





# HELLO

Welcome to Issue 85, January  
2023 edition of the RCPsych  
Old Age Faculty Newsletter

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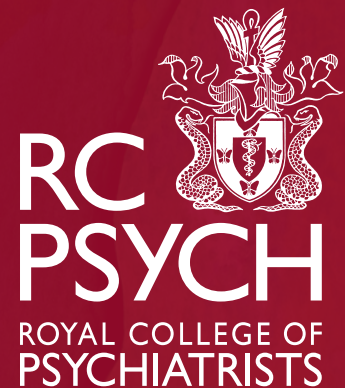
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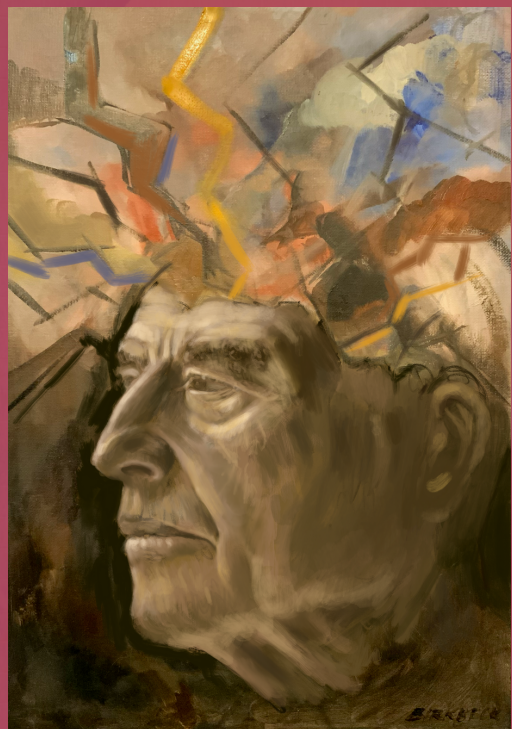


## Cover Artwork

"De Novo" (2022)

by Robert Birkbeck, Old Age  
Psychiatry Higher Trainee

Dr Birkbeck has contributed  
to this edition with an  
interesting article exploring  
"Emergent artistic creativity  
in dementia: A research  
summary" on page 11



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# Update from the editorial team

Hello again from the Editorial Team. Hope you are all keeping safe and well. How time flies... its 2023 and our January Newsletter is out for reading. Hope you all had a lovely festive period and had some time off to recover and rejuvenate.

The newsletter has a refreshing new look created by our Trainee Editor Anne. This edition has its usual updates. The Chair's report highlights all current relevant issues.

The update by Dr Amanda Thompsell, the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement and Prof Alistair Burns as always provides food for thought with the Hokey Kokey In and out model and of course offers some hope for those with dementia with the results of the Lecanumab trial.

If you are interested in legal aspects, there are three informative articles by Dr Curtice and his medical students, which help us understand making Best Interests decision, coercive control and important legal cases.

This edition also contains the Cochrane corner which as always has been interesting to read. Sadly we believe due to logistical reasons this is the last so thank you Jenny for your excellent contributions.

The edition contains the advert for the Newsletter essay competition – the title for this year's competition is 'Can we live and age as who we truly are? The future of equality, diversity and inclusion'. The last date for submission is 27th January 2023.

There is an advert for trainee representative for the Faculty so higher trainees, please feel free to apply.

Our review expert Dr Howard as always has provided an interesting book review.

The next newsletter is in May 2023, so the last date for submission of articles is 31st March 2023. Let us know what you think of the fresh new newsletter, and feel free to email me on [drsharmib@gmail.com](mailto:drsharmib@gmail.com) with ideas, suggestions and of course articles for the future newsletter. We welcome artwork submissions for future newsletter covers.

**Dr Sharmi Bhattacharyya**  
**Lead Editor**



# View from the Chair

**Dr M S Krishnan (Krish)**  
**Chair of the Faculty of**  
**Old Age Psychiatry**



**@deliriumkrish**

Dear colleague,

Wish you all a happy, healthy and prosperous New Year. Hope you had a break and spent some quality time with your friends and family during the festive season.

I am sure you will enjoy the fresh look of our newsletter. Thank you to our amazing editorial team and special thanks to our trainee editor Anne who has worked hard to produce this new look.

For the first time after 2 years the executive committee met face to face at the college on 2nd November. We welcomed our newly elected members.

In the strategy meeting, the following topics were chosen, and the committee established 5 breakout groups (with workforce as the overarching 6th topic) to come up with action points:

1. Memory clinics
2. CMHT and SMI, functional illness
3. Research/new treatment
4. Raising profile/interface/engaging with other organisations
5. Education

Unfortunately, we had the train strike scare that limited some the members to travel. We are planning to continue with the strategy discussion in the new year and will share the discussion minutes in the next newsletter.



Dr Chineze Ivenso our academic secretary and a group of Exec members are busy planning for our next annual conference in March 2023.

We have agreed to conduct this one as Hybrid event on 16,17th March 2023. After 2+ years it would be great to meet our faculty members F2F but also those who are not able to join can benefit from the online streaming. Chineze is working with our CALC team and will update a template program once we have confirmed speakers..

For updates and registration check the link [Faculty of Old Age Psychiatry Annual Conference 2023 \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/faculty-of-old-age-psychiatry-annual-conference-2023)

Dr Ivenso also has been working with NIHR colleagues and secured some bursary for early careers colleagues to attend the next conference. Details will be posted at the conference page. Hope you will consider submitting abstracts to the conference and encourage your trainees too. The deadline for submission is 9 January 2023.

## View from the Chair

Dr Ivenso also has been working with NIHR colleagues and secured some bursary for early careers colleagues to attend the next conference. Details will be posted at the conference page. Hope you will consider submitting abstracts to the conference and encourage your trainees too. The deadline for submission is 9 January 2023.

We are excited to run the joint faculty winter event (Old Age & Liaison) on 9th December. We have an excellent program and good engagement from our members.

Josie and I met with our PsychStar Dominic and we look forward to working with him over his time with our faculty.

Thank you for your support with the survey we did with Alzheimer's society.

I attended an event organized by ARUK and discussed about our key priorities as faculty in managing dementia diagnosis and treatment. I also participated in a press briefing highlighting the importance of workforce and resources into memory services to be ready for emerging disease modifying treatments.

On that topic we also had collaborated with Northern and Yorkshire division to run the Dean's Grand rounds. We had excellent engagement with over 1150 registered and over 600 watching the webinar live. If you have not attended, you can watch it here

[Dean's Grand Rounds: Memory Clinics – 24 November 2022 \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/dean-grands-rounds-memory-clinics-24-november-2022)

**Please continue to engage with our faculty twitter page [@RCPsychOldAge](https://twitter.com/RCPsychOldAge).**

Look forward to seeing some of you on December 9th at the college or online. Hope you all have a good Christmas Season. I would like to take this opportunity and want to be the first one to wish you all a very happy healthy and prosperous 2023. Would be great to see you at the faculty conference in March 2023.





# Newsletter Update



**Professor Alistair Burns** - [alistair.burns@manchester.ac.uk](mailto:alistair.burns@manchester.ac.uk)

**Dr Amanda Thompsell** - [amanda.thompsell@nhs.net](mailto:amanda.thompsell@nhs.net)

In terms of dementia, one of the main developments over the last few weeks has been the publication in the New England Journal of Medicine on the study of Lecanemab in early Alzheimer's disease (<https://www.nejm.org/doi/pdf/10.1056/NEJMoa2212948>).

We have rehearsed the history of the monoclonal antibodies here before – Aducanumab did not progress earlier this year in terms of the application for a licence in Europe and a couple of weeks ago, the results of the studies on Gantenerumab led to the decision about it not progressing either. The fourth monoclonal antibody, Donanemab will present its results probably sometime next year.

The story of Lecanemab gets off to a good start in terms of a peer reviewed publication in what must be one of the world's most prestigious medical journals. Comments had been made before about the lack of peer review of the other agents.

The study involved 1795 participants (aged between 50 and 90), with a diagnosis of mild cognitive impairment or mild dementia due to Alzheimer's disease. This immediately presents a challenge to clinicians who believe that mild cognitive impairment and Alzheimer's disease are different things – but involve a discussion that you can have Alzheimer's disease without having dementia and so you can have Alzheimer's disease which causes symptoms of mild cognitive impairment.

People in the trial needed evidence of amyloid on PET or cerebrospinal fluid. The primary end point was the change from baseline at 18 months on the Clinical Dementia Rating (the Sum of Boxes) – a 6 item assessment, each with 3 points giving a range of 0-18. Other endpoints included our old favourite, the Alzheimer's disease assessment scale (ADAS COG), the Alzheimer's disease composites score and the Alzheimer's Disease Cooperative Study Activities of Daily Living Scale for Mild Cognitive Impairment (many traditional measures of activities of daily living assess more towards the severe end of the ADL spectrum).

Lecanemab or placebo were given intravenously every two weeks or a placebo. The randomisation took into account factors such as if the diagnosis was MCI or mild Alzheimer's disease, contemporaneous prescription of anti-Alzheimer medication, apolipoprotein a4 status and where the study was carried out (several countries were involved).

There was a significant difference in terms of a decreased deterioration in the Lecanemab arm compared with placebo on the Sum of Boxes (nearly one half of one point). Almost 700 people took part in a sub study showing that the Lecanemab group had a greater reduction in brain amyloid than the placebo group. Infusion related reactions occurred in about a quarter of the participants and imaging abnormalities (such as oedema or effusions) occurred in just over 10% of the treated group.

## Update for the Newsletter

The conclusion of the study was that “longer trials are warranted to determine the efficacy and safety of the Lecanemab in early Alzheimer’s disease” but nobody could argue that this is not a useful and helpful signal to start with.

The usual limitations of the study are discussed – for example, it was only for 18 months, the drop out rate was 17% (not helped by some challenges about conducting it during the COVID pandemic), and there were a number of statistical issues raised (on which I do not have the expertise to comment).

In previous studies, clearing amyloid in the brain did not seem to be accompanied by improvement in symptoms. The suggestion was made that this was because the illness was too far advanced – this study suggests that starting early may have an effect.

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## The Older Adult Mental Health Update

Inspired by recent political developments, this time I will take for my theme – the Hokey Cokey.

### In

From early 2023 there should be an opportunity to be part of a National Quality Improvement Programme for implementing the new Mental Health Act. All Mental Health Trusts can nominate wards to take part in this – and there is a definite wish to include older adult wards.

### Out

Virtual wards – the NHS’s unique answer to the metaverse – provide a way of extending hospital services into the community so people

can stay at home. Whilst there is a focus on frailty the guidance available at [B1382 Supporting Information for integrated care system \(england.nhs.uk\)](https://www.england.nhs.uk/mentalhealthsupportinginformationforintegratedcaresystem/) clearly mentions partnership between secondary, community, primary, social care and mental health services and also emphasises the need to involve carers in decision making.

### In

The draft Acute Inpatient Mental Health Care for Adults and Older Adults Guidance has been published to support timely access to high quality therapeutic care, close to home and in the least restrictive setting possible and is available on the Futures webpage ([Acute Inpatient Guidance - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform](https://www.futures.nhs.uk/acute-inpatient-guidance-nhs-england-national-adult-and-older-adult-mental-health-programme-futurenhs-collaboration-platform)) This specifically mentions older adult wards.

Stemming from the Health and Care Act 2022 the Secretary of State has the power to issue guidance to organisations across health and care system on what the “duty to cooperate” powers mean in practice (under Section 82 of the NHS Act 2006). As a result the Department of Health and Social Care is producing Statutory Guidance on Discharge from mental health and learning disability inpatient settings. This document when finalised will definitely be worth looking at as it will apply to older adult and dementia wards.

Meanwhile, your concerns about the way “discharge to assess” has worked in care homes in some areas has been passed on to the Community Health services team at NHSE&I.



## Update for the Newsletter

### Out

Four new publications will be of interest to those dealing with older people's mental health in a community setting.

The community mental health transformation

roadmap has been developed to show a simple visual representation of all of the different elements of transformation that need to be delivered in order to meet the LTP commitments.

Please find below links to the roadmap resources:

- [CMH Transformation Roadmap](#)
- [CMH Transformation Roadmap Interim Annex](#)
- [Enhanced Care in Care Homes guidance](#)
- Recommendations for older adults to access and benefit from rehabilitation services should be coming out soon and will be in a similar style to the earlier recommendations on Eating Disorders services ([2022 Older Adult Eating Disorders Framework - v2.0 - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform](#)) and on Complex Emotional Needs services ([Older Adult Complex Emotional Needs: Standards for Services - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform](#))  
Both eating disorders and complex emotional needs have webinar resources as well.
- The Anticipatory Care interventions framework has also been published – [Anticipatory Care: Model of Care \(housinglin.org.uk\)](#) and has specific sections on mental health and loneliness and isolation as well as cognitive impairment
- Get it Right the First Time - [Mental Health Adult Crisis and Acute Critical Care](#)

## Shake it all about

Getting it right first time (GIRFT) continues to focus on acute and urgent community response pre (hopefully avoiding discharge) and post discharge and will be having a systems wide webinar focused on older adults mental health on 25th January 2023.

Following the publication of the NICE

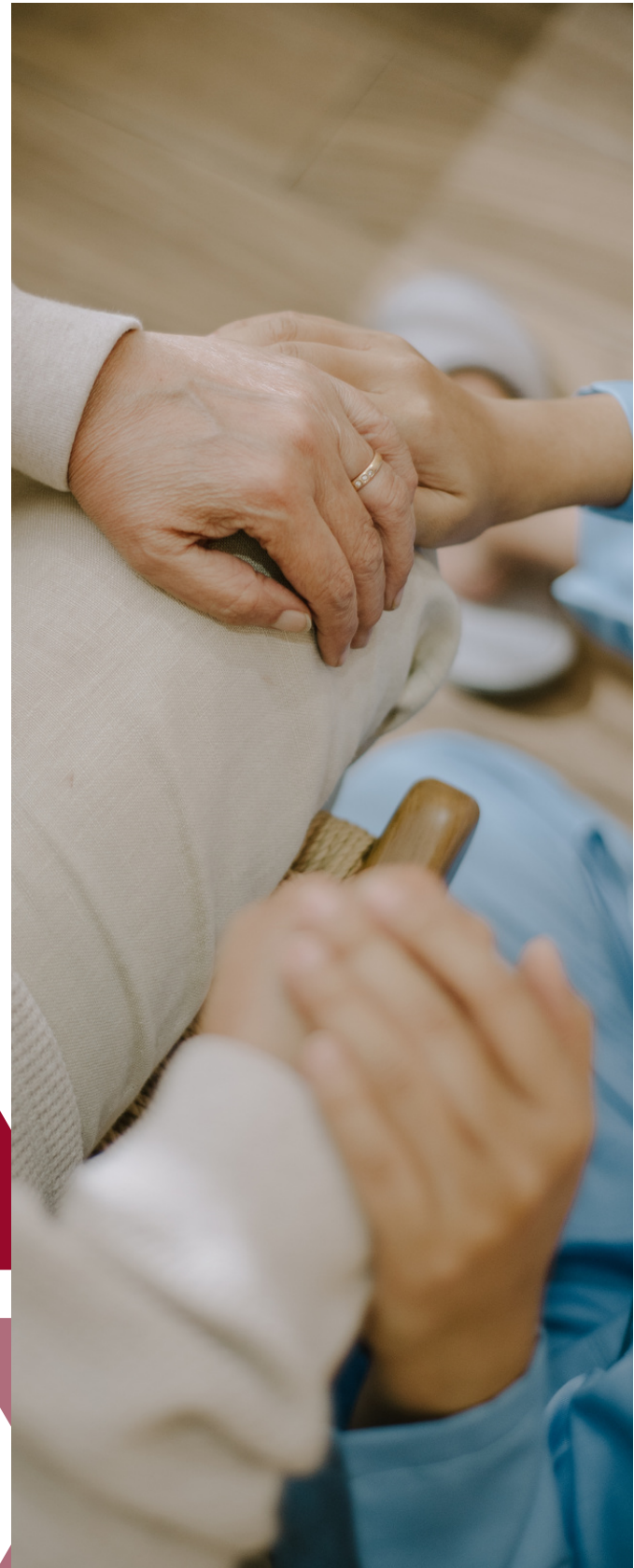
guidance on self harm in September 2022 ([Overview](#) | [Self-harm: assessment, management and preventing recurrence](#) | [Guidance](#) | [NICE](#)) there has been increased interest in the recommendation 1.5.12 "For older people who have self-harmed, ensure that a mental health professional experienced in assessing older people who self-harm carries out the psychosocial assessment" and how that will work in practice.

## Update for the Newsletter

### That's what it's all about

I am sure you are all fed up with me saying outcome measures for Community mental health transformation are coming but the Frequency Asked Questions (FAQ) document has now been published [20221031 CMH Outcomes FAQs v1.0 FINAL \(1\) - NHS England National Adult and Older Adult Mental Health Programme - Future NHS Collaboration Platform](#). Just a brief reminder that the outcome measures are Recovering Quality of Life ReQoL 10.Goal based outcomes (GBO) and DIALOG. All three tools are free to use and the FAQ document has lots of helpful links . It is expected that all systems will meaningfully embed all three recommended PROMs by the end of 2023/24 and that the outcomes scores are included in the monthly Mental Health Services Data Set. It is envisioned that benchmarking data is likely to be available in 2023/24. The implementation guidance for these outcome measures is still to be produced.

As always, we would be happy to hear your views and thoughts on national developments so please do not hesitate to contact us .





# The Old Age Psychiatrist: Annual Essay Competition

The title for this year's essay competition is:

**Can we live and age as who we truly are?  
The future of equality, diversity and inclusion.**

We all aspire to live as our true authentic selves.

How can Old Age Psychiatry support equality, diversity and inclusion in the future? Or is aging frowned up?

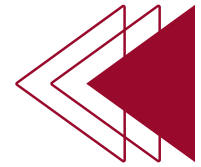
We would love to hear your thoughts on how Old Age Psychiatry can impact the future of equality, diversity and inclusion and empowering older adults to have control over how they wish to lead their lives.

Entries should be no more than 1000 words long. We accept all forms of creative writing including essays, poetry and short stories. We welcome submissions from everyone including Old Age Faculty Members, consultants, trainees and medical students. Please submit your entries to **[oapcompetition@gmail.com](mailto:oapcompetition@gmail.com)** by no later than **5pm on Friday 27th January 2023**.

Please include your name, grade, address and preferred e-mail address when submitting your entry. There is a first place prize of £100, and £50 for the runner up! Winners will have their essays published in the following edition of the Newsletter and will receive a day's free registration at the RCPsych Old Age Faculty Conference in March 2023.

We are organising a fantastic line up of expert judges who will be excited to read your entries!

# Appropriate prescribing of antipsychotic medication in dementia: A New Toolkit



**Bishara, Delia - Consultant Pharmacist, Mental Health for Older Adults & Dementia  
South London & Maudsley NHS Foundation Trust**

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## Introduction

A new toolkit for the "Appropriate prescribing of antipsychotic medication in dementia" has been developed by members of the Yorkshire and the Humber Clinical Network and London Clinical Network NHS England Groups.

This resource aims to help clinicians navigate the complex challenges they face when considering the initiation, continuation, and discontinuation of antipsychotic treatment for people with dementia. It provides a breadth of information, resources, and evidence of best practice to help professionals ensure that antipsychotic medications are used only when absolutely necessary, that potential risks are reduced and gives support with deprescribing where appropriate.

## Background

Antipsychotic drugs are sometimes used to treat some of the more distressing behavioural and psychological symptoms of dementia, such as aggression and psychosis. However, in the vast majority of cases, they only have a very limited, short-term benefit in treating these symptoms; and they can significantly increase the risk of serious adverse effects, including accelerated cognitive decline, falls, blood clots, stroke, and mortality. These associated risks often outweigh the benefits and therefore these agents should only be considered as a last resort in people with dementia.

In 2008 the government commissioned the Banerjee Report (Time for Action an independent review of the use of antipsychotic medication for people with dementia). The report concluded that antipsychotic use was too high in patients with dementia, and that the associated risks outweighed the benefits in most of these patients because these drugs seemed to have only a limited positive effect in managing dementia symptoms. The report triggered a national drive to reduce the rate of inappropriate prescribing of antipsychotics in dementia.

Recent research led by the University of Exeter and King's College London compared current prescribing and pre pandemic prescription rates of antipsychotics and found that, overall, the number of people with dementia receiving these prescriptions had soared from 18 per cent to 28 per cent since 2018, with prescription rates of over 50 per cent in a third of care homes<sup>1</sup>. This led to the development of the "Appropriate prescribing of antipsychotic medication in dementia" Toolkit.





### Aims of the toolkit

The aim of the resource is to provide guidance and information to address:

- uses, risks and alternatives to antipsychotic medication
- risk reduction in antipsychotic prescribing
- support for local systems to deliver best practice in antipsychotic prescribing and de-prescribing where appropriate.

The toolkit is intended to support Integrated Care Systems working with providers: GPs, GP practice pharmacists, Primary Care Network (PCN) pharmacists, Trust clinicians, staff in care homes, acute hospitals, Memory Assessment Services (MAS) and Community Mental Health Teams (CMHTs). It may also be a useful source of information and support for people living with dementia and carers.

Sharing and using the toolkit should:

- encourage reviewing the use of antipsychotic medication for people living with dementia across systems
- support identification of good practice and/or areas for improvement

With a focus on shared decision making and a rights-based approach for all those involved in the care of people with dementia.

### References

The pharmaceutical Journal 11 August 2022. Antipsychotic use in people with dementia living in care homes rose during COVID-19 pandemic.



### Next steps

The toolkit content and resources will be reviewed in 12 months' time; feedback and additional resources would be welcomed.

Link to the toolkit and supporting resources:

- **Toolkit: Appropriate prescribing of antipsychotic medication in dementia**
- **Video: Overview of the toolkit** (12 min)
- Recorded conversation sessions for different audiences

#### **Pharmacists**

#### **Mental health providers**

#### **GPS, community and care home staff**

### Acknowledgement of Authors and Contributors (in alphabetical order)

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# Emergent artistic creativity in dementia: A research summary



**Dr Robert Birkbeck - Specialist Registrar (ST5) in Old Age Psychiatry  
Sussex Partnership NHS Foundation Trust**

## Introduction

Dementia is a syndrome in which patients and families typically experience progressive loss; loss of memory, function, language, identity, social role, safety, and orientation alongside many other examples. However, there is a particular pattern of neurological damage which appears to promote creativity in some patients, either changing existing artistic output, or introducing new artistic expression to patients with no previous inclination. In this overview I am focusing primarily on visual creativity, but other creative domains are also reportedly affected, including the production of poetry, sculpting, music and writing, with variation depending on the dementia subtype.

## Summary

This paradoxical increase (or 'de novo' appearance) of visual creativity in some patients with dementia was highlighted in a series of case reports in the 1990s and is part of a wider phenomenon known as "paradoxical functional facilitation" in which damage in one part of the brain which usually provides an inhibitory effect on another then allows for disinhibition and excitation in the usually inhibited area. There are also very rare case reports of de novo artistic skills emerging following epilepsy and subarachnoid haemorrhage. In dementia the most documented examples of this phenomenon are in the frontotemporal lobar degeneration (FTLD) spectrum, which includes motor neurone disease (MND), progressive supra-



**"De Novo" (2022) by Robert Birkbeck**

nuclear palsy (PSP), behavioural variant frontotemporal dementia (bvFTD), corticobasal degeneration (CBD) and the primary progressive aphasia (PPA) (including Semantic Dementia (SD)). It is difficult to obtain accurate population frequency due to the challenges in diagnosing these disorders accurately, however there are estimates of up to 17% of patients with FTD and 20% of patients with Parkinson's disease (PD) reporting de novo visual artistic creativity.

Pelowski et al (2022) recently produced the first systematic review of this emerging field,

with a detailed analysis that describes the hypothesised impact of dementia on visual arts creativity by subtype. Pelowski et al. found that there were some emergent themes in the case reports. For example, there was a described loss of technical ability and creativity in Alzheimer's disease (AD), whereas both of these factors were increased in frontotemporal dementia (FTD), PD and aphasia (the latter also led to increased emotional expression). CBD also led to increased creativity. FTD and CBD patients also showed increased abstraction, with FTD patients also showing increased symbolism specifically. Patients with PD, Dementia with Lewy Bodies, PSP, CBD and FTD all showed a tendency to choose blue colours over red as their disease progressed. The physical aspects of painting were also affected, with reduced mark-making fluency in AD and decreased brushstroke depth, fluency and visual coherence in CBD.

This apparent link between neurodegeneration and emergent creativity has led to a gradual increase in research focus over the last twenty years. Mayseless et al. (2014) describe a patient who experienced a temporary burst in artistic creativity following acute haemorrhage to the left temporoparietal region, which then declined and completely disappeared as the haemorrhage receded. Mayseless and her team then conducted a small trial with healthy volunteers which demonstrated that decreased activity in the left temporoparietal lobes in subjects predicted greater creativity in a task.

This research builds on a hypothesised model of creativity called the 'dual process' or 'twofold' model in which creative ideas are purported to be 'evaluated' in the dominant temporoparietal area after being 'generated' in the non-dominant temporoparietal lobe. In theory, the 'logical', 'analysing' dominant left lobe acts to evaluate and inhibit (i.e. analyse / process /

filter) information sent by the 'free-associating' symbolic right. If the evaluation is too strict, too relaxed, not discerning enough etc. then there may be disruption to the carefully balanced back and forth flow of the looped creativity network. In cases where this network is damaged in the dominant fronto-temporoparietal cortex e.g. in FTLD or brain damage, then the lack of inhibition/evaluation of the right 'idea generating' network may lead to increased creativity.

A previous case report presented by Seeley et al. (2008) may support this hypothesis. This case describes a female patient who developed primary progressive aphasia (PPA) and was later diagnosed with corticobasal degeneration (CBD). The patient developed de novo visual artistic skills which peaked 6yrs prior to any overt symptoms of CBD, with initially highly symbolic and synergistic artwork (i.e. 'painting' a piece of music or painting the

numerical concept of Pi) that gradually declined in creativity, changing towards exclusively representational work. The team hypothesised that early pathological changes in the inferior frontal gyrus (dominant hemisphere) may have contributed to the pre-clinical creative change. The patient was still actively painting despite having lost most of her spoken language skills by the time of her diagnosis. The patient's neuroimaging and autopsy showed degeneration of the left inferior frontal-insular, temporal and striatal regions and enhancement of the right posterior parietal cortex. The paper proposes multiple hypotheses regarding the aetiology of the enhancement of the right posterior structures of their patient, including the potential for early degeneration of the left inferior frontal cortex (IFC) leading to disinhibition of the right posterior cortices. The dual process model would support this interpretation.



The paper also highlights that some patients with non-dominant (usually right sided) frontotemporal lobe damage become hypergraphic (i.e. experience an overwhelming urge to write) whilst patients with dominant (usually left sided) frontotemporal damage become focused on visual stimuli and objects. A strong "compulsion" to create visual art was described by their patient. It has also been noted elsewhere that patients with left temporal lobe degeneration develop compulsions which focus on visual objects and the visual environment. At the same time semantic knowledge is lost and language loses meaning. By contrast, for patients with right temporal lobe degeneration, visual aspects of the environment are much less important, with instead a greater compulsion towards letters and words. This compulsive drive can lead to a significant artistic output in patients with de novo artistic abilities.

### Discussion

Broadly speaking, the themes discussed above present an emerging field of research within neurology, neuropsychology and neuropsychiatry which seeks to explain the

connections between language, creativity and both functional and organic neuropathology. Some potential therapeutic applications for this research might include art therapy for patients with aphasia who may have increased dependence on the visual world for emotional expression rather than language, but also possible diagnostic roles in analysing the artwork of patients with mild cognitive impairment (MCI) for potential signs associated with dementia, or in those patients for whom there is diagnostic uncertainty regarding subtype. There are also potential applications outside of dementia e.g. the implications of the 'creativity network' hypothesis on left frontal lobe hypometabolism in depression, and emerging trials in applying right dorsolateral pre-frontal cortex (DLPFC) repetitive transcranial magnetic stimulation (rTMS) for patients with autism.

We do not yet understand the neurological relationship between creativity and language, however, patients with emergent artistic ability in the context of dementia are providing crucial clues in our attempts to unravel this complex phenomenon.

References are available on request



# Sixth Form Student Experience

**Dr Suki Greaves - Consultant Psychiatrist**  
**South London and the Maudsley NHS Foundation Trust**



Having always been keen to encourage students to consider psychiatry as a career, I decided to focus on students at school, and their work experience placements.

I have always enjoyed teaching and have also been aware of the difficulties that students at school have had, trying to secure useful and valid work experience placements. I felt that I, and my community team old age service, would be able to offer a valuable experience to students, whilst also hopefully opening their eyes to a possible career in psychiatry.

## **How did the work experience placement evolve?**

Initially I had been approached directly by a sixth former, aiming to pursue a career in medicine, and following the success of this, I decided to put my name forward to their school, as one of their recognised work experience placement choices.

Following this, I have had students yearly, from this and also other schools through word of mouth. It has been an interesting and enjoyable experience, and I, and I believe they, have learnt a lot from it.

The school I am affiliated with, have asked me every year to take 2 students for a week, each year, who are aiming to do medicine..

## **Setting up the work experience**

I have found the process of setting up the work experience to be fairly straightforward.

The school ask me to fill in forms relating to consent, details of the placement, risk assessment and liability insurance details.

I sent forms, from our Trust, to the students to be completed, relating to contact details,

parent/guardian consent, confidentiality and criminal convictions.

I inform the school and the Trust that the students will be supervised at all times by a member of staff.

These having been completed, I am provided with the student's school email addresses and am asked to liaise with the students via this means.

I contacted the students to identify what their objectives are and what they hope to gain from their placement. Generally, students tell me that they just wish to gain an insight into psychiatry and to see as many patients as possible with different psychiatric illnesses.

## **Organising the week**

I then set about organising the timetable for the students.

My aim is to ensure that the students have good exposure to not only old age community psychiatry but to gain experience in as many different psychiatry settings as possible. Also, to see how different doctors work and their differing teaching styles.

The timetable I construct roughly includes:

Home visits with me.

They join our local Home Treatment team.

They join our GP trainee and two STs for home and Outpatient appointments.

They also go our local DGH and join a medic for an acute care of the elderly outpatient clinic.

I feel this gives them a well rounded view of psychiatry as a whole in many different settings as well as a good feel for life in a busy general hospital.

I provide them with the timetable before starting the week so that they know what to expect and where they are expected to be.

Prior to seeing the patients I contact them to ensure that they are happy for the students to be present. I also inform the students that should they find anything in the assessments distressing, they are free to excuse themselves from the assessment at any time.

In terms of how the assessments are carried out with the students present, I am keen when the students are with me that they are involved as much as possible in the assessment. Before the visit I provide the students with some previous correspondence regarding the patient.

I discuss the patient briefly with them prior to seeing them and gave them small tasks to complete eg carrying out the MMSE or asking about biological symptoms of depression. I am often pleasantly surprised, however, at the degree of engagement that the students demonstrate, asking intelligent and thought provoking questions, often in areas that I may not have covered.

After the visit we discuss the patient and I gave informal feedback as to how I feel they had performed during the assessment and we discuss how they could further improve on their interviewing technique.

### **Feedback**

At the end of their week I fill in feedback questionnaires on each student that are provided to me by the school. I also ask each of the doctors that had taught them to provide formal feedback on each student and have a discussion with the students individually about their feedback, encouraging reflective practice. I also give the students feedback forms to fill in, for each of the doctors that have taught them. This is valuable to the trainee doctors and also contributes to their own training portfolio.

The feedback that I receive from the students has been very positive as reflected by the fact

that I continue to get requests to take students each year. Areas that I have endeavoured to improve upon following their feedback to me, include, trying to streamline visits as much as possible, to minimise them having to wait in for long periods between visits, though I always encourage students to bring work or reading matter with them so they use up any free time as productively as possible.

### **Drawbacks to having work experience placements**

To ensure that a work experience placement is successful, does require quite a lot of organisation to be confident that the week is interesting and productive. You also do have to take time out of your schedule to be sure that the students are happy, know where they are supposed to be and that everything is running to plan.

### **What are the benefits to work experience placements?**

I believe that work experience placements are not only beneficial for the student, but encourage the "employer" to examine their own work environments and working practices. It can be an opportunity to offer a fresh perspective and new vigour to one's place of work and highlight areas of good working practice as well as areas that can be improved upon.

I certainly considered my own teaching practices and how to ensure that I "pitched" it at the right level to suit the sixth formers. I also tried to integrate the students with other team members of all disciplines as much as possible. I believe this was helpful in emphasising the importance to all staff the need for our service to create an environment that was welcoming, informative and attractive to students who might then consider a career in psychiatry in the future.

For me, it was ultimately a very rewarding experience and I will continue to offer placements in the future and, I hope, continue to learn much from it, with each successive year.



# Capacity to consent and coercive control



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**Dr Martin Curtice – Consultant in Old Age Psychiatry  
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## Introduction

This article summarises a fact-finding hearing by the Court of Protection in the case of welfare issues.

## Background

P is 65-year-old woman with lasting injury following a subarachnoid haemorrhage in 2018. This has left her with physical weakness, impaired cognition and spatial neglect and requiring 24-hour care. She was deemed to lack MCA capacity regarding her residence and care and decisions about contact. She has resided in a care home since 2019, where she was subject to a standard DOLS authorisation.

Since P's haemorrhage, concerns were raised by professionals regarding the overbearing nature of her husband's (MB) involvement. He was felt to be intimidating and impeded activities in her recovery. The behaviour was continued into the care home and it was felt to be in her best interests that MB's access to P be significantly limited. MB had been married to P since 1981 and they have four adult sons. P lived with MB until her hospitalisation in 2018. MB proposed that it was P's expressed wish to return to their home. Failing this he wanted all restricted access lifted.

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## The issues for the court

It was agreed that fact finding would pertain to the following

- whether there was a pattern of coercive and controlling behaviour
- the impact of MB's behaviour on staff and the provision of care
- whether MB was motivated to negatively impact P's relationship with her family
- whether there was an incident of inappropriate touching in 2020
- the impact of MB's contact and conduct upon P

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## The witnesses

An earlier direction hearing concluded that evidence be given by a limited number of people, the court heard from: one of the children, S; P's sister, PD; the senior matron and safeguarding lead at the hospital; the general manager of the care home and the

nurse that witnessed the alleged incident of inappropriate touching. Also taken into consideration, as per the requirements of the MCA, were P's wishes regarding her desired contact with MB. MB gave lengthy evidence but called no witnesses.

### **The evidence: before the haemorrhage**

P's sister described the marriage as having a significant deleterious effect on P, she went from an outgoing and adventurous woman to increasingly isolated. Both P's sister and son were able to corroborate an unhappy marriage and that P sought to leave several times. P had left for a refuge but would later return as she was unable to tolerate the conditions. She had three, short-lived jobs, during her marriage. Each was met with hostility by MB who monitored her activities and made unsubstantiated accusations. P was expected to surrender her earnings to her husband leading to her employer holding back some of the pay to give to her covertly. MB denied this and suggested the jobs were seasonal contracts or were left owing to P's wishes.

He also explained away his receipt of P's wages as her choice, a claim felt to be refuted by the actions of the employer.

The court heard how MB's actions impacted P's relationship with her family. Whereas P would previously go out with her sister on a weekly basis, each occasion was subject to surveillance by MB until he forbade the contact entirely. He also created an atmosphere such that P felt she was no longer able to visit her older children.

P's behaviour was noted to change significantly when MB was away when she would revert to her personality known before her marriage. The notability of this was that her children urged her to leave the marriage.



### **The evidence: the haemorrhage**

In 2015 P suffered her first brain haemorrhage. She recovered fully and returned home. In March 2018 P collapsed with a subarachnoid haemorrhage and was taken to hospital, she never returned home. Between March and July 2018, she was treated in hospital after which she was transferred to a neurorehabilitation unit. As part of her recovery process several activities were encouraged including, wearing her own clothing; surrounding herself with familiar items and being visited by friends and family.

MB was seen to be interfering in these activities by taking her personal affects home, preventing family and friends from visiting, and requesting that she be isolated in a private room. He also sought out junior staff that he could more easily manipulate and insisted that it was only he who understood P's wishes. MB explained that his interference was at P's request, however staff advised that P would answer a leading question in the way she was expected to.

A safeguarding meeting was held in February 2019 to address MB's conduct in the context of staff and family fears about P returning home. The outcome was to restrict MB's access to two-hourly supervised visits.

### **The evidence: the care home**

In April 2019 P moved into a care home that was uniquely suited to her needs. MB would visit for two hours per day in the evenings. The behaviour observed while P was in hospital was mirrored in the care home. He would harass senior staff with endless emails and continued to intimidate junior staff. On one occasion he presented himself to the care home in the company of a solicitor to obtain a Lasting Power of Attorney over P, despite an awareness that she lacked capacity for this decision.

Care home staff describe P as often rejecting physical contact with MB. She appeared withdrawn in his presence and became re-energised once the visit was over. There was evidence of inappropriate touching in February 2020 – MB was observed to run his hand over P's vaginal area and P responded by saying 'no, no, no'. This was denied by MB who insisted he was massaging her calf. The court refuted the observation could be so heavily misinterpreted.

During lockdown visitation ceased and MB had fortnightly video calls with P until garden visitation resumed in Summer 2020. During this time MB and P's sons visited on alternative weeks.

In March 2021 P was given notice of their plan to terminate her residence due to difficulties created by MB. Since this time, and in light of the order by the court in April 2021, all contact between MB and P has been virtual.

The official solicitor attempted to engage with P to understand her wishes however her answers appeared contradictory. It was felt her feelings were best gleaned from her demeanour. Staff reported that P was more engaged and happier since physical contact ceased however P was noted to derive some pleasure from the calls.

### **The findings**

The court found there was a pattern of coercive and controlling behaviour that continued following P's injury; MB had also sought to limit P's contact with her family. This had negatively impacted care home staff and interfered with the provision of care given MB's reluctance to accept their input. P was often felt to have found contact with MB upsetting and unwelcome although she also derived some pleasure from it.

In relation to MB, the court expressed some sympathy for his current situation – his wife had a catastrophic medical event and he had completely fallen out with his children and was ostracised from them. The court described a 'bleak' and 'dismal' picture of a man who confined himself in his room when at home where he still lived with two children. On MB, the court concluded the tragedy of his 'plight' lay in his inability to see that his woe was 'to a very large extent of his own making'.

### **On welfare**

It was felt that P's need to remain at the home would be the priority and, if required, to the detriment of her contact with MB. During closing submissions MB accepted that he could not meet the needs of P.

The judge did not make a best interests judgment that contact should resume, but instead recommended a trial of contact during which P's reactions could be further assessed. The judge also recommended a limited resumption of email communication. A further hearing was pending.

### **Conclusion**

This case highlights the insidious nature of a lifetime of controlling behaviour and where suspected or proven the necessity of the MCA to ensure best interests is applied where capacity is lacking. Also highlighted are the intricacies involved in establishing best interests in a case where the interpretation of an individual's wishes may be difficult to fully ascertain but where seeking information from varied collateral sources is imperative.

### **Case reference**

1 MB v PB [2022] EWCOP 14 (15 March 2022)

The above Court of Protection judgment can be found in full at [www.bailii.org](http://www.bailii.org)





# 'Catch 22' When a patient needs a pacemaker

**Dr Martin Curtice – Consultant in Old Age Psychiatry  
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## Introduction

This article describes a Court of Protection judgment from 2021 – it involves a best interests decision (s4 MCA 2005) for an 81-year-old gentleman (TS) and the need for a pacemaker. Two trusts were involved, one responsible for providing TS's physical healthcare, and the other responsible for providing TS's mental health care. They jointly sought declarations as to:

1. TS's capacity to make decisions regarding the fitting of a pacemaker, and
2. It was in TS's best interests for a pacemaker to be fitted.

The trusts also sought a deprivation of liberty order authorising, if necessary, proportional restraint and use of force if required to carry out any procedure.

## Background

TS lived alone. He had no children from a previous marriage. He had four siblings but no on-going contact and no friends or family involved in his care. TS was detained under s2 MHA in March 2021 having presented as agitated, irritable and believing he had been poisoned by the police. He was detained under s3 MHA in April 2021.

On the 17th April TS had an A&E admission following an episode of chest pain. Thereafter he was diagnosed with asymptomatic Mobitz type 2 heart block, the standard treatment for this being a pacemaker. On the 21st April TS agreed to a pacemaker being fitted and this was due to occur two days later. However TS changed his mind and did not consent to the procedure up to the court hearing in June 2021. The court hearing was on the 15th June and another procedure was planned for two days later, subject to the outcome of the court hearing.

## Mental health issues

TS's consultant psychiatrist gave evidence – TS was diagnosed with a delusional disorder, had symptoms from around 2012 and was known to a CMHT since 2016. The disorder was untreated for many years and had deteriorated markedly since 2020. The entrenched nature of his delusional system was described. Various delusions were described including that TS believed for many years he had been deliberately persecuted by the council, police and various others, including the current treating medical staff, as part of a conspiracy against him. TS had previously had delusional beliefs that his neighbours were listening to his phone calls and following him and he had put foil on his windows to prevent cameras looking in. In hospital he was reluctant to eat food or take medication unless from a sealed package in an effort to reassure himself it had not been tampered with.

In relation to his heart disorder, TS believed it had been caused by torture perpetrated on him by the police and council who had poisoned him. TS believed he had no mental health issues and hence did not need any treatment.

### Cardiology issues

The court described the medical evidence from the consultant cardiologist and anaesthetist. It was explained a heart block presents with a serious risk of cardiac problems including sudden death. TS had had a myocardial infarct (2009) and an angioplasty procedure (2015). Without a pacemaker it was very likely that TS would develop symptoms (dizziness and fainting) and could die at any time (the risk of asystole was around 35% per year). TS was considered at greater risk due to the background of IHD and his psychosis. The consultant cardiologist explained the benefits to TS of having a pacemaker were 'overwhelming' and he could not think of a 'patient with capacity with a clear indication, who has refused one'. The only options were between having a pacemaker – thus enabling TS to receive antipsychotic medication – or no treatment at all. The procedure was regarded as 'straightforward', took about an hour and could be done under local anaesthetic (general anaesthetic being a last resort). The associated risks were relatively moderate and manageable. The mortality rate was very low and the post-operative recovery was straightforward.

### 'Catch 22'

The applicants in this case described the 'Catch 22 situation' – unless TS received antipsychotic medication, his delusional disorder would not potentially improve, but he could not receive such medication until the pacemaker was fitted. Once it was fitted the benefits would be immediate in terms of being able to receive medication. The judgment noted there was 'no guarantee' that medication would improve TS's disorder, but it may 'enable him to regain capacity, or mitigate some of the delusional disorder' and his 'interpersonal relationships and quality of life' may improve. The consultant psychiatrist thought it unlikely TS would physically attempt to remove the pacemaker.

### Capacity

There was no dispute that TS lacked capacity to make the decision as to whether a pacemaker should be inserted. TS was able to understand the nature and purpose of a pacemaker, and could retain relevant information, but his ability to use/weigh the benefits and risks of a pacemaker was distorted by his delusional disorder and his lack of insight into this.

### Best interests

The judge spoke to TS on two occasions and noted his wishes and feelings. He noted TS did 'not object to the procedure per se; the real issue is the timing'. TS acknowledged a pacemaker would have health benefits but objected to the procedure by saying 'what's the point' if the police were still attacking and persecuting him. The judgment noted that numerous court judgments had emphasized 'time and again in a variety of different contexts, that best interests is a very broad context'.



The judgment noted salient issues in the balancing of best interests in TS's case:

- (1) TS's wishes and feelings were not based on an objection to surgery in principle, but a delusional belief that he would agree to a pacemaker after the persecution from the police and others ended. 'His views therefore could not carry predominant weight.'
- (2) Without a pacemaker TS was likely to experience harmful symptoms. There was a probability of premature death 'in circumstances where there is a strong presumption in favour of prolonging life.' The benefits to his physical health would be immediate and substantial.
- (3) This was the conventional and low risk procedure for heart block. The risk of fatality was low. There were 'very substantial benefits which outweigh the minor medical risks identified.'
- (4) The possibility of a risk to TS's mental health if the procedure was carried out against his will had been carefully considered. The benefits significantly outweigh the risks and future antipsychotic treatment would at least ameliorate the consequences.
- (5) In general terms for his age TS was 'in reasonably good health.'
- (6) In the past, and significantly, at a time when he was capacitous, TS had not opposed an angioplasty and an operation for carpal tunnel syndrome (both being under local anaesthetic). It seemed 'that if TS was capacitous now, it is likely that he would consent to the procedure without any real demur.'
- (7) At present, he experienced a much reduced quality of life. He was placed on a unit where he did not wish to be. He was surrounded by those who he considered were engaged in a conspiracy against him. His psychosis could not be treated until a pacemaker was fitted. If the pacemaker was fitted treatment could commence on his delusional disorder and his quality of life could swiftly improve. There was then every possibility he would be able to go home.

### Conclusion of the court

The judgment noted the 'clinicians have plainly treated and considered TS's case with considerable sensitivity and thoughtfulness.' The judge concluded it was a 'clear-cut case' and in TS's best interests to have a pacemaker fitted. A deprivation of liberty order was authorised to cover circumstances that might justify the need for sedative medication being administered 'incrementally' to potentially include physical restraint and general anaesthetic were TS to resist. The pacemaker was duly fitted on the 17th June 2021 – TS 'went willingly' to theatre

and the procedure used local anaesthetic and no sedation/restraint was needed. Subsequently, it was planned to commence antipsychotic medication the next day.

### Case reference

1. TS, Re (Pacemaker) [2021] EWCOP 41 (17 June 2021)

The above judgement can be accessed for free at [www.bailii.org](http://www.bailii.org)

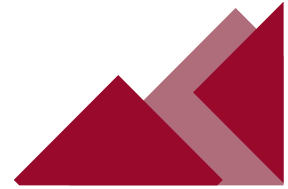




# The Court of Protection: Residence and Best Interest

**Apoorva Thakur - Medical Student**  
**University of Warwick Medical School**

**Dr Martin Curtice – Consultant in Old Age Psychiatry**  
**Coventry and Warwickshire Partnership NHS Trust**



## Introduction

This article reviews a Court of Protection case<sup>1</sup> involving an older lady with dementia whose care and placement became a point of contention between her children and nursing home staff.

## Background

P is an 86-year-old Iranian woman who moved to the UK in 2002. She has two sons (HS & SS) and a daughter (KS). She has a diagnosis of Alzheimer's dementia with poor functional status and significant daily care needs – she is doubly incontinent and has a history of falls such that she needs assistance of two for any transfers.

In August 2020, P was admitted to hospital and underwent operations on her hip. Prior to this she was living with her daughter KS. Whilst in hospital, P contracted COVID-19 and developed a hip infection. When she was deemed suitable for discharge there was discussion about the most appropriate location for her to convalesce – KS believed she could return to live with her, but the two sons believed she needed 24-hour care.

In February 2021, after an agreement was reached between the local authority and the family, P was moved into a nursing home. Due to disagreements and deteriorating relationships between P's children and the care home, the local authority made applications to the Court of Protection in 2021 regarding P's capacity to make decisions about where she should live and the care she should receive. Following an initial hearing in March, there was an escalation of distrust especially between the care home and the daughter, such that in July the care home decided to serve notice on the placement e.g. both sides made allegations arising from each other. This prompted another court hearing. Following this P was moved into a new care home in September. A further hearing occurred in November. It was agreed by all that P lacked MCA capacity to make such health and welfare decisions. It was also acknowledged there was a 'very deep and long-lasting rift between P's children' such that they were unable to agree on what was in her best interests.

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## Available options

The parties in the case agreed there were three viable options:

1. P remaining in her current placement.
2. P moving to live with her daughter.
3. P moving to live with her son (SS) and his family.

The latter two options would be on a trial basis and involve a package of care (up to the level of P's current care home fees).

An OT assessment concluded that each of the three available options would be 'viable in terms of care and support in broad terms'. In terms of looking at P residing with her daughter or son, the OT did not identify reasons for excluding or preferring either option but being able to access a garden area and being able to see her family as much as possible would improve her quality of life. A SW report similarly concluded any of the three options were viable in terms of care and support (the SW produced a table comparing the three options; there being 'little to distinguish' between them). However she was concerned the care package may break down if P were placed in KS's flat and felt that only the care home placement option would enable P to see her family 'as freely as is in P's best interests'. The SW gave 'very compelling evidence about the extreme nature of the acrimony and disputes in this case', some being 'petty and unseemly', arising from the family conflicts and the subsequent demands this placed upon staff and the impact on other residents of staff time being taken up by issues arising from the family disputes.

### **Best interests decision-making**

The judgment analysed various issues around the weighing up of evidence for the best interests decision as to where P would reside. The salient issues were:

- The impact on P of moving between different locations – the SW noted that moving to her current care home was distressing for her. Hence it would be prudent to try and minimise future moves. The judgment observed any moves should be made with a long-term outcome in mind e.g. it would not be acceptable to have separate trial periods of living at KS's and SS's homes.
- There was time pressure in that there was a four-week deadline for a decision to be made about placement at the care home.
- There were reasons indicating that trial periods at either KS's or SS's home would not be successful – primarily centering around KS's behaviour. There were incidents of KS having disputes with care home staff, hospital staff and with carers when P was staying with her. It was noted KS had difficulty accepting advice from care professionals which unintentionally caused harm to her mother. When P was staying with SS, KS raised safeguarding concerns about the care SS was providing (hence were P to move in with him this scenario may well occur again and jeopardise this).
- The judge noted there did not seem to be malice in KS's actions and it was probably her overprotectiveness, and own ideas of what might be in P's best interests, that were influencing her behaviour.
- KS no longer participated in joint meetings with care home staff and other family.
- The precedent of KS's inability to productively engage in dialogue with staff raised serious concerns that care might break down again in the future if P were to be placed with her – there were legitimate concerns about the 'sustainability of any care package'.
- On a pragmatic level it was noted in the current climate of scarcity of care workers, recurrent disputes with different companies may lead to the event that there was no local company willing to undertake care.

- The judgment noted potential positives to P being placed with family – albeit P was unable to express her wishes/feelings about this, there was a clear importance of P's family to her (she moved to the UK to be near her family) and it was inferred she would wish to see them as often as possible. The family tensions however suggested being placed with family would not be conducive to P having a restful and peaceful home environment, and that overall the care home represented 'neutral ground' for the family. Another benefit would be that with family, P would be rooted in Persian culture and surrounded by those who spoke Farsi (although, due to the effects of the dementia, it was 'debatable' how much she understood spoken Farsi). All the children agreed however the care home was meeting P's cultural needs.
- Access to outside space – evidence suggested P reacted positively to being in gardens which were available at the care home and SS's home but not at KS's flat.
- The judge was concerned that KS's evidence 'demonstrated a complete absence of understanding of that indirect impact on P' from the ongoing family conflict, as well as 'a complete lack of understanding of how the general family conflict may discourage others from visiting P'.

### The conclusion of the court

Following weighing and balancing the various issues above, the court ruled 'somewhat unusually' that it was in P's best interests to remain at the care home as the least restrictive option under a deprivation of liberty order. This enabled frequent family contact from which P derived 'great enjoyment' and would 'improve her quality of life with all of the other positive benefits for her health and well-being that will flow from that.' While there were concerns between 'the fraught family dynamics' and care home staff, a statement of expectations of all concerned had been created, which the judge believed would reduce the burden on the care home/staff of the issues between the children (particularly of KS potentially 'undermining the placement') and hopefully prevent a breakdown in future care.

### Case Reference

Reading Borough Council v P (by her litigation friend, the Official Solicitor) SS, HS and KS [2022] EWCOP 27 19th May 2022

The above judgement can be accessed for free at [www.bailii.org](http://www.bailii.org)





# Cochrane Corner

Dr Jenny McCleery

Joint Co-ordinating Editor

Cochrane Dementia and Cognitive Improvement Group

## Featured review: Cognitive stimulation to improve cognitive functioning in people with dementia

The NICE dementia guideline mentions quite a number of non-pharmacological interventions to consider, and some which should not be offered due to lack of evidence, but makes only two direct recommendations for psychosocial interventions which should be offered universally to people living with dementia. The first, rather non-specifically, is "a range of activities to promote well-being that are tailored to the person's individual preferences" and the second is group cognitive stimulation therapy for people with mild to moderate dementia.

The authors of the Cochrane review on cognitive stimulation therapy (CST), led by Professor Bob Woods, have just updated a review last published in 2012 \*. This provides a rigorous evaluation of the research investigating the efficacy of CST. Is the special status NICE awards CST among non-pharmacological interventions justified?

For a psychosocial intervention, CST has an impressive volume of literature investigating its efficacy. Between the 2012 review and this update, the number of included studies increased from 15 to 37 (with 2766 participants).

This increase in the number of studies allowed the authors to try to investigate factors which may moderate efficacy, such as modality (individual or group), session frequency, setting (community or care home) and dementia severity. Their primary outcome was cognitive function, but they were interested in a range of other outcomes including quality of life or well-being, mood, activities of daily living, behaviour, 'behaviour that challenges', communication and social interaction, quality of relationship with carers and family carers' own emotional well-being. As well as interesting results, the authors' discussion provides a very clear analysis of the nature and quality of the evidence and I would strongly recommend reading it in full. It is not possible to do full justice to this excellent review in a short article.

Consistent with other findings over the years, the review finds that, pooling all eligible studies, there probably is a small beneficial effect of CST on cognition assessed at the end of treatment (median treatment period 10 weeks; median number of sessions 20): the standardised mean difference between CST and control groups was 0.4 (95% CI 0.25-0.55) and the evidence was judged to be of moderate certainty using GRADE methods.

## Cochrane Corner

In the 25 studies which included the MMSE as an outcome measure, the mean difference between groups was 2 points, which the authors considered to be clinically significant, equivalent to about 6 months of decline and hence on a par with the benefits offered by cholinesterase inhibitors. Sadly, however, only 8 studies looked for persistent effects at post-treatment follow-up assessments and the evidence that a small cognitive benefit persisted after 8-12 months was of low quality.

This evidence for cognitive benefit was accompanied by evidence for a clinically relevant improvement in communication and social interaction (7 studies - all of group CST, 702 participants); small improvements in instrumental ADLs, self-reported mood, anxiety and general behaviour; and probably also small improvements in quality of life, behaviour that challenges and basic ADLs. There was little or no effect on caregiver outcomes.

It was notable that there was significant heterogeneity between studies for almost all outcomes and much of this was hard to explain. There were too few data on individual CST to be able to draw any firm conclusions about how it compared with group delivery. For other potential effect modifiers, there were only sufficient data for subgroup analyses for the cognitive outcome. The total number of sessions offered appeared to be less important than the frequency, with CST just once a week possibly being less effective than more frequent sessions. There was no clear difference between studies recruiting only in the community, although a number of

larger studies recruited from both settings and, in the absence of individual patient data, were excluded from this analysis. There was some tentative evidence of a larger cognitive effect in studies where participants had a baseline MMSE at or above the median score of 20 ('mild dementia'), compared to those with worse baseline cognition. ('moderate dementia').

The review does not include any data on cost-effectiveness, which will clearly interest commissioners. However, those lucky enough to be working in services which are commissioned to provide CST can feel fairly confident that they are doing something useful. And for those elsewhere, striving for better resources for post-diagnostic services, this review may assist the case.

### Cochrane news

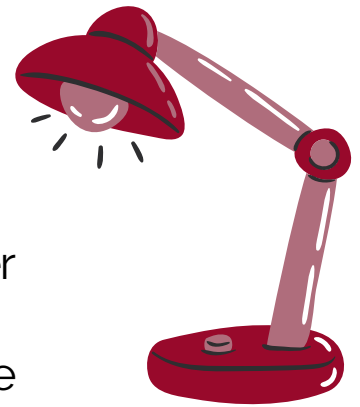
Cochrane is currently undergoing significant restructuring. From April 2023, NIHR will no longer be funding topic-specific Cochrane review groups in the UK. Different structures are being put in place to support the continuing production of Cochrane systematic reviews, and to involve the clinical community. Please keep an eye on the Cochrane Community website ([www.community.cochrane.org](http://www.community.cochrane.org)) over the coming months to keep up-to-date with developments and opportunities.

★ Unfortunately, due to copyediting delays, the updated review has not been published at the time of writing. However, it should be in the Cochrane Library before this newsletter goes out. Go to [www.cochranelibrary.com](http://www.cochranelibrary.com) and search for 'cognitive stimulation'.

# Research Update

Dr Anne M. Bonnici Mallia

Trainee Editor, RCPsych Old Age Faculty Newsletter  
Clinical Fellow in Medical Education, NELFT  
Dual Old Age and General Psychiatry Higher Trainee



**Broadbear et al.**

## **Development and Preliminary Evaluation of a Rapid Screening Tool for Detecting Borderline Personality Disorder in People Aged over 60 Years**

Doi: <https://doi.org/10.1080/07317115.2022.2123727>

This study explored the reliability of a new screening tool for detecting Borderline Personality Disorder (BPD) in people over 60 years old. The study included 22 participants with confirmed BPD and 21 gender-matched BPD-negative controls. Participants were recruited from community and inpatient mental health services, including acute wards and long-term care facilities.

The investigators designed the Spectrum Screening Tool for BPD in Older Adults (BPD-OA) arguing that that diagnostic criteria in the DSM-5 and ICD-11 is less sensitive in this age group. Investigators described the symptom expression of BPD in older adults, including a review of the literature, with persistence of emotional dysregulation, interpersonal difficulties, intense anger, insecure attachment with heightened features of emptiness, somatic symptoms and depression like symptoms. Conversely there was a reduction in impulsivity and unstable identity as well as less frequent but more lethal suicide attempts and different expression of deliberate self-harm.

Results from the study demonstrated at a threshold of 4 out of eight diagnostic criteria the BPD-OA had a sensitivity of 0.82 and a specificity of 0.62. The BPD-OA scored four out of 22 BPD confirmed participants as false negatives and eight out of 21 BPD-negative participants as false positive. Five out of the eight diagnostic criteria – intense unstable interpersonal relationships, chronic dysphoria, fear of abandonment, self-harm and suicidality – were found to be statistically significant in differentiating BPD confirmed from BPD-negative participants.

The BPD-OA was compared with the Diagnostic Interview for Borderlines-Revised and the McLean Screening Instrument for BPD, validated screening tool in adults. The BPD-OA was found to be statistically significant in differentiating between the BPD and BPD-negative groups ( $p < 0.005$ ) in contrast to the other two adult screening tools that were not found to be statistically significant in this study. The study shows promising results for the development of a screening tool for BPD in older adults. The authors acknowledged the limitations of the study sample and further need for refinement and evaluation to enhance the BPD-OA sensitivity and specificity.



## Research Update

Baril et al.

# Lighter sleep is associated with higher enlarged perivascular spaces burden in middle-aged and elderly individuals

DOI: <https://doi.org/10.1016/j.sleep.2022.10.006>

In this cohort study a sample enrolled in the Sleep Heart Health Study which were enrolled the Framingham Heart Study. The study included 522 participants from the aged between 39-81 years of age, the majority of which were aged between 45 and 65 years of age. Participants had undergone polysomnography and MRI imaging between 1995 and 2014.

The study aimed to analyse the relationship between enlarged perivascular space possibly representing impaired glymphatic system function to sleep architecture and total sleep time, age, ApoE e4 carrier status and hypertension. Sleep architecture was divided into N1 sleep, N2 sleep, N3 slow wave sleep and rapid eye movement (REM) sleep as well as Apnoea-Hypopnea index.

The glymphatic system is important in the clearance of toxins from the brain including beta amyloid and tau pathology involved in dementia pathology. Glymphatic clearance function has mainly been linked to N3 slow wave sleep from increased cerebrospinal fluid flow.

Results showed a link between greater enlarged perivascular spaces with longer duration and higher percentage of N1 light sleep ( $p = 0.008$  and  $0.003$ ) as well as shorter duration and lower percentage of N3 slow wave sleep ( $p = 0.028$  and  $0.055$ ). In ApoE4 E4 carriers longer duration of sleep was associated with enlarged perivascular spaces ( $0.043$ ), in particular longer REM sleep duration, and in non-carriers shorter sleep time was associated with enlarged perivascular spaces ( $0.037$ ). In those over 60 years and older and participants with hypertension longer N1 light sleep duration was associated with higher enlarged perivascular spaces ( $0.017$  and  $0.009$ ).

Findings from the study indicate that less slow wave sleep duration and longer light sleep is associated with higher enlarged perivascular spaces. These enlarged perivascular spaces are thought to represent small vascular disease resulting in accumulation of toxins, inflammation, reduced cerebrovascular flow and increased oxidative stress due to disruption of the blood brain barrier function and draining of interstitial spaces. In turn these promote amyloid and tau pathology linked to risk of dementia.



## Research Update

**Chatham et al**

# The Use of ECT in the Elderly—Looking Beyond Depression

DOI: <https://doi.org/10.1007/s11920-022-01353-0>

This literature review aimed to explore up to date evidence around the use and safety of electroconvulsive therapy (ECT) in older adults for a variety of mental health conditions. The authors conclude that ECT as a safe and tolerable treatment in older adults. ECT remains mainly used for treatment of depression in older adults. It remains underutilised for other conditions despite promising results and minimal short term side effects, limited but small and few studies available.

The authors describe that ECT is a robust treatment for depression and bipolar disorder in older adults as evidenced by multiple studies since the 1930s. Both unilateral and bilateral ECT are efficacious in improving symptoms of depression including a rapid improvement on suicidal thoughts. Older adults respond faster and require less treatments compared to younger adults. A study of patients with bipolar disorder type 1 included in the review did not show significance for manic or hypomania switch with ECT treatment for bipolar depression. ECT used for other mental health conditions may be partially effective through improving co-morbid depressive symptoms.

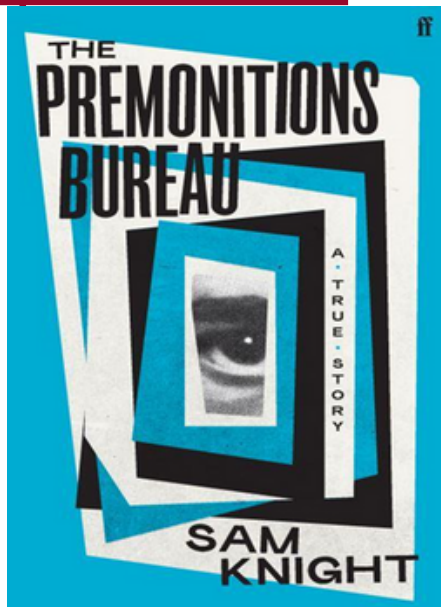
The authors described a randomised single blind study comparing clozapine treatment with and without the course of ECT in treatment resistant schizophrenia. Results showed that 50% of the participants met the response criteria in the ECT plus clozapine group but none in the clozapine only group. Participants in the control group were subsequently treated with ECT of which 47% met response criteria.

In catatonia ECT shows a response rate of 80–100% and should be considered within 24–48 hours of non-response to benzodiazepines. A case series referenced in the article showed that right unilateral ultra-brief ECT was effective and considered to have lower risk of cognitive side-effects compared to bilateral ECT.

Neuroleptic malignant syndrome (NMS) is a rare but potentially fatal emergency. The studies referenced evidence that ECT contributes to complete or partial recovery from NMS and decreased mortality as well as possibly reducing risk of relapse of NMS upon re-challenge.

A retrospective study of 50 participants showed that there was a reduction in Behavioural and psychological symptoms of dementia (BPSD) with ECT treatment as well as a reduction in the use of pharmacological interventions. Additionally, the authors reference a systematic review which showed an 88% improvement in BPSDs. Different articles cited showed that overall ECT was effective and well tolerated in people with dementia with transient delirium being the most common side effect. Evidence supporting ECT use in delirium is restricted to case reports indicating improvement in medication resistant delirium.

A literature review of 213 participants with Parkinson's disease receiving ECT showed improvement in Parkinson's symptoms both in those with and without co-morbid mental health conditions. A double blind controlled study of 11 participants with severe Parkinson's disease showed that ECT compared to sham ECT showed a statistically significant improvement during the "on" phase levodopa treatment.



# Book Review

## The Premonitions Bureau by Sam Knight

Review by Dr Anitha Howard  
Consultant Psychiatrist,  
Bensham Hospital,  
Gateshead



This Premonitions Bureau by Sam Knight is a little unusual- the title suggests a book in the genre of science fiction, but this is the bizarre true story featuring a jobbing Psychiatrist and the paranormal.

The book opens with a national disaster in 1966 in Aberfan, Wales- a mining incident caused a landslide that destroyed the local school and killing most of the children in the village. Dr Barker, a psychiatrist wondered if people could have had premonitions about the tragedy before the event and if so could this knowledge be used to prevent this. So, he set up The Premonitions Bureau to log people's premonitions to determine if they came to true in a semi-scientific way.

The book focusses on the life and work of Dr Barker who also happened to be a member of the British Society of Psychical Research and his quest along with a journalist (with a background in science) to track premonitions and the consequences on his professional and personal life.

But the reason why I really enjoyed this book was the description of Dr Barker as a jobbing psychiatrist in the sixties and his involvement in the reform in the provision of mental health services. He worked with Barbara Robb from the Aged Elderly in Government Institutions Society to reform services for older people. The descriptions of the patients stuck in old Victorian asylums and their care made interesting reading. The book also touches upon a devastating fire in the asylum leading to deaths of many of the patients- a fire that ironically wasn't predicted.

The book also touches upon Dr Barker's other research including Munchausen syndrome and including a book on how people could die from fear. Dr Barker was a celebrity doctor appearing on talk shows and book tours- the author captures the tension between the administrators in his NHS hospital and Dr Barker because of his increasing fame and notoriety.

Dr Barker achieved so much before his death in his forties and this book reflects a different time when a psychiatrist could actually have the paranormal as an area of research.





# Trainee Focus



Welcome to the new part of the newsletter, focusing on subjects you as trainees will find especially useful and relevant. Please get in touch if there's anything you'd like covered or if there's anything you'd like to write yourself! Topics could include special interest placements, leadership opportunities, research projects or anything you think would be interesting for your fellow trainees to read about.

For our first edition we are lucky to have an informative piece from a new Consultant on what she's found important when making that transition from ST6 to Consultant.

We hope you enjoy!

All the best,

Lizzie and Funmi

## OLD AGE HIGHER TRAINEE REPRESENTATIVE OPPORTUNITY

**DR FUNMI  
DEINDE  
&  
DR LIZZIE  
ROBERTSON**



We are looking for one enthusiastic volunteer to step into the role of higher trainee rep, as Dr Funmi Deinde steps down after a year of service and obtaining CCT. We are looking for an individual with the motivation, experience and skills to continue the exciting work and responsibilities of higher trainee rep, alongside Dr Lizzie Robertson.

The role of rep involves participation in meetings with members of the Executive Committee (with oversight to the whole Faculty) and the Special Advisory Committee (who are responsible for training issues). Our meetings have been a mixture of in person and online.

We are also part of a team organising the Old Age Trainees' Annual Conference which will be held in the Winter of 2023 as well as contributing content and ideas to the new Trainee section of the Old Age Faculty Newsletter.

As with previous reps, there is the opportunity to contribute towards improving the quality of training and teaching provided to trainees. There is also the opportunity to get involved in projects to facilitate positive and wider exposure of our specialty to core trainees, allied health professionals, medical students and foundation doctors. We have found our time as trainee reps very enjoyable, insightful and rewarding, and can highly recommend the role.



Those who are interested (ST4 and above), send an email expressing your interest to [olufunmi.deinde@nhs.net](mailto:olufunmi.deinde@nhs.net) and [E.Robertson@nhs.scot](mailto:E.Robertson@nhs.scot) by **January 31st 2023**

## Trainee Focus

# "That's just, like, my opinion, Dude"

**Dr Meroe Grove - Consultant in Old Age Psychiatry  
East Lothian Community Hospital**

An oft said phrase to me by my ST6 supervisor. His Lebowsky misquote was delivered with an appropriate degree of nonchalance, but it transpired to be a surprisingly insightful lesson as I approached consultant-hood. It enabled me to shift from being a trainee, asking for advice and following closely, to a fellow professional who has their own ideas and way to do things. The more I've gained experience, the more I've realised that seeking one correct response to a situation is over-simplistic in our world of greys. And just because opinions differ, it does not mean that mine is wrong. Progressing to being a consultant gives you the chance to work your own way and develop things around you (people and services), as well as yourself. Here are some things I've found important.

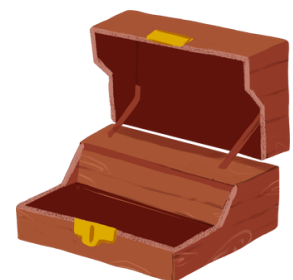


## You can do this

You might not feel ready, but who does? It drives me bananas the number of trainees who tell me that they are strategically delaying becoming a consultant because they fear they are not accomplished enough yet. All of the people who have said this to me will be good consultants. They just don't see it in themselves. Most of your learning is on the job, not in preparation for it.

## You are a scarce and valuable commodity

You are likely to have several job opportunities to pick from. Ensure that you negotiate. That idea makes most of us squirm, but genuinely; ask for compressed hours, ask for an 8:2 not 9:1. You have to do this job a long time and you need to be well to do the job well. Changes which are small for your employer can significantly impact on your longer term satisfaction.



## Find a good peer group

This is not a ticky box exercise. A good peer group can be a profound source of support, education and interest.

## Trainee Focus



### Get a mentor

I approached a previous supervisor who knew me well through various stages of training. She seemed touched to be asked and we met once a month and discussed the things that I felt too silly or embarrassed to ask my colleagues. It really helps.

## Job Plan!

Job plan accurately and ask for things to be changed if your job plan does not fit. Attend your job planning meeting (which you may have to request if it is not forthcoming) with a clear timetable of your past two weeks. There are apps or even just do it on a piece of paper. My colleague (of Dude fame) clearly stated that I was working more than my 10 sessions covering vacancies. Without resistance, I was increased to an 11 session job, with back pay. I would not have had the confidence then to have asked, but now I would. If you are suddenly expected to take on additional duties, put to your managers where this fits in your job plan; you may need paid more or relieved of other duties.



### Mind the manager

On a related point, before doing my job, I had no idea how important it was to get on with your managers. We are a little separate as trainees to the workings of a hospital or clinic. You do not have that buffer as a consultant and having a good manager can be the difference between a service running smoothly or deflating. Try and meet your manager before you go for a job and make good, early connections with them.

## A good admin team will save you

Similarly, I can't overstate the importance of your admin team. You need to have full time cover. A good admin team will save you time and more than likely save your arse on occasion. Get a good system with your secretary and establish this early. Build on that relationship. Bring them snacks.



I hope you find the next steps positive and exciting; there are so many good points about being a consultant rather than a reg. You can do it. But that's just, like, my opinion, Dude.



