that you were going to see somebody?
C. Cathy: When did I see anybody here?
Int: Last week.
C. Cathy Did I? - You see I don't remember.

The Chapley relatives were positive about their experience of the mental health consultation/liaison model with Charlie describing his belief that such service was an integral part of normal practice.

C. Husband Charlie: I don't know why [the mental health nurse] were asked to see [my wife] in the first place, I suppose I thought that it just always happened. Anyway I'm glad...because she
Flora reflects the responses of other relatives in Chapley Hospital, describing how she felt supported following the process of mental health consultation/liaison. She went on to describe, like Angela above (p155) how it helped her plan her mother's future care. Oliver, whose wife had had a stroke rendering her unable to speak, wished that he had been able to see someone at Glimster General.

Int: And when she had an assessment, what do you think was the potential value for you and for her, or was there any?

C. Daughter Flora: I think one of [the] roles, one of the things was to act as an advocate for my mother and for me, or a mediator I suppose as well and I think that has been a very powerful thing...

G Husband Oliver: What, a specialist? Yes I'd quite like [my wife] to see someone to clear up this depression business and to see if anything can be done to help her frustration.

The Glimster staff express frustration at the current mental health service, which they see as over-stretched and distant from general hospital staff members. Sue expresses a desire for a more integrated approach whereby staff are more involved in giving and receiving information about the older person who has been referred. She describes the exclusivity of the traditional approach in mental health service provision.

Int: When the psychogeriatrician comes to see your patients, what is the experience like?

G Manager Sue: Isolated really. Very much they go and speak to the patient and write a report. There's no active involvement from the nurses' point at all...Often the diagnosis has been put down and recommendations for treatment. And what sort of things would be the recommendation?

G Manager Sue: Medications mainly, medications...She doesn't actually do any treatment on the patient. She doesn't do any sort of treatment plan or give any advice to nurses. It's just one-off assessments.
All the respondents were asked for their opinion on the preferred profession of the mental health practitioner responding to referrals from the general hospital staff. The older people at Chapley and both groups of relatives gave divided opinions with most feeling that expertise rather than profession was the issue of importance. In line with the organisational differences discussed in Chapter 6, Rachel’s intuitive response is to expect the mental health professional to be a doctor. However, with exploration she realises that this may not be essential, although she feels that her mother would expect a doctor. Her supposition is supported in the older peoples’ Glimster cluster who do indeed anticipate that a doctor would carry out such intervention.

G. Daughter Rachel: I would always think that it would be a doctor, you know, a psychiatrist, but I suppose a nurse may be alright if she knew what she needed to know. These days it doesn’t seem to matter so much about it being a doctor though I think maybe my mum would prefer it to be a doctor because of her age you know. But actually I think that nurses may be a bit better because they can look at the bigger picture.

Within the staff groups the majority at both hospitals would prefer the availability of a mental health nurse, with the remainder saying that the profession was not relevant, rather the knowledge and expertise. The reasons for the nurse preference all reflect the traditional hierarchical power of medical staff discussed above (p32). Doctors are seen as above others and therefore less accessible. Psychiatrists are, according to Nurse Fiona, “one league out of my understanding”. Hannah, a doctor herself, underlines how she sees the restriction of the social division. Christine, in line with Roberts (1997), feels that a nurse is more accessible and visible and Elizabeth declares that a nurse is thought to have a more holistic view on the older person’s situation and thus provide more practical, down to earth, advice.

C. Consultant Hannah: I know that I would have to work for much, much longer and harder, even with my own nursing staff, to achieve the level of acceptance and understanding that [a nurse has] from day one. And so a psychiatrist coming here, a medical psychiatrist, will be treated, in public, with a kind of respect and deference, things like that, but the nursing staff will not listen, or will qualify what they hear, especially if we were talking about very nursing things. I cannot tell a nurse what to do, as a doctor. A nurse will not listen to me.
teaching them about nursing practice and a lot of care of the confused patient is about nursing.

Int: The normal scenario that you get a doctor in response to your referral, whereas here you get a nurse. What do you see as the pro’s and con’s of that one? If there are any? ... There probably is a different focus because nurses tend to be more practical and realistic about what people can do and not do whereas doctors are a little bit “head in the clouds”. Some more than others and wouldn’t perhaps see the realities of day-to-day issues and how a patient might manage.

The majority of staff in both sites want more input from mental health specialists. However, there are site differences. In Glimster this is expressed as a general desire for advice and someone to talk things over with, as Zoē suggests. However, there is little detail about the potential impact of such service because of lack of experience and possibly because the extent of the potential need is not identified. Interestingly Zoē alludes to a feeling that speaking to someone in mental health is not a direct link, emphasising the extent of the Cartesian division. A telephone contact does not serve to breach the gap, whereas person to person may do so.

G. OT Zoē: I think it would be useful to have a named person who could be contacted for advice and, in the same sort of way that we have people who liaise with district nursing services, you have a named person who you can talk to, we obviously do have colleagues who we can speak to in mental health, but there doesn’t seem to be that direct link with the hospital.

In Chapley Hospital, while the above quotes about nursing intervention appear to suggest satisfaction, there is a clear will for mental health liaison services to increase in order to rescue staff further from that which they do not perceive as part of their role. This occurs in Chapley despite an apparent acquisition of skill in caring for older people with mental health problems as I explore below. There is then a suggestion that skill development does not remove the desire not to care for this group of people. Indeed it may increase dissatisfaction.
This exploration of the data emphasises, among staff in both sites, the ongoing perception of the mind/body split characterised by historical models of service provision. Although use of the consultation/liaison model, and the presence of nurses, is welcomed, it appears that the motive for presence may be founded in historical avoidance rather than with the view of service integration and improvement in care and outcome for the older people.

On reflecting on the nature of this data, I note that I did not ask any of the research participants who the mental health professional should be employed by, or indeed which organisation would run the special ward that people with mental health problems should go to. I return to this consideration in discussion about potential future services in due course.

8.2.3 Other Possible Service Needs

Lastly, in considering how people responded about the potential perfect service, I consider other voiced ideas. The majority of the staff at Chapley had ideas about alternative approaches to care and had given this consideration, as Christine demonstrated in suggesting the use of a tagging system to minimise the risk involved in wandering. Only two staff members at Glimster had alternative considerations. This appears to emphasise further the invisibility of mental health problems to staff in the Glimster site unless they are of major challenge. Ann is one of several staff members who want more emphasis placed on talking approaches to addressing mental health problems in old age.

C. Physio Ann: Counselling, counselling, counselling.... Because I think that, you know, it's just like for anybody else. Like if I have a problem, you know, and I can't talk to anybody about my problem then I start building up something that it doesn't really necessarily. I mean it's not really the reality, but that's the reality I'm leading so, you know, if I don't have somebody that help me to go through, and that's what happens with many of our patients, I think.

Among each of the cluster groups some respondents suggest that service could be improved if there were more staff, especially nurses, to spend time with older people with
mental health problems. Interestingly none of the nurses expressed this view, suggesting that they do not want to fulfil such a role.

In this section I have examined ideas on mental health service provision for older people with mental health problems in the general hospital setting. There is a general consensus that the current situation requires improvement either by providing more mental health specialists or by removing those with mental health problems from the setting. It is worth remembering again that these desires centre on the construction of mental health problems in old age in this setting as characterised by visible disruptive behaviour. It appears that the views are most adamantly held by those who perceive themselves as particularly adversely affected by the presence of people with mental health problems; that is all cluster groups, other than the older people with recognised mental health problems and the Glimster General staff who do not see the problems so readily. The Glimster older people, the relatives and the Chapley staff feel in need of information and support, they feel disrupted, or that their relative is disrupted, or that they are being asked to do a job that they do not readily embrace.

Increased diagnosis of mental illness as a result of increasing knowledge generates more people who are deemed to be mentally ill, and a need for knowledge and acceptance from within medical and other services. I suggest that this proliferation of perceived illness may also encourage a dependence of non-experts on experts in the general hospital setting, enabling staff to move responsibility to psychiatry either by seeking separation or by bringing in external expertise.

However, conversely psychiatry may seek to resist, perceiving, as encouraged by the direction of current policy guidelines, the degree of the mental health problem as minor and manageable by lesser experts (Kessell 1996) unless it is a “severe and enduring” mental illness such as psychoses (DoH 1999). Such divisions potentially leave issues of mental health problems in old age out in the cold and addressed by nobody, as I have noted with regard to depression (Chapter 7). The lack of clarity about where mental
health problems in old age belong, organisationally and politically, facilitates the lack of recognition that is so apparent.

I now move on to consider any educational impact of mental health service provision before considering the implications of this research in future service provision.

8.3 Education / Knowledge

In this section I consider the data around the staff's skill and knowledge in providing care and treatment to older people with mental health problems. Participants were asked their views on the knowledge and skills of staff and also to consider possible influences on that knowledge and skill.

In analysing the data a potential link emerges between the educative influence for staff who experience the mental health consultation/liaison model and how they view mental health problems, specifically dementia. I look initially at the responses from older people and relatives.

8.3.1 Trained to Cope

Among the older people, particularly at Chapley Hospital, there is an assumption that the staff have the necessary knowledge and ability to fulfil their roles. This is particularly so because they have the innate personal qualities which, as Arthur puts it, "equip them for the job". Mary emphasises her belief that these qualities are more necessary than any formal education and in doing so underlines the traditional approaches to care characteristic of Glimster's culture. In line with Alistair Hewison's (1995) study, examining power within the nurse patient relationship on an elderly care ward, nurses legitimately use persuasion in order to achieve compliance in those who initially are not happy to comply.
G. Mary: I mean the nurses have been brilliant. I mean, sort of, lay and listen, you know... Do you laugh at them, do you ridicule them, no, I mean. Nurses seem to be so good at cajoling them into doing what they want... They do the best with the experiences they’ve got of love and life... I mean sometimes them bids are more important than any degrees or anything.

In considering knowledge and skills, several of the older people at Glimster while initially expressing belief that this was sufficient, became more ambivalent on exploration. Selina talks of nurses being “trained to cope” in performing tasks associated with incontinence and so on, but that they need to have and to be more understanding. Olive places distance between herself and those seen to have mental health problems placing the “they”, people with mental health problems, as different. It is only when she is encouraged to give attention to what she has said that she can personalise the nursing response and consider how she may react were she to be nursed in this way. Indeed she became angry at the idea that anyone would consider calling her a “good girl”.

Int: Do you think that the nurses know how to handle that sort of thing here?

G. Olive: Well, generally. I don’t know how they do and I think they’re wonderful. Mind you, I’ve come to the conclusion that you treat people, the ones you’re talking about, as if they are children. You know, “come on darling” and all this, what I call rubbish. Um and I don’t know how they do it. I really don’t... They say “there’s a good girl” and things like that.

Int: How would you feel if somebody said “There’s a good girl” to you?

G. Olive: Shut your face!... Um, well. They seem to know who to say it to, I think. I hope.

Int: Do you think they get any training?

G. Olive: I can’t say. I’ve no idea. No idea at all. They seem to keep an eye on them but, I don’t know if that’s just inside them that they do it, that sort of thing.

The relatives, in both hospitals, show less confidence than the older people, concurring that there is knowledge and skill shortage. In Glimster a greater emphasis on the need to expand knowledge is linked with the call for a specialist environment, away from their loved ones, as mentioned above. Those participants whose relative has been identified as having a mental health problem are more focussed towards education in the current
setting. They particularly look at practical issues such as recognising the need for pain relief and providing diet. In expressing such concerns Flora, concurring with Dormer (2004), is mindful that the presence of people with dementia in general hospital wards is inevitable and that therefore such skills must become part of the staff’s repertoire. She feels that the presence of a mental health professional aids such learning, in this case about giving analgesia.

C. Daughter Flora: I certainly do think there are education issues because people with dementia are going to continue to be cared for in acute settings. Someone like my mother she is vulnerable because she cannot explain what is wrong... At the beginning of her admission following the operation she refused analgesics...I think I certainly felt it left my mother quite helpless really because they didn’t see it...I wasn’t convinced about it I felt it was very early on and that she could well have needed something... [Now] certain nurses in particular who have really taken the trouble to get to know my mum and who have really got a lot of understanding about what she does need, and that has been very positive to me that is this way of working together at its best.

8.3.2 Osmotic Learning

It is the staff groups that differ most in their responses when contemplating their knowledge and skills and whether they have a need for more. Here the potential influence of a consultation/mental health liaison service model is evident, through what I call Osmotic Learning. As has been suggested in the literature (Scott 1988, Roberts 1997, Harrison 2006b) the Chapley hospital staff appear to have absorbed knowledge through their regular contact with the consultation/liaison service. Such a finding concurs with the literature that describes one of the key differences between the traditional and the consultation/liaison models of mental health service provision as being the focus upon education as part of the role (Dormer 2004, Draper 2001, Baheeratha and Shah 1999). Caplan (1970) felt that the most influential aspect of the mental health consultation liaison role is that of collaboration. It is through such collaborative working,
with someone perceived to be in a position equal to oneself and approachable (Sensky et al 1985, Roberts 1997) that *osmotic learning* has occurred.

There is a suggestion within the data that those who have been exposed to more mental health expertise are more accepting of older people with mental health problems and recognise more readily their need to know even more. I first consider the responses from Glimster staff before making comparison with their colleagues at Chapley Hospital.

There seems to be a complex picture around knowledge and skill at Glimster General. This is emphasised by the organisational priority to move people through the system, together with the perception of hopelessness about older people with mental health problems, as discussed elsewhere. Like Val, the majority of the staff feel that they provide appropriate care for people with “general dementia”, that is those described in Chapter 7 as “poor things”, who are perceived as helpless and dependant on staff for their every need. Their desire for education tends to centre on, as Trish puts it, the organisational goal of “know[ing] where to send them to”.

G. OT Val: Yes, memory loss is fine, we're more than happy to treat these people. We’re quite good I think, the nurses try to establish routine. They're very good if people need feeding, encouraging them, that type of thing. It's very accepted that people, you cannot expect people to remember what they are doing, to be able to get dressed. They expect to giving all care, basically. I think that we could do, definitely, with more training as a whole staff, nurses, OTs, everybody in mental health in the elderly. I don't think we’re too bad with general dementia, people know signs and ways of talking to people and that.

Among the respondents at Glimster General there were two staff members who had expanded their knowledge in dementia care through attendance at external courses. Their enthusiasm and skill is evident in some responses within which they describe person centred dementia care strategies as championed by Tom Kitwood (1997) and subsequent others. However, Sue is unsure that the rhetoric is applied in practice, an assertion and supported by the lack of similar responses from other Glimster staff participants. This
potential difference between taught knowledge and skill acquired through osmosis, due to mental health service presence, is a potential difference between the service models.

G. Service Manager Sue: Well, it's talking to them, it's talking to the relative. I mean there are little instances; I mean, there was one lady that used to, she was always wandering around and fiddling with things, and we just gave her little jobs to do and she was quite happy. We helped her take all the linen off the trolley, she refolded it up and put it all back again. And she was quite content with that. And you may be able to find, the reason that somebody folds things up really neatly, that's maybe that they have always done that, they've done something in their previous life, their work, they've done that sort of thing, you know not folding linen but that sort of thing...They're just re enacting something.

Int: Did you find that? How did you know that?
G. Service Manager Sue: Talking to them, their friends, their relatives. I wouldn't say it routinely happens, but it has happened.

In Chapter 7 I noted that the staff in Glimster General more readily see older people with mental health problems as “poor things” than their counterparts at Chapley Hospital. This is reflected also in a greater expectation in Glimster, for older people to move from hospital into institutional care. Naomi appears to support the supposition that memory impairment precludes a return home from this organisation even when external expert advice from a mental health specialist suggests otherwise.

G. Dr Naomi: Because she's got a purely psychiatric condition and is awaiting a nursing home bed.
Int: A dementia like condition?
G. Dr Naomi: Err, yeah along those lines. Slightly just a personality disorder with it as well. I don't know exactly, I can't remember all the bits and pieces but [the psycho geriatrician] has seen and, you know, is happy that she can go home with that condition but she's not going home, she's waiting for a nursing home bed so she's delayed here and it's probably inappropriate. And it's probably inappropriate for the rest of the people in that bay as well to have her there.

This disregard of advice may suggest that the sporadic and distant nature of the traditional model of mental health input has no influence on how those with mental health problems in old age are perceived. Naomi’s belief that this woman is incapable of managing at home is not swayed by the expert’s perception. There is evidence to suggest
that the consultation/liaison model enables the expert to be heard and that the Chapley Hospital staff are more ready to contemplate the older person going home, despite potential risks.

An emerging philosophical difference in focus towards older people with mental health problems is characterised by Linda and Kate, from Glimster General and Chapley Hospital respectively. Linda, like some of her other colleagues and the older people at Glimster, talks about the positive innate quality necessary to care appropriately for older people who may be confused. She describes how the staff are naturally sensitive, empathic and patient in “dealing with” care and doing things for older people. Kate practices a more person centred approach, and suggests that the assumed caring attributes may be “too much”, and may not be beneficial to the patient. She and others of her colleagues, talks of her developing skill in considering the rights and risks involved in meeting the care needs of people with dementia. She cares about rather than cares for the older people in the hospital.

C. Discharge Nurse Kate: But the fact that we have a resource...we have have quite a large amount of education in that respect in a drip, drip fashion... For instance this case conference that we are setting up for next week, Without [mental health] input we may not have gone down that route [enabling the person to go home]...Particularly the risk element.. and I think that's probably where we, as a hospital, perhaps fall down. I think as nurses and as doctors we can try and care too much....We can't cope with letting go because we are carers. And that is where the mental health expertise is a good influence on us.

Other Chapley staff members also focus on the influential role of a mental health practitioner suggesting that they have increased awareness and ability to recognise, explore and work through situations. Their knowledge and skills have developed through their regular contact with mental health expertise, rather than through formal education as experienced by some of their colleagues at Glimster General. Both Christine and Dianne demonstrate development in their knowledge and skills not evident in the other site.

C Dr Dianne I try and find out why - if it is confusion I would find out whether they had had it for a long time, try and talk to their
family, try and talk to people that know them, if they are coming in straight away to hospital to find out whether that is new for them and just get an idea of what it is all about. ... I mean I have learnt more in this job than I have done before with that... and then obviously because [the mental health nurse is] there.

C. Nurse Christine

I think personally we are a bit more aware and we might pick up on issues earlier because we have been in touch with [a mental health nurse who has] explained what things you look out for and people are more aware of picking up on maybe strange things people have said and their behaviour... and sometimes a bit of it stays in there for a bit and someone will behave in a certain way and you think "Oh I remember that, I can relate that back to something".

The staff at Chapley hospital, where they have more exposure to mental health expertise, are more aware of their perceived shortcomings are more keen to learn more. However, this awareness of need is contradicted by their desire for problems to be taken away or dealt with by more mental health specialists in their midst, as explored earlier in this chapter. It is noteworthy that there is also a site difference in the demand for education in that the Glimster staff sought generic knowledge of both depression and confusion, drawing on the bio-medical model of clear classification characteristic of their more rigid organisational model. The Chapley staff, in line with Rachel Norman’s (2003) finding that staff wish to understand the people and their behaviours in order to enhance their care, focused on confusion, but they ignore depression.

C. Nurse Fiona: I've been to a few specific courses on management of or recognising problems and they have been a great help and now I need something more.

Having examined how the participants view the service and the knowledge and skills requirements, both in the present and in the ideal, I will now discuss the findings about the current situation and give consideration to the implications for future practice which I explore further in Chapter 9.
8.4 Discussion

The distinct difference in the organisational cultures of Chapley Hospital and Glimster General, with the latter being more governed by organisational and professional structures, is evident throughout the content of this chapter. Although Chapley Hospital is driven by the same political agendas there is evidence of some greater consumer, person centred, awareness. Given the site differences, it is not possible to make clear comparison between the two sites and conclude that this is an effect of the model of mental health service provided. However, there do emerge some interesting differences that suggest some influences attributable to the differing approaches, particularly among staff responses.

The data that I have presented here suggests that the presence of a mental health consultation/liaison model of service facilitates osmotic learning which enables staff to approach their patients in a more person centred way. However, in this discussion section of the chapter, I consider the lack of influence on the recognition of the presence of depression. I also look at the ongoing will, across cluster groups, to avoid issues that pertain to mental health problems by whatever means are seen as potentially available. Such will to avoid, even in the presence of developing skill, suggests that people within the general hospital setting are not ready to embrace mental health problems in old age as “Everybody’s Business” (CSIP 2005). Lastly in this section I return to the social constructions that influence perceptions of mental health problems in these settings and suggest that they also service to sustain the view that mental health problems in old age are external to general hospital business.

I noted in Chapter 7 that in both hospitals depression in old age is not readily noticed or addressed. This research displays no evidence to suggest that depression, in this population group, is recognised better in the presence of either traditional or consultation/liaison methods of mental health service provision. This lack of recognition is reflected when talking with participants about the service and the skill of the staff.
members. Focus is upon those categories of mental health problems discussed in Chapter 6; that is those that are overtly visible due to unacceptable behaviour.

The issue of recognition and attention to depression in this population group is not simply a matter of inputting expertise and education to the general hospital. As I have suggested in Chapter 7 (p200), one cannot see what one does not believe in. The invisibility and structured nature of depression within old age suggest that issues of non-recognition need to be addressed within the wider focus of social inclusion of older people as well as by advancing research into the conditions, and how it may vary with the life course, and experiences. Such research can serve to improve visibility and attention, as evidenced in the field of dementia.

In considering their level of skill in caring for people with mental health problems, the staff in Chapley Hospital demonstrate satisfaction with the current service. They feel that they have developed knowledge and skill in caring for those older people who are confused. They are more able than their counterparts at Glimster General to address and explore challenge and to enable older people to go home, in consideration of their desires and the risks involved. However, they are uncomfortable performing a role that they do not perceive as their own. It is the power of the historical stigma of mental health problems that prevents Chapley Hospital staff from embracing their skill. Such lack of ownership is further perpetuated by the ongoing political, organisational and educational divisions between service providers.

For the staff at Glimster Hospital, where the presence of older people with mental health problems on the wards is apparently less recognised and addressed, there is dissatisfaction but less discomfort with the current situation. The less visible face of mental health problems in their midst means that they have not had to confront the potential major diversion into an uncertain role, away from their core, general hospital business. In line with the organisational model, they seek taught factual knowledge. The wards in both sites, though possibly more so in Glimster, have been socially reproduced for older people with physical health problems (Fennel et al 1988) where patients are
lumped together under that category and become invisible within the setting (Goffman 1953). The staff seek to replicate the conformity of invisibility in order that they can do, what they perceive to be, their real jobs.

My suggestion that when mental health service is traditional, as in Glimster, problems are absorbed, possibly under-addressed and under-treated corresponds with Lindsay Prior’s (1993 p1) assertion that “The ways in which we organise care and treatment for psychiatric disorders serves to both reflect and constitute what such disorders actually are”. In Chapley Hospital, where there is more frequent and visible service, the problems are more categorised and overt. Although the staff have developed knowledge and skills through “osmotic learning” the problems are not wholly embraced. Henry Minardi (2004) suggests that the role of liaison mental health professionals is to influence change in practice. “There are egos that want to be massaged, overt and covert power struggles and attempts at gaining control over the work of others. Practice can be changed through role modeling, confidence building and an informal educational input supplement and encourage formal education.” It seems that such influence is occurring in Chapley Hospital, and may even have some effect on the differing focus on some elements of consumer power as opposed to those of the medical tradition and the organisation. However, Chapley staff remain uncomfortable with having to deal with that which they do not see as their job, however well they are doing so.

The will of all the cluster groups in this research, to either remove older people with mental health problems from their setting or have an increased presence of mental health professionals to address the problems suggests that, despite the purported desire of the staff for more knowledge, the overriding wish is for somebody else to deal with the problem. Through exploration and examination of the data, the suggestion is that the provision of external mental health services, using whichever model, serves to allow division to remain. The mental health expert is expected to sort out the problem, removing responsibility from those in the general hospital setting either by physical removal or by providing a lead in “dealing with the problems” as Nurse Fiona describes. Such a finding concurs with the view of Crawford and Brown (2002) who suggested that
providing external mental health expertise perpetuates negative attitudes and prevents shifts of mindset in general hospital practitioners.

The original research question sought to discover the social constructions that influence perceptions about mental health problems in old age in the general hospital setting. It is apparent that those influences not only lead to the development of perceptions but serve to sustain them. The increased presence of older people with mental health needs in general hospital wards creates challenge and has led to local and political response, in service development and guidance. However, the social constructions that detract from enhancing visibility, recognition and service integration remain in place and sustain the divisions. The historical and ongoing service and educational divisions between general and mental health perpetuate stigma and perceptions of fear, exclusion and desired invisibility. Current mental health services for general hospitals, it transpires, do little to remove the barriers.

I explore the implications of these findings with regard to potential future service further in Chapter 9. I advocate for the merging of general and mental health services in old age and in professional education. I explore a possibility that the current political driver aimed at improving service integration in general hospitals by using the consultation / liaison service model (CSIP 2005) will not serve to bring the differing constructions of mental health problems in old age together. However, before moving on to such consideration I return to the theoretical framework around which I have built this research.

8.5 A Return to the Theoretical Framework

In Chapter 1 I defined Interpretive Interactionism, in the words of Norman Denzin (1989) emphasising his assertion that both “personal troubles” and “policies and institutions” affect how we interpret social life. Throughout this work the degree of power and influence of organisational policies and institutions has shown to be all encompassing. The knowledge and perception of mental health problems in old age in the general
hospital setting has, as Foucault suggests (Porter 1998), been created by the power within the setting. The “personal trouble” is seen as the trouble mental health problems bring to the organisational culture, not to the person with the mental health problem. The stigma associated with mental illness enables those in power, both professionally and organisationally, to deflect responsibility onto others, the mental health services, whose business it is to address such issues. In psychiatric circles the “personal trouble” is diagnostically termed and as such is core to their raison d'etre. The general hospital professionals adopt the lay view of mental illness, not seeing such illness as equivalent to those illnesses within the property of general medicine.

In the rigid and controlled setting of a general hospital, mental health problems are thus seen only when they are overt and obstructive of the normality of the setting. Any problems that are not seen, in the context of challenge to the organisation, do not exist. A less rigid organisational structure and/or the presence of consultation/liaison mental health services may serve to make such differential less stringent.

Using the language of social constructionism (Berger and Luckmann 1991), the recipe for mental health problems in old age in this setting is that they do not exist, as this is not the place where the competing powers of medicine, psychiatry and organisational politics deem them to belong. They are invisible unless they impact on the smooth running of the system, be that through exhibition of behaviour deemed inappropriate or due to inability to flow through the organisational system. The silent majority of those with mental health problems therefore move through the system unnoticed and without the offer of any service. Those with overt and bad behaviour are deemed as mentally ill and within the scope of psychiatric services to address. Such a well-established taken for granted view is evidenced in the presence of ongoing separate psychiatric services, supported in policy and law, who are themselves keen to hold onto their power bases within organisational systems.

As discussed in Chapter 5, Stephen Hacking (1999) describes six grades of Social Constructionism (Box 5.1). Where the phenomenon being studied is mental health
problems in old age, the broad perception throughout this research is that of the historical concept founded on fear and suspicion of the unusual still holds. However the sites do differ and Glimster General has a predominantly “ironic” construct whereby it knows that mental health problems in old age are present but perceives that little can be done, therefore the reaction is to ignore, or indeed not to see it. In Chapley Hospital there exists a more reformist perception whereby the problem is acknowledged as bad and that something should be done by way of either removing the problem to another place or by achieving more rescue from mental health services. Again, this suggests that either the less rigid organisational structure of Chapley Hospital and/or the presence of consultation/liaison mental health services has a positive effect. Either enables people within that culture to see and act upon mental health problems in old age more creatively than their Glimster General colleagues.

8.6 Conclusion

In this chapter I have set out the data concerning service, knowledge and skill, and examined the cluster and site differences. I argue that site differences, specifically within the staff clusters, suggest that the presence of mental health liaison influences the knowledge and skills of staff and therefore how older people with mental health problems are conceptualised. The staff at Chapley Hospital are less likely to attribute pity, and appear to “care about” rather than “care for” those in their care. Those staff who have been exposed to the consultation/liaison model appear to have acquired knowledge by osmotic learning. They are more ready to embrace the challenges of working with older people with mental health problems. Yet, in contradiction, they would still prefer for someone else to do the job.

There is consensus, across the cluster groups, that issues of mental ill health are not the business of the general hospital and, while the staff should have more knowledge and more available mental health staff, it would be preferable for those people who challenge the equilibrium of the setting to be cared for elsewhere. It appears that neither model of service in operation in these two sites address the issues arising: in Glimster through
perceived absence and in Chapley by perpetuating a model of exclusion through deference to mental health expertise.

While it remains the expectation that mental health problems are the rightful business of external specialists it is questionable whether the rhetoric of government documents, such as Everybody’s Business (CSIP 2005) can be realised. Consultation/liaison models may serve to perpetuate the division but traditional models seem to possibly render mental health problems more invisible. Depression however is invisible in both sites.

In summarizing the component parts of the analysis and discussions within these last three chapters, it is evident that the way in which mental health problems in old age are perceived in these settings is a product of the culture of the setting, lay representations of mental illness and the combined stigmas of old age and mental illness. Perceptions are produced and influenced by the historical power of bio-medical psychiatry as it has separated from that of general medicine, and also by the growing organisational power. This latter is the product of providing a health service built on the principles of a market economy. That mental health services are provided as a separate, marketable, product seems to protect others from having to consider mental health problems in their midst, particularly when presentation is covert. The many older people in general hospitals with invisible mental health problems are thus not seen because nobody thinks they are there. Thus the lay position of mental health problems as being characterised in social deviance, and feared, is held safely in that place by a society that is happy with that arrangement.

In the final chapter I draw together the conclusions drawn through this research and further discuss the resultant implications for future services for older people with mental health problems in general hospital.
Chapter 9

Conclusion, Recommendations and Implications for the Future

9.1 Introduction

I started this work with a will to discover whether mental health problems in old age were perceived differently within the health care setting of a general hospital as compared with those of medical psychiatry. I also sought to consider how the older people with mental health problems in the general hospital setting could best have their health service needs met. Using methodology based upon the theoretical framework of social constructionism (Berger and Luckmann 1991) the research sought to see the social world of the general hospital from the perception of those within it.

In this concluding chapter I draw together the various strands of theory that have emerged and have been explored in the last three chapters. I highlight the key findings under the three headings of culturally determined problems, structured depression, and perpetuating division.

The first section confirms that mental health problems in old age in the general hospital setting are perceived with influence from the power structures within the setting and by broader lay perceptions, associated with the combined stigmas of both mental illness and old age. I note that the perceptions of medical psychiatry are not a major influence in defining mental health problems in this setting.

The second section explores again the concept of depression and its invisibility among older people in this setting. I describe this structured depression as an artifact of the structured dependency of old age described by Townsend (1981). I also speculate that depression, when it occurs as one enters the last years of life, in chronic ill health, may be a different phenomenon than that currently medically defined. I consider how this position of social invisibility may be addressed.
Thirdly I bring together conclusions on service provision. I note some advantage in the consultation/liaison method of mental health service provision, particularly due to the influence of osmotic learning. However, I conclude that any external mental health service provision serves to perpetuate the Cartesian division, between general and psychiatric services, and facilitate the ongoing lack of acceptance, and indeed invisibility, of mental health problems within non mental health settings. I suggest a need for radical service and professional education review if current perceptions are to be challenged.

Prior to concluding the chapter I reflect on the research methodology and my experiences in conducting this research.

9.2 Culturally determined visible problems

In considering the answer to the first of my research questions:

What are the social constructions that are drawn upon and that generate perspectives on mental health problems in old age in the general hospital setting?

I conclude that mental health problems in old age in the general hospital setting are defined, across sites and cluster groups, by the extent to which the confused person conforms to the requirements of the social setting. Perceptions are formulated with the influence of the broad lay concepts of mental illness and exaggerated by the rigid and controlled setting of a general hospital ward. The divisions between normality and abnormality in this setting are emphasised by the systems and power relationships that dominate the culture, through both the stringent organisational structures and the biomedical focus.

What may elsewhere be perceived as a minor deviation from the norm is readily classified as a mental health problem in these settings. Older people defined as having a mental health problem are therefore those who are perceived not to fit in, either through
their behaviour or, particularly in Glimster General, because they do not conform to organisational expectation.

In Chapter 1 I presented the following quote from Peter Berger and Thomas Luckmann:

> It is our contention, then, that the sociology of knowledge must concern itself with whatever passes for “knowledge” in the society, regardless of the ultimate validity or invalidity (by whatever criteria) of such “knowledge”. And in so far as all human “knowledge” is developed, transmitted and maintained in social situations, the sociology of knowledge must seek to understand the processes by which this is done in such a way that a taken-for-granted “reality” congeals for the man in the street. In other words, we contend that the sociology of knowledge is concerned with the analysis of the social construction of reality.

(Berger and Luckmann 1991 p15).

This research suggests that “knowledge” about mental health problems in old age in the general hospital setting is similar to, but exaggerated from, the popular view of such problems within society as a whole. I have confirmed that the bio-medical constructions of mental illness through diagnosis, held within psychiatric services, are not shared by the people interviewed within the general hospital setting, including those who work within the health service.

One may suggest that the research has been hampered by the discovery of organisational and power differences within the two, initially apparently comparable, hospital sites. However, these differences have served to clarify the fundamental importance of power and organisational structure in influencing views upon what constitutes a mental health problem. Both hospitals display the influence of traditional bio-medical power. They also are both bound by the same government directives that focus their attention on throughput and prevention of delays in moving people through the system. However, it is clear that Glimster General is more tightly politically driven, with Chapley Hospital apparently beginning to display some influence from the power of the consumer. While I have noted that Osmotic Learning occurs due to the presence of a consultation/liaison nurse, this can only be said to a factor in the nature of those perceptions.
Figure 9.1  
Influences on Perceptions of Mental Health Problems in Old Age in the General Hospital Setting

FORCES THAT PROMOTE VISIBILITY & RECOGNITION

- Increasingly Present
- Government Focus and Guidance
- Osmotic learning
- Increased challenge to the setting

FORCES THAT DETRACT FROM VISIBILITY & RECOGNITION

- Consultation / Liaison Service – A compromise position that impedes social inclusion
- Cartesian Divisions
- Lack of shared perception
- Fear
- Ageism
- Stigma
- Organisational Separation of general and medical health.
- Organisational Structure of the general hospital
- Traditional Consultation
I now refer to figure 9.1 in reiterating the range of social constructions that both influence and sustain perceptions of mental health problems in old age in the general hospital setting. Of course, as I have emphasised throughout this work, the influence differs between the two sites but the elements are the same.

I have diagrammatically shown that mental health problems in old age in the general hospital setting are either visible or invisible. There are forces that promote the visibility and recognition of those with mental health problems and those that detract from such visibility and recognition. My view is that the ongoing presence of these social forces perpetuates the unaccepted and often invisible nature of mental health problems in the general hospital setting.

The forces that promote attention to the issues are the increased presence of older people with mental health problems in the social setting and the resultant perceived challenge on the smooth running of the systems. In response to this growing visibility of this “new” social group, government guidelines promote and highlight the need for attention and a move away from the traditional psychiatric focus (DoH 2001a, CSIP 2005). During the time taken to complete this research mental health consultation / liaison services have proliferated in an attempt to address the service challenge.

In Chapter 8 I explored the positive influence of the presence of a consultation/liaison mental health service in facilitating osmotic learning, thus promoting the development of knowledge and skills among non-specialist staff. There is however a cautionary note in respect of the positive force of osmotic learning in that its benefits are outweighed by the detracting forces that I reiterate below. If learning occurs due the influential presence of an external mental health service provider the staff involved know, but do not own, the knowledge and skill that they have developed. Such inductive education would therefore better be provided by experts within the organisation, thus making mental health issues in old age part of the general hospitals organisational agenda.
The forces that detract from visibility and recognition include the ageist invisible social construction of depression in old age, as I explore in the next section. The ongoing divisions in both service provision and in professional education also serve to prevent non-specialist staff from believing that issues of mental health and illness have anything to do with them, as I explore further in the section headed "perpetuating division". The combined stigmas of both mental illness and ageism emphasise a perceived alien status of this group of people. It is notable that all the research participants, in one way or another, sought to distance themselves from association with mental health problems. Other than for depression, there were no overtly acknowledged descriptions of mental illness from within the experience. The mental health problems were always exhibited by somebody outside oneself, ones relatives or, in the case of staff, ones proper patients.

The numbers of older people with mental health problems in general hospitals have been increasing, year on year, due to changes in mental health service provision and increased longevity. However, the issues arising are not accepted as having a proper place in the general hospital. The lack of belief that these people do belong in hospital, when they have an acute medical problem, is not clarified by conflicting political messages. There is a lack of shared perception between politicians, organisations and service users and staff about what constitutes a mental health problem. While guidance suggests a need to embrace the issues of older people with mental health problems as "Everybody's Business" (DoH 2001a, CSIP 2005), separate mental health services, and associated education systems, exist to provide for those with severe and enduring need (DoH 1999).

As this work demonstrates, when mental health problems are noted in this population group they are always perceived as severe, questions of degree are not considered. There is no concept of being a little mentally ill, it is an all or nothing construction. People are mentally ill either by virtue of their behaviour or by their inability to meet service requirement through social incompetence. The language of psychiatry, and indeed the political language associated with psychiatry, is not shared outside the specialty. However, mental health problems in old age in the general hospital setting are, almost
exclusively, described as descriptive of the diagnostic label of dementia. Dementia is the mental health problem of old age.

It has long been the lay view that mental health problems are defined by unusual behaviour, that is behaviour that is outside the realms of normality within a given culture or setting. In the general hospital this lack of conformity is viewed in terms of the effect the individual and their presentation has on the equilibrium of the setting. Perceptions are formulated either through observed overt unusual presentation or covertly due the impact of the individual on the hospital system through passive inaction. Those perceived to have mental health problems are deemed to be a threat to that equilibrium. They are overtly or covertly disruptive to the normal business of the setting. The predominant feature, in line with the literature (e.g. Pilgrim and Rogers 1999), in description is that of behaviour perceived as unfitting to the hospital setting. In contradiction to the recent literature on dementia that encourages a perception that dementia damages the brain and not the person, in this setting people with mental health problems are seen as damaged, and even damaging, people.

Particularly in Glimster General there are some older people who are categorised as “poor things” rather than mentally unwell. These are people with dementia who are attributed no social capital, they are socially dead (Sweeting and Gilhooly 1997) and as such do not fit into a setting where there is an expectation of conformity and recovery. From the staff perspective such people only become visible, as having mental health problems, when they challenge the throughput of the system. At that point they move from being poor things to become problematic things, like their counterparts who overtly misbehave. This suggests that many such “poor things” remain invisible and are removed from the setting to care homes without having been afforded a voice (Gillear and Higgs 2000). They have lost all power, are socially excluded and can exercise no choice as it is assumed that they are unable to manage or engage in discussion or decision making. Conversely the people with perceived mental health problems exhibited through their behaviour, or lack of conformity to the rules, possess liminal power (Turner 1974) through the attention that
their behaviour draws. However, this power serves to stigmatise rather than empower them. They are defined as socially inept and are thus marginalised.

The perception of social dependence is in line with theories of ageism whereby older people are assumed to require the nurture of able minded and cognitively proficient younger adults. Whether their presentation is overt or covert people behave towards them as though their cognitive ability has left them completely.

When an attributable behaviour is present, any other potential cause including the presence of a biological illness, even if considered, seems to become secondary to the predominant deviant presentation. There is little evidence of any differentiation between delirium, acute confusion with remediable cause, and dementia. I find the lack of recognition of this curable medical condition potentially alarming and suggest that this is an area that requires more study. As I have discussed (p156), the lack of reference to delirium, particularly in the more ordered, bio-medically focused Glimster General, may be explained if delirium is defined as a medical, rather than psychiatric, diagnosis. However exploration is desirable.

As I have said, it is clear that perceptions, even among staff members, are markedly different from those within the field of psychiatry with a general conclusion that mental ill health is defined through behaviour rather than any other diagnostic symptomology. As demonstrated with the “poor things” a dilemma occurs between the classification of old age and that of mental health problem, making singular construction impossible (Hacking 1999). The individuals may be seen as bad, yet the group, as older people, are socially inadequate. Therefore to be recognised as having a mental health problem in old age the behaviour needs to only marginally move from the expected norm of conformity and passivity expected in old age especially in this setting. This dichotomy of definition between bad, and being pitied and in need of nurture leads to conflict, particularly in considering how needs can be met. A potential compromise position, a specialist ward within the general hospital, seems to appease the conflict. It removes the stigmatised
person but also defines them as not "bad" enough to warrant admission to a mental health unit.

In summarising this section, I suggest that the very controlled nature of the general hospital setting, a rigid microcosm of the wider society, makes deviation from a strict norm highly noticeable and all the more intolerable. Those who are perceived to have mental health problems are thus potentially more visible in this environment than elsewhere. Conversely however, there are problems, defined within psychiatry as mental illnesses, which are invisible in this setting as they are seen as part of normal ageing. As they do not adversely impact on the business of the hospital they are not noted. Foucault (1967) described mental illness in terms of unreason and irrationality, here it appears, only the latter is applicable in that irrational behaviour is the definition used. If one is solely without reason in old age, society accepts this as normal.

I have discussed above those people with memory problems who are excused the label of mental illness due to their age and their passivity until they threaten the organisational system. I now go on to re-examine and conclude upon the phenomenon of depression.

9.3 Structured Depression

Exploration of the data suggests that depression in old age in this setting is an invisible phenomenon and I suggest that this is so as it is an artifact and extension of the Structured Dependency (Townsend 1981). Misery is seen as part of the fabric of old age, particularly in the presence of ill health and hospitalisation, and it is not seen as remediable.

The theory of structured dependency (Townsend 1981) describes a state driven process whereby older people are socially moulded into dependent beings, through enforced processes such as fixed retirement ages and low income. Depression can be seen as a product of structured dependency caused by the inferior social position into which older people are placed. They are discarded as socially useless. Alternatively depression, or the assumed normality of depression, can be said to be a cause of structured dependency.
Because society assumes that to be old is equivalent to being sad and miserable, social uselessness is assumed. Society therefore reacts in order to necessarily discard those who are assumed to be unable to play a full social part. This duality, of potential cause and effect, runs parallel to the biomedical literature that defines depression as caused by, or causative of, physical health problems (Godfrey and Demby 2004). To extend on Townsend’s theory then, I suggest that depression in old age in this setting is an artifact of structured dependency as Structured Depression and as such it is accepted as the norm and is invisible.

The nature of the general hospital setting, combined with the experience of ill health and ageist perception of social uselessness, combine to formulate a powerful perception of inevitable depression in the circumstance of hospitalisation in old age. Depression is seen as an intrinsic part of the experience and, as such, is not separated from the whole. To the outsider it is seen as an intrinsic part of membership categorisation (Baker 1997) for older people in general hospitals. Such a perception renders depression accepted, intrinsic and invisible.

Unlike depression in the general population, which has become the acceptable face of mental illness and readily recognised and treated, depression for this population group is infrequently considered. For the staff in the general hospital this contradiction can cause confusion. They may conceptualise low mood as being a structured component of being a patient, yet they are theoretically aware of the diagnostic category of depression. However, the lay view, of inevitability and hopelessness, overshadows any professional knowledge.

Current government policy direction, in terms of mental health problems, has removed depression from the scope of specialist mental health services, except when it is severe and causing significant risk. This exclusivity of mental health service to address severe mental health problems leaves the minor conditions, such as depression, to be addressed by non specialist services (DoH 1999, CSIP 2005). This policy move away from depression as a mental illness reflects societies changed view and acceptance of
depression as a life condition rather than an illness. However, because depression is an invisible and normal artifact of old age, neither older people themselves, nor non specialist staff, perceive it. Arguably, due to ageism, depression in old age, particularly in the general hospital setting, has not achieved the same degree of medicalisation as that for other social groups. It does not exist as an ontological reality.

The danger then lies in its presence being overlooked by both general and mental health services, with medicine not seeing it, and psychiatry not seeing it as their business. Thus older people are left to suffer with an unrecognised potentially remediable condition. A condition that is life threatening and enhances the risk of early institutionalisation (Godfrey and Demby 2004, Manthorpe and Iliffe 2005, RCP 2005).

In examining the data, concern about the invisibility of depression uncovers specific areas in need of further study in order to advance understanding. There is a suggestion, within the data, that there may be differences in depression, as it is diagnostically recognised and experienced in older old, as opposed to younger old, adults. This may particularly be the case for older people who are moving towards their life's end. There is a suggestion of accepted inevitability, in the absence of clear feelings of sadness, present in some of the older participants. This area warrants specific research attention, as does the differing rates of depression among women of different ages.

With regard to the latter I have considered the apparent absence of diagnosis of depression in older people in hospital. This cohort, specifically the older women, were, in the mid twentieth century readily diagnosed with depression and arguably over-treated, in line with the medical recommendation of the time, using tranquilising medication. Yet now they remain unrecognised as in any need of attention, and under-treated. I conclude that their invisibility underlines the power of ageism. These women, now that they are old, are not fulfilling their former valuable role in raising the post-war generation. They now hold much reduced and invisible social value.
The invisibility of depression in this setting raises major challenges for the future. As I have discussed in Chapters 4 and 7, much of the recent literature and policy direction with regard to depression in old age (DoH 2001, Godfrey and Denby 2004, Manthorpe and Iliffe 2005, RCP 2005, CSIP 2005) has focused on the under recognition of this medical phenomenon. In line with the limited literature (Rapp et al 1988, Grout 1997, Rothera et al 2002) they note that staff believe that they readily identify depression in absence of evidence that they do, as is mirrored in this work. The need to increase recognition of indicators of depression, and therefore facilitate appropriate action, has been emphasised.

However, this attention to recognition of indicators of depression assumes that depression is accepted as a social reality in a given setting. This is not the case for older people in the general hospital. The invisibility of depression as a concept, in this setting, means that the potential for its presence, and therefore attempts to search for indicators, does not enter the mindset of the social actors. As Stephen Hacking (1999) suggested, the danger in exploring a “thing”, in this case depression, as a social reality to be constructed, is that we initially assume its reality as a starting point. In psychiatric circles depression is perceived as a reality, in the general hospital setting, for older people; it appears that it is not. The same rules of recognition cannot be applied by those who do not perceive the phenomenon in the first place.

Depressed older people, like cognitively impaired older people who cause no disruption, are unnoticed unless they disrupt the organisational system by not getting better and moving out. If they are not noticed due to this organisation need, they are invisible and assumed to be merely old and inevitably dependent and needy. Their low self esteem, combined with their low social position as old, renders them without a voice. Indeed their own perception appears to be that this is as it inevitably should be.

It seems that the issue of recognition of the phenomenon of depression in old age sits alongside the social need to eradicate ageism. Social inclusion is the key to enabling the mental health needs of older people to be viewed and addressed in the same way as those of their younger counterparts. In the field of general health care much progress has been
made in removing age specific services and service exclusions. However, in mental health service a clear chronological age division remains in place.

Given that there is a markedly different perception of depression in mental health and general hospital settings, providing in reach services from psychiatry, from a different paradigm, is, according to the findings here, unhelpful. Indeed the Chapley Hospital staff mention depression less readily than their Glimster General counterparts. It seems that what is required is a paradigm shift from within, facilitated by generic education of health staff and political attention to the breaking down of divisions between general and mental health services as I discuss below. Until this happens the practitioner in the general hospital and the mental health specialist will continue to have different views on what constitutes depression, and indeed mental health problems. For example, when an older person is admitted with a significant infection and fails to get up and about after medical treatment is complete, the general hospital staff assume either an ongoing medical problem or inevitable age related change whereas the mental health worker considers depression but does not focus on potential ongoing physical health problems (see Peplau 1964).

The issue of depression in old age brings many challenges, not least to the older people currently suffering in silence and invisibility. Ongoing research is essential in this area but will be, as I found in recruiting candidates for this research, very challenging. The very nature of the condition, its social invisibility, the associated low self esteem and the resultant social isolation, makes achieving an appropriate sample very difficult. However, such barriers must be overcome. Appropriately researching and addressing issues of depression in old age will not only relieve the suffering of many, improving their quality of life, and the length of life, but contribute to the political and organisation agenda of minimising length of hospital stay.

I now move on to conclude on the research as it pertains to future service for older people with mental health problems in the general hospital setting.
9.4 Perpetuating Division

Part of the initial concern that fuelled this research was a lack of clarity about how best to provide mental health services for older people with mental health problems in the general hospital setting. I have found that neither the traditional model nor the consultation/liaison model, as provided in these sites, provides an ideal option. However, in answer to the second research question, there is some influence from the model on perceptions of mental health problems in old age.

Those staff who have had regular contact with a mental health professional, through the consultation/liaison model, demonstrate a more person centred approach in caring for confused older people. They have achieved increased knowledge and skill through osmotic learning and are more focussed on meeting individual desires. This learning may also improve differentiation between dementia and delirium. However, the use of the consultation/liaison model does not have an effect on the ability of non specialists to recognise and address the needs of people with depression in old age.

Interestingly, although the consultation/liaison model creates more positive perceptions about people with mental health problems, it does not encourage staff in embracing the mental health agenda as core to their role. Rather, the continued provision of an external specialist service perpetuates the traditional Cartesian division. The availability of mental health specialists facilitates ongoing stigma and the will for those in the general hospital setting to be rescued from having to accept and contemplate how to absorb and meet the needs of people with mental health problems in their setting. People within the social world of a general hospital, in both sites, either want people with visible mental health problems to be removed, or they want experts to manage the issues for them. It is clear that the taken for granted reality is that mental health problems are the business of mental health services and not the business of general hospitals.

The way in which health services are set up, that is by having specific and separate general and mental health services, emphasises this view of separateness. Professional education,
delivered separately, adds to the chasm. Such rifts minimise the potential, and the
incentive, for non-specialists to embrace the mental health agenda. These arrangements
seem to suit both those in general hospital who are comfortable in avoiding mental health
issues, and mental health practitioners and organisations who retain power through their
exclusive expertise.

The nature of continuing external mental health provision contradicts government rhetoric
about social inclusion and the need for mental health problems in old age to be embraced
by non specialists (DoH 2001a, CSIP 2005). Government guidelines emphasise the
presence of older people with mental health problems in all health care settings and
encourages social inclusion through focus on recognition, education and appropriate
attention. *Everybody's Business* (CSIP 2005) suggests that the presence of mental health
liaison teams in general hospitals aids best practice. The participants in this research
clearly support such a recommendation. However, the support for such intervention
seems to be driven by a will to avoid having to be in contact with a stigmatised
phenomenon, rather than by a wish to improve the care for older people with mental
health problems.

As aptly described by John Holmes et al (2002) older people with mental health problems
in general hospitals fall “between two stools” with psychiatric services concentrating on
those with “severe and enduring” mental illnesses (DoH 1999) and general hospital staff
and their organisations, neither recognising need nor perceiving meeting such need as
within their remit. Arguably this gap, into which people can fall, has widened since the
closure of the asylums, the move to community care and, more recently, the policies of
“New Labour” and the NHS plan. Within this new way, the role of mental health services
has narrowed and is defined as being solely to provide care and treatment for those with
enduring mental health problems (DoH 1999). Theoretically therefore those with lesser
problems, those not diagnosed with schizophrenia or bipolar disorder, are deemed the
responsibility of others within the health service. However, culturally this shift of
acceptance and responsibility has not occurred. As demonstrated by the participants here,
mental health problems are not seen to be within the scope of general hospital business.

Gwyn Grout
The amalgamation of services for older people with both physical and mental health problems has been a subject of political speculation since the Macmillan report of 1926 (p7) which advocated for mental health wards to be part of every general hospital site. Similar political rhetoric, for improved service integration has, and continues to be, voiced in various guises, most recently in the recommendations of the Care Service Improvement Partnership (CSIP 2005). However, there remains little evidence to suggest that a powerful driver will break down the organisational barriers that perpetuate the position of isolation and persistent stigma of mental illness. Just as the recommendations of the Macmillan report never came into fruition, arguably due to the will of the emerging medical power of psychiatrists who wished to hold onto their power base, there now exist large mental health trusts whose interests are served by maintaining the status quo. Social political rhetoric may continue to strive towards the integration of services but stigma and historical and ongoing power issues continue to prevent it. The social stigma and fear of mental illness, in our risk averse society, provides rationale in favour of the ongoing social exclusion from mainstream services.

As I have discussed, there has been an increase in mental health liaison provision in recent years, with many Mental Health Trusts seeking to further increase the service. However, Mental Health services experience difficulty in achieving commissioning for such provision. The reason that services are not purchased is, I suspect, due to the same invisibility phenomenon discussed in Chapter 7. Visible mental health problems are addressed by existing service, other problems, defined as mental illnesses by those who work in mental health services, are not seen. Thus need for service is not perceived. Just as practitioners cannot perceive depression, service managers and commissioners cannot perceive the extent of the need for attention.

It appears that, at present, mental health consultation/liaison services are the sticking plaster over the gaping wound of the social exclusion of older people with mental health problems in the general hospital setting, providing the illusion that the sticking plaster is enough to meet the needs of these people.
I suggest that radical philosophical change is required if the invisibility and social exclusion of older people with mental health problems in the general hospital setting is to be addressed. As I have shown, there is evidence in this research, that the integration of mental health specialist staff with their general hospital colleagues can influence knowledge and skill. The ideal service, based on the findings of this research, would appear to be integration of that mental health expertise, by employing people with the relevant expertise, within the organisational structure of the general hospital. Through such integration older people with mental health problems would be seen as integral to the normal business of all staff, with the experts within facilitating osmotic learning through the “drip, drip” development that Kate describes.

Issues related to mental health, within the health agenda, could then be embraced as a feature of the one agenda, with mental health expertise and specialism becoming a branch of the health agenda in the same way as cardiology is such a specialism. Thus those with a non-specialist need would become the normal business of the non-specialist ward, with the specialist accessible within.

Within such a model there is potential for specific wards to address those with specific needs while minimising the risk of such a ward becoming a new “asylum” for those that others do not want to see. This could occur in the same way that specialist neurology and urology wards, for example, exist at present. There are currently emerging models of shared care wards in general hospitals in the United Kingdom (RCP 2005) whereby wards in general hospitals specialise in the care of older people with both medical and mental health problems. Limited research in the United States (Bartels 2003) provides positive evidence for similar community models but research is required specifically examining such shared care wards.

In summarising this section, I suggest that the ongoing division, both in professional education and in the organisation of services, is the result of the political division between general and mental illness. People with mental health problems are seen, socially and
politically, as a threat to social order; therefore they continue to be treated separately. Although recent guidance has made it clear that psychiatric services need only attend to those who are an ongoing risk to themselves and/or others, the lay opinion does not separate people in this way. Professionals outside psychiatry share the lay opinion, and therefore expect mental health services to address the needs of all of those who they perceive to have mental health problems. While government policy, and professional qualifications, continue to exclude focus on people with mental health problems from the mainstream, as seen in the National Service Framework for Long Term Conditions (DoH 2001b), and separate power bases exist, integration is unlikely.

To view this from the perspective of interpretive interactionism (Denzin 1989) society wants and needs the power within mental health services to remain in the structure and organisation of psychiatric care as it is now. The research participants exhibit desire for people with mental health problems to be out of their sight and not within the scope of their social world, in this case the social world of a general hospital.

In concurrence with Bartels (2003) I agree that an essential starting point for integration of services for older people with mental health problems is to address the way in which health professionals, particularly nurses and doctors, are educated separately in general and mental health specialties. Only when health problems are not thus divided can integration occur. Future service must seek to close or obliterate the current structures that serve to sustain division. Both theoretical medical knowledge and evidence of the popular perceptions of visible and invisible mental health problems must be used in combination in order to ensure that the needs of older people are better met.

Throughout this work I have been challenged, both practically and philosophically, by the experiences and discoveries within this research. Before drawing my final conclusions, I reflect on the journey.
9.5 Reflexivity and Reflections

Of course as I have moved through this work, and particularly as the influence of various power dynamics as crucial to the phenomenon have emphatically emerged, I have had much cause to consider my own position in this conundrum. My research interest is in how those within the general hospital setting construct mental health problems in old age, using whatever passes as knowledge in that setting (Berger and Luckmann 1991). I have had to be ever mindful of my own thoughts and perceptions when gathering and analysing the data. My professional background places me within the power structure of psychiatry and mental health services. During the period of this research, as an employee, I have experienced the growth of bigger and more organisationally powerful mental health trusts with a vested interest in sustaining their position as experts in, and providers of, mental health services. The development of mental health liaison services to general hospitals can, as I have argued, be seen as a means of holding on to the traditional power base, sustaining control of the mental health agenda.

Professionally I have worked from this organisational position while the analysis of my research data suggests that this is not the best way to provide services, care and treatment for older people with mental health problems or to overcome the stigma and fear that dominates the lay view of mental illness. My field notes are full of my deliberations and discomfort about the torn position I felt, doing a job that may perpetuate divisions. Before I embarked on this research I was comfortable that a consultation liaison method of delivering service for older people in general hospitals was probably effective and useful. The analysis and exploration of the data suggests that this may not be so. At one point I did apply for a job, in a general hospital, seeking to provide the service from within that seems necessary.

From field work diary: “Today I am going for an informal visit for a job in a general hospital. Reflecting on why I am doing this it...it is due to my will to challenge this dualism. To encourage acceptance of mental illness from within. I am sure that I won’t get the job because I belong on the other side.”
I did not get the job as the hospital concerned were not actually seeking someone to perform that role. In line with my findings, they were happy to assume that mental health services are provided from external experts and were satisfied with the status quo. They did not share my perception of the degree of need for attention to this agenda.

Through conducting this research my own perceptions of mental health problems in old age in the general hospital setting have markedly changed. I no longer feel comfortable that the professional role I fulfil, as a mental health liaison nurse, is the best way to meet the needs of older people in hospital.

I have also examined the process and the experience of the research from a more pragmatic perspective. Here I consider the methodology and some possible shortcomings and how problematic issues may have been better overcome, had I been able to predict them.

There are many things that I would consider doing differently were I to conduct this work again, knowing what I know now. I would certainly be more prepared for the necessary rigours of the ethics committees and would ensure that I only had to conduct the process once.

Of course, given the proliferation of consultation/liaison mental health service provision in recent years, I would not now have to carry out the research in a site where I also held a clinical role. This would have provided a more level playing field within settings, with none of the participants having met me before. Although I have been scrupulously careful in minimised the potential effect of former relationships, personal anonymity would have been preferable.

The biggest change of focus that I would make were I to repeat this work, would be my attention to the nature of the samples of older people and relatives. I had not considered, from my position within the mental health paradigm, that the older people in Glimster general who had not seen a mental health professional, would so clearly appear to me to
have mental health problems that nobody had noted. Nor had I anticipated that people
diagnosed with depression, in Chapley Hospital, would overwhelmingly not engage in
research. In future work on depression much methodological attention will be necessary
in achieving a sample. The older peoples sample clusters also differed in that those at
Chapley almost all had dementia and sometimes had difficulty in recalling their recent
experience in the setting to the same degree as their counterparts in Glimster General, and
as such were not wholly comparable. The relative groups were dissimilar in that one
cluster had experienced mental health service and one had not, thus making comparison of
experience impossible. I have also considered the lack of comparability of organisation
structure between the sites and whether or not such diversity could have been avoided. I
conclude that earlier recognition of the differing cultures was not possible. It was only
when I was immersed within the settings that the differences became apparent. As has
been evidenced throughout analysis and discussion, the diversity of the settings added to
the findings rather than deferred from them.

Lastly, in reflection it is interesting to note that I had not considered extensively enough,
my own taken for granted views about mental health and illness; that is those views held
due to my professional position within mental health services. Particularly this position
caused me to initially assume that participants would come up with depression as a mental
health problem of old age. I had to change my approach when this did not occur.
Secondly, my professional position caused me not to question participants about who they
felt should provide mental health services. In line with my personal history, I just
assumed such issues to be within the rightful scope of psychiatric services. It was not
until I was conducting analysis that I realised the depth of my own beliefs in this regard.
This reflection serves again to emphasise the power of historical views and the challenge
that exist, even in those who seek to challenge them.

Notwithstanding the limitation described here, I am confident that I have achieved and
demonstrated that the methodology used provides data that addresses the questions that
were asked within the research.
9.5 Conclusion

I started out in this research to consider whether or not people in the general hospital setting viewed mental health problems in old age differently than those in psychiatry. The answer is a resounding yes.

In the general hospital setting older people are recognised to have mental health problems when they are cognitively impaired and when they challenge the setting in some way. This may occur overtly, through behaviour, or covertly, by not fulfilling the expected patient role in moving smoothly through the hospital system.

Older people who, in psychiatric terms, are depressed, are not seen. I suggest that structured depression is perceived as an artefact of old age, especially in combination with ill health and hospitalisation. More research attention is warranted on the broad issues of depression in old age, particularly as it may differ in gender, age and disability. If such attention is forthcoming issues of depression in old age may achieve the same advancing focus and status that is now afforded to people with dementia.

I have considered the necessary service requirements for older people with mental health problems in general hospital settings. The research has revealed that current services, whether they are of the traditional or consultation/liaison model, serve to rescue non-specialists from having to meet the challenge of embracing mental health issues as part of their world.

I have explored the social constructions that inform perceptions of mental health problems and models of service delivery and note that influences of stigma, history, professional and organisational power are significant. Those who hold political power proffer social inclusion and integration of services. However, I conclude that current policies, guidance, and organisational and educational structures serve to ensure that mental health problems are kept at arms length, under the umbrella of mental health services. This keeps the agenda away from the fearful public who are happy with this arrangement.
The provision of consultation/liaison services, that provide proxy integration of service, are a sticking plaster option. Integration and acceptance of mental health problems in old age as part of general hospital business requires a radical review of both service organisation and professional education. By developing the presence of expertise within, mental health issues in old age could become part of a general health care paradigm, that does not differentiate physical from mental health.

I recommend that political attention must be given to the divisions in service structure and professional education. Currently the social constructions that influence perceptions of mental health problems in old age also serve to sustain them.
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APPENDIX 1 Information sheets.

Relative information sheet 2.(version3)

RESEARCH INFORMATION SHEET

Study Title: MENTAL HEALTH ISSUES AND OLDER PEOPLE IN GENERAL HOSPITALS

Thank you for considering participating in the research.

My name is Gwyn Grout and I am a researcher looking at the experience of older people in hospital.

Before you decide to take part it is important that you understand what will be involved. Please take time to read the following information carefully and, if you wish, discuss it with others. Please do not hesitate to ask me if there is any thing that is not clear or if you would like more information.

It is up to you whether or not you take part. You are free to withdraw at any time and without giving a reason. This will not affect your relative’s care. Nobody will be upset if you decide not to take part.

What is the research about?

At present the care and treatment for older people in hospital, who have mental health problems, are provided in different ways. The research will compare two hospitals and ask the views of 20 older people, 20 relatives of older people who are in hospital and 20 staff members, about mental health problems and how they feel that mental health needs can be met.

Can anyone participate?

Participants will include hospital patients who are over 65, relatives of patients in hospital and staff associated with the care of older people. If you have had been involved with mental health services in the past, it may not be appropriate for you to take part.

If I choose to participate, what will I have to do?

You will be asked to agree to be interviewed. The interview will last approximately half an hour and focus on your views, associated with your experience of your relative’s hospital stay. You will be asked to allow the interview to be taped in order that what you say can be accurately reported, without interrupting the flow of conversation. If during the interview information is brought up which may require clinical attention the interviewer will discuss with you whether you would like her to deal with that information after the interview is over.
How does the research aim to help older people and their families

By comparing two ways of providing service and by seeking views, the research aims to focus attention on how service can be delivered in the future.

How will my privacy be protected?
All the information collected during the research will be strictly confidential. Your name, or any identifying information, will not be disclosed. Any information used when the work is published will not identify you or the hospital. Hospital notes are not being used in this research.

Who else is involved with the research
I am conducting this research under the supervision of the Department of Sociology at the University of Surrey and aim to complete the work by 2005. My employers,..., are sponsoring my work. ...Hospital Trust and the ...Hospital NHS Trust are fully aware of the research project.

The detail and conduct of the study has been approved by both ...and ..., Local Research Ethics Committees.

Will anyone be getting paid for taking part?
Nobody is receiving payment for participation in this study. No monies are for any expenses involved in participation.

Can I receive information about the research when it is complete?
If you wish you can ask to be informed of the conclusions of the study. On request, the researcher will ensure that you receive a report. You may also request a copy of the tape recording of the interview.

What if I want to complain?
If you have any cause to complain about any aspect of the way you have been approached or treated during the course of the study the normal National Health Service complaints mechanisms are available to you.

If you require any further information in order to reach a decision or clarify any of the above information please feel able to contact me: -

Telephone:
Pager

THANK YOU FOR YOUR INTEREST.

Gwyn Grout
RESEARCH INFORMATION SHEET

Study Title:
MENTAL HEALTH ISSUES AND OLDER PEOPLE IN GENERAL HOSPITALS

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Before you decide to take part it is important that you understand what will be involved. Please take time to read the following information carefully and, if you wish, discuss it with others. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information. It is up to you whether or not you take part. You are free to withdraw at any time and without giving a reason. Nobody will be upset if you decide not to take part.

What is the research about?
At present the care and treatment for older people in hospital, who have mental health problems, are provided in different ways. The research will compare two hospitals and ask the views of 20 older people, 20 relatives of older people who are in hospital and 20 staff members, about mental health problems and how they feel that mental health needs can be met.

Can anyone participate?
Participants will include hospital patients who are over 65, relatives of patients in hospital and staff associated with the care of older people. If you have had been involved with mental health services in the past, it may not be appropriate for you to take part.

If I choose to participate, what will I have to do?
You will be asked to agree to be interviewed. The interview will last approximately half an hour and focus on your views, associated with your experience of your work with older people. You will be asked to allow the interview to be taped in order that what you say can be accurately reported, without interrupting the flow of conversation.
How will my privacy be protected?
All the information collected during the study will be strictly confidential. Your name, or any identifying information, will not be disclosed. Any information used when the work is published will not identify you or the hospital.

How does the research aim to help older people and their families
By comparing two ways of providing service and by seeking views, the research aims to focus attention on how service can be delivered in the future.

Who else is involved with the research
I am conducting this research under the supervision of the Department of Sociology at the University of Surrey and aim to complete the work by 2005. My employers, …NHS Trust, are sponsoring my work. … Hospital Trust and the … Hospital Trust are fully aware of the research project.

The detail and conduct of the study has been approved by both the … and …, Local Research Ethics Committees.

Will anyone be getting paid for taking part?
Nobody is receiving payment for participation in this study. No monies are for any expenses involved in participation.

Can I receive information about the research when it is complete?
If you wish you will be informed of the conclusions of the study. On request, the researcher will ensure that you receive a report. You may also request a copy of the tape recording of the interview.

If you require any further information in order to reach a decision or clarify any of the above information please feel able to contact me: -
Telephone:
Pager

THANK YOU FOR YOUR INTEREST.

Gwyn Grout
RESEARCH INFORMATION SHEET

Study Title: MENTAL HEALTH ISSUES AND OLDER PEOPLE IN GENERAL HOSPITALS

Thank you for considering participating in the research.

My name is Gwyn Grout and I am a researcher looking at the experience of older people in hospital.

Before you decide to take part it is important that you understand what will be involved. Please take time to read the following information carefully and, if you wish, discuss it with your relatives and friends. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information.

It is up to you whether or not you take part. You are free to withdraw at any time and without giving a reason. This will not affect your care. Nobody will be upset if you decide not to take part.

What is the research about?
At present the care and treatment for older people in hospital, who have mental health problems, are provided in different ways. The research will compare two hospitals and ask the views of 20 older people, 20 relatives of older people in hospital and 20 staff members about mental health problems and how they feel that mental health needs can be met.

Can anyone participate?
Participants will include hospital patients who are over 65, relatives of hospital patients and staff who provide care for older people. If you have had been involved with mental health services in the past, it may not be appropriate for you to take part.

If I choose to participate, what will I have to do?
You will be asked to agree to be interviewed. The interview will last approximately half an hour and focus on your views, associated with your experience in hospital. You will be asked to allow the interview to be taped in order that what you say can be accurately reported, without interrupting the flow of conversation. If during the interview information is brought up which may require clinical attention the interviewer will discuss with you whether you would like her to deal with that information after the interview is over.

Gwyn Grout
274
How does the research aim to help older people and their families?

By comparing two ways of providing service and by seeking views, the research aims to focus attention on how service can be delivered in the future.

How will my privacy be protected?

All the information collected during the research will be strictly confidential. Your name, or any identifying information, will not be disclosed. Any information used when the work is published will not identify you or the hospital. Hospital notes are not being used in this research.

Who else is involved with the research?

I am conducting this research under the supervision of the Department of Sociology at the University of Surrey and aim to complete the work by 2005. My employers, Hampshire Partnership NHS Trust, are sponsoring my work. ... Hospital Trust and ... Hospital NHS Trust are fully aware of the research project.

Unless you do not wish it your/your relative’s G.P and hospital Consultant will be advised of your participation.

The detail and conduct of the study has been approved by both the ... and ... Local Research Ethics Committees.

Will anyone be getting paid for taking part?

Nobody is receiving payment for participation in this study. No monies are for any expenses involved in participation.

Can I receive information about the research when it is complete?

If you wish you can ask to be informed of the conclusions of the study. On request, the researcher will ensure that you receive a report. You may also request a copy of the tape recording of the interview.

What if I want to complain?

If you have any cause to complain about any aspect of the way you have been approached or treated during the course of the study the normal National Health Service complaints mechanisms are available to you.

If you require any further information in order to reach a decision or clarify any of the above information please feel able to contact me: -

Telephone:
Pager

THANK YOU FOR YOUR INTEREST
APPENDIX 2

INFORMATION SHEET FOR GP (Produced at the request of the Ethics Committees)

MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL

GP and Consultant Information Sheet

Research being undertaken by: -

Gwyn Grout RMN MSc

Telephone:
Pager

I send you this information sheet to advise you that your patient ____________________ has agreed to participate in the study.

I enclose the relevant information sheet (Patient/relative information sheet 2.(version 3)) for your reference.

If you require any further information, have any points for discussion or wish to receive information on the results of the study please contact me.

Please note that there is no GP input in this study.
APPENDIX 3

Consent Form – Patient Participant
MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL

Name of Researcher:  Gwyn Grout
Centre number:  
Study Number:  

Please indicate your consent to each of the following statements by placing your initials in the box and signing below.

I confirm that I have read and understood the information sheets dated _________ (version ___) for the above study, and have had the opportunity to ask questions

I understand that my participation is voluntary and that I am free to withdraw at any time without my care or legal rights being affected now or at any time.

I consent/do not consent (please delete as applicable) to my GP and hospital consultant being advised of my participation.

I consent/do not consent (please delete as applicable) to the interview being tape recorded

I agree to take part in the above study.

I consent/do not consent (please delete as applicable) to my relative/carer/friend being invited to be involved in this research.

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GwynGrout    277
MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL

Name of Researcher: Gwyn Grout
Centre number:
Study Number:

Please indicate your assent to each of the following statements by placing your initials in the box and signing below.

I confirm that I have read and understood the information sheets dated __________ (version ___) for the above study, and have had the opportunity to ask questions.

I have discussed the research with the participant and confirm that he/she agrees to participate.

I understand that participation is voluntary and that the participant is free to withdraw at any time without care or legal rights being affected now or at any time.

I assent/do not assent (please delete as applicable) to the interview being tape recorded

I assent/do not assent (please delete as applicable) to my relative’s GP and hospital consultant being advised of participation.

I agree that________________ take part in the above study.

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A copy of this assent form will be kept by the representative and by the researcher.

GwynGrout
278
Consent Form - Relative

MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL

Name of Researcher: Gwyn Grout

Centre number:
Study Number:

Please indicate your consent to each of the following statements by placing your initials in the box and signing below.

I confirm that I have read and understood the information sheets dated __________ (version __) for the above study, and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time without affect the care or legal rights of either me or my relative now or at any time in the future.

I consent/do not consent (please delete as applicable) to the interview being tape recorded.

I agree to take part in the above study.

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A copy of this consent form will be kept by the participant and by the researcher.
**Consent Form - Staff**

**MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL**

Name of Researcher: **Gwyn Grout**

Centre number: 
Study Number: 

**Please indicate your consent to each of the following statements by placing your initials in the box and signing below.**

I confirm that I have read and understood the information sheets (staff version) dated___________ for the above study, and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time.

I consent/do not consent (please delete as applicable) to the interview being tape recorded
I agree to take part in the above study.

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_A copy of this consent form will be kept by the participant and by the researcher._

Gwyn Grout

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APPENDIX 4

PARTICIPANT DATA SHEETS
Older Person
MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL

Name:
Centre number:
Study Number:

Given Information sheets on:
Consent/Assent received on:

Interview conducted on:

Request detail of research results:
    Copy of tape :

AGE:
GENDER:
ETHNICITY:

TIME FROM ADMISSION TO REFERRAL:

REASON FOR REFERRAL:

PROFESSION OF REFERRER:
PARTICIPANT DATA SHEET – RELATIVE/CARER

MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL

Name:

Gender:

Ethnicity:

Relationship to patient:

Centre number:
Study Number:

Given Information sheets on:

Consent received on:

Interview conducted on:

Request detail of research results:

Copy of tape:

______________________________
PARTICIPANT DATA SHEET – STAFF

MENTAL HEALTH LIAISON FOR OLDER PEOPLE IN GENERAL HOSPITAL

Name:
Gender:
Ethnicity:
Profession:
Centre number:
Study Number:
Given Information sheets on:
Consent received on:
Interview conducted on:
Request detail of research results:
    Copy of tape

______________________________
GwynGrout

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APPENDIX 5

INTERVIEW GUIDE 1

The following subjects will be explored during the course of each interview, though not necessarily in the order stated:

♦ Concept of mental health/illness
♦ Concept of mental health service provision
♦ Being informed
♦ Feelings about having to see a mental health professional
♦ The expected profession of the mental health professional
♦ Detail of any experience they have had
♦ The perfect service

Staff will also be asked about:

♦ Referral reasons and process
♦ Any affect on own knowledge and skills

Added after 3 interviews

If depression is not mentioned, ask views on it.
Appendix 6

The Research Participants

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APPENDIX 6

WARD POSTER

University of Surrey,
School of Human Sciences

RESEARCH STUDY

This ward is participating in a study examining how older people, in hospital, may best be helped with any emotional, memory or mental health problems.

The research is taking place in the Chapley and Glimster Hospitals.

If you are eligible for inclusion in the research, a member of the ward team will approach you with further information. You will then be given time to decide whether or not you wish to participate.

For further information please contact the researcher:
Gwyn Grout – telephone