

**Mental Health in Old Age Bulletin  
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# **MENTAL HEALTH IN OLD AGE BULLETIN ISSUE 13**

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## EDITORIAL

### Educating general nurses involved in the provision of dementia care



The fear and trepidation of many towards people with dementia never ceases to amaze me. The misconception that they will become violent appears to be a common factor, which is fuelled by the uninformed and misrepresented portrayals of mental illness and violence by the media. The lack of public awareness of dementia may result in labels of “weird” or “strange”, which, in turn, promotes these fears.

People with dementia are especially vulnerable to acute physical illness, accidents and falls, all of which may lead to general hospital admission. When a person with dementia is admitted onto a general hospital ward, their feelings of stress and insecurity may result in a negative change in their behaviour, including resistance to care or verbal/physical abuse towards staff. Consequently, staff are often at a loss with how to care for the dementia patient, which may result in avoiding the patient. My role as Specialist Dementia Care Nurse addresses these particular issues.

My role was established in 2001 as a joint venture between South Manchester Acute Service and Manchester Mental Health Partnership. It was in response to the lack of provision of integrated services for people with dementia in a general hospital setting and was therefore developed within a framework influenced by policies and guidelines, as in the National Service Framework for Older People (Department of Health, 2001). It was also developed partly as a result of a survey carried out in the Acute Trust, which revealed difficulties in the provision of effective care for people with dementia (Page and Gooch 1999, unpublished). Findings of the survey showed that 273 of the 300 nurses (91%) wanted support from the Specialist Mental Health services for older people. Support is now provided, by myself, through regular training programmes of healthcare staff. This often takes a traditional didactic approach, but also includes situation-based education and role modelling. Recent training courses I have delivered have included ‘challenging behaviour’, ‘abuse’ and ‘Person-Centred Approach to Care’.

My role takes the lead in the education, development and delivery of dementia care to healthcare professionals. Although I am employed by the Acute General Hospital,

I also work alongside Old Age Psychiatry, in ensuring assessment targets and appropriate care for the dementia patient and patient with cognitive impairments are achieved. As part of South Manchester's Nursing Strategy to improve patient care, I am currently working in partnership with South Manchester PCT in order to integrate and improve the pathways between primary and secondary care settings. I would hope, that with continued training and educating people to understand dementia and approaches to care, they will no longer feel threatened by people with dementia.

As I am aware there are only two posts of this kind in the UK, it can be a difficult and isolated role and close contact with the Mental Health team is essential, in order to keep oneself up-to-date with new developments and treatments in mental health and dementia care. In the 3 years I have worked in this role, I have received over 650 referrals from staff, carers and relatives seeking advice and support for the person with dementia. Much of my time is devoted to face-to-face contact with the dementia patient, assessing their needs. This sometimes causes a conflict of interest with colleagues. A 'thick skin', confidence and diplomacy is essential in this post!

In addition, I am also undertaking an MSc in Dementia Care at Manchester University. This is beneficial both personally and professionally from a research and evidence-based perspective. It also provides a network-base with others who work in the field of dementia care.

I hope this has given some insight into my role as Specialist Dementia Care Nurse and my overall aim to make a difference in the care of dementia patients.

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## **ARTICLE**

### **A hierarchical approach to BPSD**

Behavioural and Psychological Symptoms of Dementia (BPSD) cause great distress to patients and carers as well as contributing significantly to increased healthcare costs and levels of institutionalisation. Within care home settings overall quality of life is decreased and levels of stress for frequently young and inexperienced staff are raised by neuropsychiatric symptomatology and disturbed behaviour. Low levels of training about dementia and pressures on staff numbers can combine to result in early recourse to psychotropic medication. Particular problems with this already less than ideal approach have arisen recently following C.S.M. concerns about risperidone and olanzapine adding to earlier ones over thioridazine.

Alternatives may be little understood and insufficiently systematised for the variable mix of trained and untrained personnel involved. An approach is offered here which does not contain new material but tries to structure responses in such a way as to maximise prospects of benefit while deferring potential drug toxicity for as long as possible. The underlying contention is that the higher up this hierarchy an

intervention can be made the greater the appropriateness and the corresponding prospects of success. Inputs can be at more than one point simultaneously but hopefully there is educational benefit in systematically working through the following options in an orderly sequence.

### ***STAGE A : Underlying Illness***

#### 1. Context

Is the underlying diagnosis definitely one of dementia and does the problem behaviour come under the rubric of BPSD? Is it sufficiently severe to justify intervention and for whose benefit is treatment being sought?

#### 2. Physical illness

Is there treatable medical co-morbidity e.g. delirium temporarily complicating the dementia? Has the issue of hitherto unsuspected pain been given adequate consideration? Have the “staples” of UTI, chest infection and drug toxicity been adequately investigated?

#### 3. Psychiatric illness

Might the presenting phenomenon form part of a recognisable psychiatric syndrome, such as depression or psychosis, with an equally well recognised treatment strategy?

### ***STAGE B : Hidden Meaning***

#### 4. Personality

Especially where a behaviour is puzzling or resistant to initial attempts at management it may be appropriate to consider what is known about premorbid personality traits, patterns of activity and coping strategies. This is likely to involve increasingly detailed discussions with family and previous carers where relevant.

#### 5. Environment

A good deal is known about making aspects of the physical environment “dementia-friendly” and particular attention to this may be of particular relevance in institutional settings. General hospital wards are especially problematic and major change may not be feasible but even levels and patterns of lighting or labelling of doors can help. Consideration should be given to whether the “problem” patient may be over- or under-stimulated.

#### 6. Carers

Levels of education about dementia can be a particular issue for an often inexperienced and relatively rapidly changing population of care home staff. Greater understanding of difficulties can promote increased tolerance as well as

development of coping strategies. Intensive carer support has been shown to be of at least comparable efficacy to medication but all too often is simply unavailable.

### **STAGE C : Empirical Treatments**

#### 7. Behavioural Interventions

This may require further detailed description of the Behaviour as well as thought about possible Antecedents and Consequences. The hope is that an appropriate response will “fall out” of progressively more careful descriptions of predisposing and precipitating factors, of what actually happens and of what then follows. Even relatively circumscribed attempts to manage contingencies and “shape” behaviour can fall foul of inconsistencies in approach between individual staff members or shifts.

#### 8. Empirical Geropsychopharmacotherapy

Pragmatic drug treatment of behavioural or neuropsychiatric aspects of dementia has a definite, if limited, evidence base but currently faces a period of uncertainty over emergent cerebrovascular and metabolic risks. Day-to-day pressures on general practitioners and junior hospital doctors can result in antipsychotics being deployed in response to single symptoms well before this point in the hierarchy. Amidst current uncertainties and a relative paucity of trial data in relation to older agents in this context it is more important than ever to pay particular attention to some general principles for the use of psychotropic medication in older patients with dementia viz.

- Consider whether any potential side effects are especially to be feared or avoided (e.g. extrapyramidal in DLB, autonomic in delirium, cardiac post-M.I. etc.)
- Consider whether any potential side effects (e.g. sedation or even lowering of blood pressure) might be helpful in a particular instance
- **Start low and go slow**
- Have a clear sense of hoped-for outcome(s) and titrate dose with same in mind

Review any ongoing requirement for medication on a regular basis even (especially!?) when there has been a “good” response.

The above pertains even more strongly when psychopharmacotherapy is being employed in conjunction with treatment of a physical disorder or is being combined with a behavioural approach and clarity over its specific role is at a premium.

#### 9. Adjunctive Approaches

A range of therapies and strategies has been utilised in dementia generally and applied to BPSD in particular. Reality orientation and validation therapy are well-established though of possibly limited applicability. Aromatherapy and bright-light therapy are currently under careful scrutiny for addressing agitation and Snoezelen rooms appear to suit some patients. Music therapy in dementia has recently been

subjected to Cochrane Review and found methodologically limited but has enthusiastic advocates for its role in persistent vocalisation. Consideration of whether a “problem” patient is over- or under-stimulated does seem an important general principle. “Failure-free” activities which individuals find enjoyable appear to have their own intrinsic merit irrespective of whether unequivocal benefit can be demonstrated in addressing specific problems.

Evidence is generally lacking for proposed combinations of hierarchy components but few of the interventions, apart for medication, have a real capacity for harm when due attention is paid to ongoing monitoring and assessment. The diverse needs of a wide variety of carers called upon to face challenging behaviour in the context of dementia are considerable and their starting resources are often modest in the extreme. Hopefully a systematic approach to what will often seem bizarre as well as worrying phenomena can offer at least a modicum of assistance.

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## **BOOK REVIEW**

### **Dementia nursing: a guide to practice**

Edited by Rosalie Hudson. (2003) Melbourne. *Dementia nursing a guide to practice* Ausmed Publications Pty Ltd, 334 pages

This book’s focus is on nursing people with dementia in residential care in an Australian context. It promotes a person centred approach to care and covers a broad range of topics. My initial impression was positively influenced by the provision of photographs and biographies of each contributor which aligned with the books core values. It was a slight frustration therefore that this approach was not carried through to the title which might usefully emphasise the person with dementia.

The Antipodean focus realises some issues regarding transferability to the UK notably the extent to which nursing care is delivered in respective settings and the inclusion of country specific terminology such as “legislative jurisdictions” and “DONS” (the acronym attributed to Directors of Nursing in residential care). As a consequence the chapter on history and issues may not resonate with care staff in this country.

I would recommend this book as a useful resource for a range carers to dip in and out of. The sections are self contained and offer useful insights and advice. The inclusion of sections addressing physical aspects of care is welcome. The application of principles to the dementia care environment has much practical utility and chapters on pain management, palliative care and nutritional issues are notable in this respect. Other areas considered include the relative’s perspective, wandering, the spiritual dimension, sensory loss, environmental issues and a pot pourri of creative approaches to care. This chapter addresses topics such as poetry, drama, dance, music and sensory stimulation. Its inclusivity means that the topics are



addressed relatively superficially and the reader should consider this a first port of call to further reading.

A book that focuses on nursing is significant in the context of an increasingly multi-disciplinary field and I was interested to see how the case for nursing intervention was developed. In this respect an emphasis on the complexity of the work involved was important. In addition the more successful contributors emphasised pre-requisite skills and directed the reader to processes and tools of assessment that guide subsequent interventions. Notably, though, there is a significant amount of material contained within the book that all carers will find helpful.

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## **WEBSITE REVIEW**

### **The Experience of Dementia**

Here are some links to information about the experiences of people with dementia and those who care for them.

Alzheimer Research Forum [www.alzforum.org](http://www.alzforum.org) carries a section devoted to the experience of AD. Items are changed periodically. At present on [www.alzforum.org/dis/car/adexper/ewens.asp](http://www.alzforum.org/dis/car/adexper/ewens.asp) there is an article called It's difficult to think straight in which someone who cared for a dementia patient for over five years describes five hours of caring and gives a powerful account of the challenges involved. There is a link also to an interview with an AD sufferer posted on the Alzheimer's Spoken Here website on <http://alzsh.net/jqa.html>.

The Alzheimer's Society (UK) website offers a section devoted to Real Lives in which people with dementia, carers, friends and family members tell their stories in their own words – [www.alzheimers.org.uk/Real\\_lives/index.htm](http://www.alzheimers.org.uk/Real_lives/index.htm).

There are also the You Are Not Alone pages on [www.alzheimers.org.uk/AlzheimersForum/youarenotalone.htm](http://www.alzheimers.org.uk/AlzheimersForum/youarenotalone.htm) which feature 'Predicament of the month', currently 'telling the children about an AD diagnosis'. There is also a page with poems from people with dementia which offer insights into their experience; these are to be found on [www.alzheimers.org.uk/AlzheimersForum/nowforthelighterside.htm](http://www.alzheimers.org.uk/AlzheimersForum/nowforthelighterside.htm).

Navigating from the Alzheimer's Disease International site gives access to a personal account of a woman with early-stage dementia on [www.alz.co.uk/alzheimers/experience.html](http://www.alz.co.uk/alzheimers/experience.html).

Two accounts, one from a caregiver and one from a family member of a person with dementia may be accessed on [www.angelfire.com/ny2/dementia1/experien.html](http://www.angelfire.com/ny2/dementia1/experien.html).

Articles by dementia researcher Dr. Linda Clare about the experiences of people living with both early stage and more advanced dementia which contain useful lists of references may be found at [www.mhilli.org/network/linda\\_clare.htm](http://www.mhilli.org/network/linda_clare.htm).

The Alzheimer's Society of Canada offers a short section giving one man's experience of dementia [www.alzheimer.ca/english/haveAD/livingwith-oneman.htm](http://www.alzheimer.ca/english/haveAD/livingwith-oneman.htm).

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## **YOUR PROBLEM ANSWERED**

### **Question: Day hospital care in the UK**

*As a newcomer in a Trust providing community mental health services for older people I am struck by the disparate use of day hospital services in my patch. Whilst the facility for one area focuses on people with moderate-advanced dementia whose behaviour has excluded them from other day care options, another has taken on the role of an informal memory clinic and works with people in the very early stages of dementia, whilst the third attempts to cater for a huge variety of client groups including recent inpatients and new assessments. It would seem that their different orientations have reflected the particular key interests of key staff as opposed to local needs, and none is well attended. Given the number of skilled clinicians they employ, I do wonder if they could be more effectively utilised?*

### **Answer:**

Day hospital care in the UK has been said to have a 'long and honourable history' (Murphy 1994) but, as you are probably aware, the past fifteen years have witnessed an ongoing debate as to its effectiveness. Proponents argue that the concentration of specialist resources suits day hospitals to the provision of intensive assessment and time-limited interventions, whilst they are also advocated as an effective means of providing monitoring, rehabilitation and relapse prevention, especially for people with chronic or recurrent functional mental illness. Opponents query the extent to which they actually fulfil such roles however and argue that in practice many day hospitals provide social and respite care for people who are too dependent or challenging for other forms of day care, offering little in the way of specific care or treatment.

Unfortunately there is a dearth of information available to inform this debate, with very few service evaluations have been undertaken, although one UK review found low utilisation and inappropriate referrals (largely because of a lack of alternative social day care) to be common problems (Kitchen *et al.*, 2002). There is furthermore little evidence to suggest that day hospitals can reduce the need for in-patient admission or for residential care (Woods & Phanjo, 1991; Howard 1994; Draper, 2000) although there may be other benefits for clients (particularly those with functional mental illness) in terms of improved symptoms and quality of life (Plotkin & Wells, 1993; Bramesfield *et al.*, 2001; Wormstall *et al.*, 2001). It is not clear that this

is necessarily a function of attendance at a particular facility/building however, and it may well be that such improvements reflect clients' engagement in therapeutic programmes which could be provided in alternative ways and/or in other settings.

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