Editorial

Jonathan Hillam
Consultant Old Age Psychiatrist, The Julian Hospital, Norwich

We are back in business!

Issue 50 was the last one funded by sponsorship from Pfizer and Eisai who deserve our gratitude for supporting Old Age Psychiatrist over the past 10 years. To continue publishing hard copies in the same way would have proved prohibitively expensive for the College, or indeed another sponsor in these economically challenging times. Hence the electronic version, which the College's Publications Department are putting together for us (so they are doing all the hard work). We now have more flexibility over the length of articles and of the publication overall. For now, though, we have kept the familiar format and I hope you can get used to reading it on-screen. You could, of course, print it out to read in the bath, or wherever. There are other benefits of having an electronic version. We encourage you to email it around to medical students and colleagues in other professions who express an interest. In this way, the circulation and readership of Old Age Psychiatrist should increase.

In this issue, Dave Anderson bravely attempts to summarise in a thousand words his highly successful 4-year tenure as Faculty Chair. You wonder how he ever had the time to do his day job, such has been the sheer number of agendas to influence, debates to contribute to (and win), and publications and policies to oversee. He steps down in June having made an immense contribution to old age psychiatry and to the Faculty, and we look forward to working with and supporting his successor, Peter Connolly. I am sure Peter will be contributing to Old Age Psychiatrist before too long!

Many thanks to all of you who have asked when Old Age Psychiatrist was going to appear again, and to everyone who has continued to send in articles. We apologise to all authors who, having submitted an article, have had to wait very patiently to see their work published. Normal service has been resumed, so we look forward to receiving your articles, letters, case reports, etc. Comments and suggestions about the newsletter’s content or format are always welcome.
Message from the Chair

Dave Anderson
Faculty of Old Age Psychiatry, Royal College of Psychiatrists

The past 4 years as Faculty Chair have been busier than I could have imagined: sometimes difficult and at time frenetic, but with far more highs than lows and always interesting. The world of healthcare is complex and eternally fascinating. Although I know that at the sharp end it has looked worrying for some, I never doubted that we would win debates on the big questions and I think we have – so far.

The year 2007 was a momentous year for old age psychiatry, with a raft of important reports highlighting discrimination and the unmet need of older people with mental illness; 2009 was even more so. I believe that the next few years will see a shifting focus towards older people as they are now firmly placed high on the political agenda with the UK Ageing Strategy, Advisory Forum on Ageing, and ministerial accountability. The Department of Health expects ageing will increase demand for more doctors to work with older people. All in all, I think old age psychiatry is a pretty good specialty to be part of right now.

Cauldron of controversy

Little did I know when I started in 2006 that I was entering such a cauldron of activity and controversy! Within 2 weeks, I walked into the dementia drugs furore: the appeal against the technology appraisal TA111, the first judicial review involving National Institute for Health and Clinical Excellence (NICE), then giving evidence to the Health Select Committee. This action proved far more successful than anyone imagined and the intense media attention profiled dementia on a scale never seen before.

Neither did I anticipate that our specialty would come under such threat from misguided commissioners failing to understand the principles of equality, and the need v. age discussion. Fortunately, this is mostly ignorance, as those at more senior levels do understand these principles.

In 2009, the National Dementia Strategy and New Horizons were published. These are good documents for us and our patients, and a lot of time and effort went into making that the case. The Equality Bill, which would make unjustified age discrimination in public services unlawful and create a public sector duty of equality duty, started its passage through Parliament and, if enacted, will change things for the better. We are closely involved with that process and are developing a self-assessment toolkit to allow an age equality impact assessment of mental health services.

Kite marks

In the past 2 years, we have fostered and led the development of accreditation schemes for in-patient treatment (AIMS-OP), memory services, liaison psychiatry, and the national audit of dementia care in general hospitals, confirming more attention being paid to older people. These will be important quality ‘kite marks’ for services. Personally, I was pleased to persuade NICE to develop a Delirium Guideline (out in 2010) and see the continued development of liaison psychiatry for older people. This, I believe, is an indicator that subspecialisation within old age psychiatry is likely to be needed. All of these are important drivers to improve quality of care for older people with mental illness.

We have published College Reports on institutional abuse, Black and minority ethnic elders, transition for ‘graduates’, and dementia and people with learning disabilities. The Faculty also produced the New Horizons report, and the consensus statement on older people’s mental health. In development are guidelines on in-patient services, and older people and addictions. We have responded to a multitude of consultations, given evidence to Parliamentary committees, prodced and probed the press, and produced the specialty curriculum. We have made strong relationships with other key organisations, and have representatives on several major collaborations.

On 13 October 2009, we launched a policy position statement in Parliament supporting services defined by need not age. It, more accurately, defines the unique expertise of our specialty. It re-affirms why comprehensive specialist older people’s mental health services are essential (in general, not only to treat dementia) and allows us to concentrate on what we are good at. I believe this puts our specialty on a firmer footing and creates an opportunity, but also a big responsibility, for us to develop new approaches to service delivery and better services for older people. Continued developments in healthcare will be driven by need, specialisation.
and patient choice. I hope the document *The Need to Tackle Age Discrimination in Mental Health* that supports the position statement (both on the College website) makes this clear and helps you in local discussions.

**Partners**

The work of the Executive Committee has been substantial and I thank them all for their wisdom, expertise and time which has enabled us to have a major influence on national policy. I am grateful to partner Royal Colleges, the British Geriatrics Society, Alzheimer’s Society, Age Concern and others who have supported us in difficult times. They helped to develop the consensus statement on older people’s mental health in 2008, important in itself, but which also established a vital network. Alzheimer’s Society and Age Concern helped us expand our patient and carer group, who now attend our strategy meetings – the first Faculty to do this. We have a very constructive relationship with the Department of Health which seeks our advice on important matters.

We have entered tough fiscal times, but this can be an opportunity more than a threat if we approach this properly. Priorities become the focus in hard times and necessity is a driver for innovation, imagination and cost-effective solutions. I think we have some of those solutions. Old age psychiatry was founded on necessity and innovation, and the priority to address the challenges of an ageing population will simply become greater. Your conversations need to be positive and offer solutions not barriers.

**Support the Faculty**

The more the membership is involved, the stronger the Faculty becomes, and I make a plea for members to support Faculty events. The Executive Committee has reviewed its financial position in 2009 and made several changes that will make our limited funds go further. Attendance at the residential meeting and continued professional development events are our only source of income and, sadly, despite excellent programmes and great feedback from delegates, it has declined. This is the only money we have to fund working groups to develop guidance and reports, improve trainees’ access to conferences, support our patient and carer group, organise events, and fund prizes and bursaries for trainees from home and low- and middle-income countries. Having said that, I was buoyed by the success of a joint 1-day conference with the Faculty of Old Age Psychology, British Psychological Society, in December 2009, which was grossly oversubscribed.

Unfortunately, we lost the hard copy version of the newsletter, but I am delighted that it is resurrected now in electronic form. It is highly valued and seen as a model in the College.

There are new opportunities to grasp and opportunities are always exciting. My view is that life is a sequence of opportunities and those who succeed, see them and take them. There is no other specialty I would rather be a part of and I think it has a great future. I am sure the new Chair and Executive Committee will feel the same. I wish them well. To paraphrase John F. Kennedy: ‘Think not what the Faculty can do for you but what you can do for the Faculty’.

Finally, my gratitude to my personal assistant, Helen Bickerton, without whom this work would have been immeasurably more difficult.

**References**

Learning from history
Politicians, please take heed

Claire Hilton
Consultant Psychiatrist, Mental Health Service for Older Adults, Central and North West London NHS Foundation Trust, Harrow

Through many generations, politicians, economists and health-care leaders have complained about the increasing care required by rising numbers of older people. Greater longevity, decreasing birth rates and social changes such as women going out to work have all reduced the relative proportion of younger people who could care for those who are older and frailer. These factors are long-term features of British demography. The birth rate has declined steadily since the 1870s, and by 1976 the Office of Population Censuses and Surveys was commenting on 25 years of decline in the proportion of adults of working age relative to elderly people.¹

Ambivalence

Ambivalence towards funding care for older people has persisted for nearly 70 years, ever since the Beveridge Report which laid the foundations for the welfare state.² Although recognising that unnecessary suffering may be associated with underprovision, it also cautioned against excessive resourcing of services for older people: ‘it is dangerous to be in anyway lavish to old age, until adequate provision has been assured for all other vital needs;’² Sir William Beveridge was 63 years of age at the time of his report. However, as he aged, he became increasingly critical of the inadequacies of the post-war welfare state, especially relating to problems experienced by older people.³

The philosophy of care in the Beveridge Report has been taken too literally for far too long, and has become engrained in policy making. Yet there is no excuse whatsoever for not planning for older people. We may not be able to predict birth rates or many social changes, but the epidemiology of chronic disorders and life expectancies for the population alive today (save, perhaps, for threatened pandemics or miracle drugs) means that we can predict the demands on the public purse. Society does not question paying for dependent children who have not yet contributed to the workings of society, and it should not question supporting older people who become dependent having passed through the responsibilities of adult life.

Similarity

The distinguished psychiatrist Professor Sir Aubrey Lewis⁴ wrote in 1946:

‘The psychiatric aspects of ageing are a major problem… the proportion of old people in the community steadily increases, so that they provide an increasingly high proportion of our… population which must be cared for.’

Sixty years later, the National Dementia Strategy⁵ in 2008 states with uncanny similarity:

‘Given our ageing population, this is a challenge that will only grow in size, with the number of people with dementia projected to double in the next 30 years.

This is not an illness that we can shut our eyes to, and a strategic approach is vital.’

Similar sentiments have been expressed in the decades in between. Each time, government departments or policy makers claim to rediscover an increasing elderly population.

Financial stringency

However, consistently little financial investment has been made. In 1950, the Ministry of Health proposed psychogeriatric assessment units and long-stay facilities for older people close to their homes, families and communities, away from the rural and inaccessible mental hospitals. But this recommendation was tempered with an opt-out clause: ‘It is recognised that the present conditions of financial stringency limit opportunities for action at this time.’⁶ Professor Tom Arie commented retrospectively that in 1973 the oil crisis turned out to have been the really important thing for psychogeriatrics,⁷ counteracting the optimism of two other landmark events – the publication of the government’s blueprint Services for Mental Illness Related to Old Age,⁸ and the inauguration of the College’s Special Interest Group for the Psychiatry of Old Age, the forerunner of the Faculty. Some would even say that the development of the specialty is not complete without a mention of Margaret Thatcher and Conservative policy in privatising
long-stay homes and undermining community care initiatives.

More recently, various strategies for looking after mentally ill older people such as the National Service Framework for Older People have been inadequately resourced, in particular when compared with budgets provided to mental health services for adults of working age. Economic crises have always impeded developments in public services, but old age psychiatry has lain almost buried at the bottom of the priority pile.

In November 2008, George Magnus, the eminent economist and senior advisor to one of the world’s leading financial firms, reiterated the issues of the ageing population challenge. He has high credibility – he had predicted the 2008 economic crisis a year previously, so people may well listen to him. However, his comments are not new. He stated that ‘people lose skills after 45’ – an ageist, vague and probably meaningless generalisation; even if middle-aged and older people do not acquire skills so rapidly, they have a wealth of life experience and maturity to compensate. His suggestion of remaining in paid employment to an older age to help counteract financial difficulties associated with longevity is not new. However, in times of recession and high unemployment, like in the 1920s, the converse is likely to happen. In 1925, for example, the pension age was dropped from 70 to 65 years to remove older people from the workforce, rather than encouraging them to work longer. Economic depression associated with unemployment is likely to create redundancies for older people in favour of younger people who are more likely to be supporting dependents.

**Positive action**

Magnus went on: ‘I don’t think Governments have thought about this in a coherent and comprehensive way’. I think he is wrong. Governments have thought too long. They may have listened to older people or those advocating for them, but they have not taken positive action. It is not thinking we require, but resources and implementation. Perhaps the forthcoming Equality Bill will achieve this since it aims to make it unlawful to discriminate against someone because of their age when providing goods, facilities and services. This does not mean abolishing old age psychiatry (or, for that matter, child psychiatry) but giving it equity of access to appropriate resources for an older population.

As clinicians, we must not risk becoming hardened to entrenched attitudes, unworkable ideas, and stereotypes undermining the care we can offer to older people. Old people are not ‘other’ and alien – they are us tomorrow. Politicians please take heed, or, like Beveridge, you may live to regret your decisions. Just how long do we have to wait for the government to both plan and invest for the future for all of us?

**Acknowledgement**

My thanks to Professor Tom Arie for his thought-provoking comments on this topic.

**References**

In-patient treatment is an expensive way of caring for people with acute psychiatric disorders. So the focus over recent years has been to provide high-quality multidisciplinary patient-centred care in the community as a viable and safe alternative to in-patient admission. The first day hospital in the UK was established in 1946. They were seen as an alternative to in-patient admission as they grew in number. Unfortunately, their popularity has waned over the years largely due to the limited and variable evidence justifying their effectiveness.

Reconfigured service

The National Service Framework for Older People provides guidance on the standards expected of services available to the older adult population. Everybody’s Business outlines the aims of the day hospital as a service designed to offer intensive multidisciplinary assessment and treatment to older people with complex mental health needs so far as to reduce the need for admission to hospital or to aid recovery following admission.

The model of service delivery at the Bridgeway’s day hospital, Bromley, Kent, was refocused in January 2006, in line with the strategies outlined by the National Service Framework and Everybody’s Business. Specifically, the service was reconfigured to prevent hospital admission and facilitate early discharge in older adult patients by providing acute day-hospital services (partial hospitalisation) to acutely unwell older adults with predominantly ‘functional’ mental health problems requiring intensive treatment but not 24-hour nursing care. At the outset of the reconfiguration, all patients attending the day hospital were assessed and patients not in need of intensive treatment (acute day-hospital services) were gradually discharged to follow-up by the community mental health teams. Patients with predominantly cognitive problems were referred to the memory service and appropriate referrals were made for those in need of day centres. Admission to the unit was thereafter reserved for ‘functionally ill’ patients in need of partial hospitalisation.

Treatment plans

Patients in the acute phase of their illness who would otherwise have been admitted to the in-patient unit were admitted to the day hospital if the risks did not outweigh the benefits. They were encouraged to convey themselves to the unit but transportation was provided for those who were unable to attend independently. On admission, the specialist trainee took a full history from the patients, physically examined them and requested any appropriate baseline investigations. Patient attendance varied from once a week to five times a week and their treatment plans were reviewed weekly or two weekly by the consultant old age psychiatrist depending on their illness severity and their treatment stage.

Patients were also afforded other modes of therapies including individual and group psychosocial interventions, which were overseen by a psychologist. Where necessary, an occupational therapist provided input to help optimise their daily living skills. Patients were referred to Social Services when necessary and the unit liaised frequently with general practitioners who remained responsible for the physical health of their patients.

Medication review was done with active support from pharmacies and general practitioners thereby minimising any disruption to patient care/medication adherence. When necessary, the patients were supported out of hours through the Bromley crisis team.

To compensate for the limited time the patients spend on the unit, we gathered information on their mental state at home by involving their relatives and carers in our reviews, either through telephone contact or by face-to-face discussions, bearing patient confidentiality in mind. Staff were encouraged to have both trust-based and external training to facilitate their continued professional development. Their dedication to work was rewarded by a patient satisfaction survey carried out at the day hospital in which 88% of responders expressed satisfaction with the care they received on the unit. The day hospital operated a two-way traffic system with the in-patient unit as patients were admitted to the 21-bed unit if necessary.
and transferred back to the day hospital as soon as appropriate. The recovery model was used at the day hospital and patients were subsequently discharged to the appropriate level of care such as the out-patient clinic or follow-up by community mental health nurses.

**Data**

In 2006, 2 years after the reconfiguration of services, data from the in-patient unit on the number of admissions, number of discharges and average length of stay 2 years pre- and post-reconfiguration of the day hospital were analysed. The most notable findings relate to the comparison of data between 2004 and 2007 (Fig. 1).

There was a statistically significant ($P < 0.05$) reduction in the number of in-patient admissions at the end of 2007 compared with 2004: the number of admissions fell by 37%. Correspondingly, the number of discharges from the in-patient unit fell by 26% ($P = 0.03$). A similar trend was observed in the length of stay – by the end of the second year of the partial hospitalisation model, the average length of in-patient stay had reduced by 40% ($P = 0.01$) when compared with the figures recorded 2 years before the model was implemented. Data from the third post-implementation year, although not fully analysed, showed an emerging pattern of increased length of stay on the in-patient unit and a reduction in number of in-patient admissions and discharges. This is in line with expectations, as functions of the in-patient unit had by then been mostly streamlined to admit only patients with complex needs requiring 24-hour nursing care.

**Effectiveness**

Our experience has demonstrated that acute day hospitals can be used effectively in old age psychiatry to prevent in-patient admission of ‘functionally ill’ patients and to facilitate their early hospital discharge. The advantage of the acute day-hospital model is that patients in the acute phase of their illness receive time-limited intensive ‘hospital care’ on an out-patient basis, and they have the added benefit of maintaining their independence, social skills and freedom at home. The effectiveness of this model of care is further underscored by a recent European multicentred study, which showed that clinical outcomes of acute day-hospital care are similar to those of in-patient care.

Mental health services should have a three-tiered approach in the care of acutely unwell older adult patients in need of intensive care. The three-tiered services should be in effect the home treatment team, the acute day therapy service and the in-patient unit.

**References**

Perceptual disorders in older people are common and have multiple aetiologies. The course of Alzheimer’s disease is frequently complicated by psychiatric symptoms, including coexisting depression or psychotic symptoms. Sensory impairment and isolation often contribute to organic brain disease resulting in perceptual disorders. We present six cases where patients have mistaken photographs or television images for reality and discuss the phenomenology.

Case A
An 80-year-old widow presented with a clinical diagnosis of moderate Alzheimer’s disease. On examination it became apparent that she believed there was a baby in the house and that she was responsible for looking after him and feeding him. She misidentified a rug and cushions on the sofa for a sleeping baby. A social worker found her agitated and tearful as she had a photograph of a baby in the bath which she thought had drowned. Her dementia continued to deteriorate and she later developed severe depressive symptoms.

Case B
A 78-year-old widow with hearing and visual impairment and a diagnosis of moderate Alzheimer’s disease developed delusions and hallucinations relating to television personalities and photographs. She believed that the photographs in newspapers came alive. While watching television she believed the opera singer Luciano Pavarotti had blown kisses especially for her and that the television presenter Terry Wogan had actually danced with her. She also believed that Terry Wogan was an old friend of hers and that the comedian Michael Barrymore talked to her very quietly but that she could not understand what he said. The cognitive impairment progressed and she went on to develop severe non-fluent dysphasia.

Case C
A 73-year-old man with dementia presented with memory impairment, hostility and wandering behaviour. On seeing female photographs in magazines he believed they were real and made them a cup of tea. During assessment, he pulled photographs off the wall believing they were real and took a photograph of a woman in a magazine out in the street and asked passers by to get her out of his house. He even phoned the police to evict her.

Case D
A 72-year-old lady with a diagnosis of moderate dementia presented with increasing agitation and aggression. When assessed, she was found talking to pictures on the wall, and believed that two magazine photos were real people and had put them to bed resting on the pillow with their faces upwards. She then prepared cups of tea for them and left them on the bedside table.

Case E
A 75-year-old lady presented with moderate Alzheimer’s disease. She had visual impairment due to cataracts. She misidentified photographs as being real, for example, she put a photograph of her grandchildren to bed. She had also made sandwiches and tea for a magazine picture of Curly Watts from the television series Coronation Street. This occurred mostly in the evening and on one occasion she prepared a full meal for some photographs at midnight.

Case F
An 81-year-old lady presented with depressive illness with paranoid features. She later developed dementia which progressed rapidly. While watching television she became concerned that Terry Wogan and his friends were playing golf in her front room. In her distress she tore a central heating radiator from the wall.

Discussion
Psychotic symptoms
Psychotic symptoms are common in Alzheimer’s disease, and have a major impact on the patient’s quality of life and social affiliations. They have been shown to be a major cause of anxiety and concern for caregivers and
a frequent cause of admission to hospital or care homes.

**Visual hallucinations**

Visual hallucinations are associated with more severe cognitive impairment and less insight into the psychotic symptoms. They may contribute to the patient’s dysphoria, poor orientation and resulting psychosocial difficulties including self-care. Some patients with Alzheimer’s disease believe that the hallucinations are real and can remember them; others quickly forget. Insight often fluctuates.

Frequency and severity of these visual phenomena varies greatly. They are often more intense in the evenings. Distraction or increased social contact may terminate them. The emotional response to these phenomena varies depending on the degree of insight and ranges from amusement to fear, and indifference to anger.

**Underlying mechanisms**

The underlying mechanism for psychosis in Alzheimer’s disease is not well understood. Hirono et al\(^1\) showed that a subpopulation of patients with Alzheimer’s disease who are female, of late onset, of severe cognitive impairment, and of longer duration of illness, have a higher risk of developing psychotic symptoms. Ramachandran et al\(^2\) showed those patients with Alzheimer’s disease and the ApoE 3/4 genotypes had more than a threefold increase in psychosis when compared with those with the ApoE 3/3 genotype.

**Cinegraphic sign**

Berrios & Brook\(^3\) described seven patients who treated television images and newspaper photographs as if they were real and existed in three-dimensional space. These patients talked to the images and on occasions offered them food and drink. The authors named the phenomenon ‘picture sign’ and described it as a ‘sensory delusion’. If a patient with Alzheimer’s disease or dementia of other origin presents with the belief that a person perceived in the house is real due to misidentification or a delusional misperception rather than a true hallucination, then we argue that perceiving a two-dimensional picture as real and conversing with or acting upon their belief should be recognised as a distinct and separate sign. We suggest the term ‘cinegraphic sign’ to describe this phenomenon.

Finally, people with delusions and hallucinations sometimes ascribe their experience to the involvement or influence of famous people. Historically, psychotic symptoms were commonly attributed to God, angels or demons, not just by the patients themselves but by society as a whole. But the most common people to feature in delusions and hallucinations in older people are family and neighbours. The involvement of famous people is relatively rare. The people involved in these cases are radio and television personalities. In some cases the attribution arose from seeing a picture or a broadcast of the person, and believing that the person was present in reality. There is no clear reason in these cases as to why a particular celebrity is perceived to be involved.

**Conclusions**

Photographs and television images become real in a small but significant minority of patients with dementia and probably arise from loss of function in cortical areas involved in visual association and object spatial awareness. Merriam et al\(^4\) describe how the capacity to organise perceptual information in the environment is compromised, leading to disorientation and misrecognition of stimuli. Thus subjective mental phenomena are accepted as real, and patients develop visual and auditory hallucinations.

With the increasing popularity of large televisions and the introduction of high-definition technology, we speculate that as television images become ever more realistic, more and more celebrities will be mistaken as joining people in their home.

**References**

Dementia is a well-defined condition which is prevalent among very old people but is rare within a whole population: of the order of 64 people being affected in an average practice of 10,000.

**Stretched specialist services**

Reports often criticise primary care for failing to recognise dementia and for neglecting assessment, education, information, treatment and support for individuals and their families. The implication is that people should be referred to specialist services more readily. Yet specialist services, including memory clinics, complain of being stretched by the number of referrals they receive and have invented mechanisms to reduce or ‘triage’ referrals and minimise their involvement in ongoing care and support.

Practice-based commissioning has increased the potential for primary care to control and direct the provision of services for patients. The dream is to make well-informed expert assessment, treatment and ongoing care available quickly, with minimal disruption, avoidance of stigma and at reasonable cost within primary care. Is this the way forward for dementia care?

**Primary care memory clinic**

Gnosall Health Centre in Stafford has established a primary health-care memory clinic involving a consultant psychiatrist (D.J.). It was created as part of a wider practice-based commissioning programme and with support from the Alzheimer’s Society Hearts and Brains project (www.alzheimers.org.uk/VascularDementia/index.htm).

Patients are referred within the practice via the screening framework of the practice’s vascular risk registers, or when problems are identified through clinical contacts. The practice health visitor (L.G.) has a key role in gathering and coordinating information, and liaising with patients, their family and other professionals involved in their care.

The clock test and BASDEC are used to supplement clinical descriptions. Current, recent and historical healthcare is accessed from the practice’s computerised records. Clinics are held monthly and occupy one morning session. Advantages include the following.

- Maximum use of local knowledge and resources.
- Costs of attendance away from the practice are reduced to a minimum.
- Meetings with colleagues from a local day centre, Social Services and Alzheimer’s Society.
- Focus groups with patient representative groups within the practice.
- Involvement and understanding of all members of the primary healthcare team.
- Contact with the consultant directly or via the health visitor on clinic days or by telephone at any other time.
- Minimum use of other specialist facilities: one referral to psychology, none to community psychiatric nurses, one admission to an Old Age Psychiatry ward in 18 months.
- For the consultant: direct access to patients, with full information to facilitate assessment and a ready-made follow-up system.

**Encouraging outcomes**

The first 12 months of this project have been encouraging – contact being made with more than 1:3 of the predicted prevalence of dementia in the population and at a rate three times that reported by specialist-based memory clinics.

---

*Based on a presentation at the joint meeting of the International Psychogeriatric Association and the Royal College of Psychiatrists’ Old Age Psychiatry Faculty, ‘Mental Health and Ageing – Towards a New Age of Enlightenment’, held in Dublin, Ireland, 8–11 April 2008.*
Of the 18 patients originally living at home, 15 remained at home at the end of the year.

A similar rate of contact has been maintained to 18 months – a total of 31 new patients being seen and clinics usually involving 2 new patients and two to three reviews. Most are seen at the practice, but an important minority is seen at home or in their nursing home for their convenience. Half have received a diagnosis of vascular dementia and a third a diagnosis with Alzheimer’s disease or mixed dementia. An important subgroup present other problems: depression, a secondary brain tumour, alcohol dependence and Huntington’s disease have been identified within the past 6 months.

**Conclusion**

It is possible that this approach will become adopted as the mainstream pathway for the assessment and aftercare of people with memory problems. It meets the wishes of patients, carers and professionals with a refreshing absence of fuss.

**References**


---

**Why do a Masters in Gerontology?**

**Kavita Das**

*Specialist Registrar in Psychiatry, Older People Mental Health, Sussex Partnership NHS Trust*

In 2006, I embarked on a 2-year, taught, part-time Masters in Gerontology from King’s College London. The course had been recommended to me by past graduates for high-quality teaching, thorough assessment of work and good pastoral support from the tutors. Professionals from different disciplines attended the course: psychiatrists, geriatricians, general practitioners, voluntary sector workers, and allied health professionals. This brought valuable diverse opinion to discussions and learning.

Two core modules (Principles of Gerontology, Research Methods and Statistics) were compulsory. Additionally, from a selection of specialist modules, I chose Ageing in Society, Biological Gerontology, Healthcare Services in Gerontology, and Population Studies, with the view to exploring ageing at both the individual and societal level. Each module was assessed by an essay and a presentation. This was followed by exams, but the award of the degree was dependent on submission of the dissertation. For the dissertation, I conducted an original piece of research; recruiting patients, analysis of results and writing up of the thesis was a valuable experience which has given me the confidence to pursue further research projects. As my research was on older mentally disordered offenders, I am considering forensic psychiatry as a special interest in my future career.

This course requires considerable commitment, discipline and motivation. It is vital to start dissertation work early as each step of the research took longer than expected. However, I strongly recommend this course to higher trainees in old age psychiatry. It has enhanced my clinical skills, but it has also provided me with a wider understanding of the social, economic, biological and psychological aspects of ageing, which I hope will help me to be a better doctor. The course will help fulfil research and publication needs, and develop such skills as healthcare literature searches, presentations and critical thinking. For those who wish to consider academia, this degree provides a perfect platform to embark on a PhD.

Further information on this course can be obtained from Debora Price, Postgraduate admission tutor, Institute of Gerontology (Melbourne House), King’s College London, The Strand, London WC2R 2LS. Tel: 020 7848 2735; email: gerontology@kcl.ac.uk.
Diploma of Geriatric Medicine (DGM)

Noel Collins

Specialist Registrar, Old Age Psychiatry, Central and North West London NHS Foundation Trust

The Diploma in Geriatric Medicine (DGM) examination is one of three offered by the Royal College of Physicians (RCP) (the others being the membership examination (MRCP) and the Diploma of Tropical Medicine). It is designed to give recognition of competence in the provision of care of the elderly to general practitioner vocational trainees, clinical assistants and others working in non-consultant career posts in departments of geriatric medicine, and other doctors with interests in or responsibilities for the care of elderly people.

Rusty

I sat the exam (successfully) in Spring 2007 and found it a useful and challenging way to update my rusty knowledge of geriatric medicine. The exam is split into two parts – a written (multiple choice) exam taken at the RCP in London and a clinical (objective structured clinical examination, OSCE) exam held at various other sites in England. There are two sittings of each part each year and you must pass the written exam before attempting the clinical. You are allowed four attempts at the clinical (within 2 years) before having to sit the written exam again.

The RCP website provides explicit information on both the content and skills tested in the exams (www.rcplondon.ac.uk/education/examinations/Pages/DGM.aspx). The written exam runs for 3 hours and has 60 ‘best of five’ multiple choice questions. The topics examined include the biology and epidemiology of ageing, medicine and psychiatry, pharmacology, and service provision relating to old age. Most questions were related to a common clinical presentation or patient vignette.

Intuitive

The clinical exam was the most anxiety provoking and consisted of four 14-minute clinical stations in an OSCE/short case format. Stations examine history taking, physical examination (neurology, dermatology or locomotor, cardiovascular or respiratory), other practical assessments, communication skills and ethics. As a psychiatrist, I felt most out of my depth with examination-based short cases and relied on techniques taught in medical school. In contrast, I felt very comfortable with the stations testing communication skills, which felt more intuitive.

There are resources available to help prepare for the exam, for example a textbook which bases its content around the exam syllabus and provides a readable and concise summary of the main topics.¹ There is also a 3-day residential course based at Cardiff which aims to prepare candidates for both the written aspects of the exam. I found the mock short cases, undertaken on the last day at a nearby general hospital, the most helpful. Studying clinical methods textbooks (e.g. Macleod’s Clinical Examination)² and practising various system examinations on relatives and friends was essential. The RCP website tells you all you need to know about the examination format and provides an exam timetable and application forms.

Increased confidence

The exam costs around £570 to take (and for the diploma to be issued) and requires probably a month or two of serious study. Sitting the DGM examinations does induce flashbacks to medical school at times and there are moments in the clinical exam in particular where you feel out of your depth. However, passing the DGM has given me increased confidence in treating common geriatric medical problems and a rather pretty diploma for my wall. An additional advantage of the diploma is that it grants significant exemptions off the first year of the MSc in Gerontology at King’s College, which is a course I am considering undertaking.

References

From my observations in clinical practice, our patients often have very little documentation of their personal history, particularly their childhood experiences. I myself have been guilty of the ageist presumption that older patients may not remember sufficient details of their childhoods.

I have, however, used a detailed questionnaire called the Childhood Experience of Care and Abuse (CeCA) on a group of eight patients from a medical day hospital aged between 70 and 87. All the patients had a Mini-Mental State Examination score of above 24 and no significant past psychiatric history. The CeCA is a very detailed retrospective semi-structured interview that has been validated on groups up to the age of 50. The questionnaire is rated for categories of care and abuse during childhood and can take between 45 minutes and 2 hours to carry out. All the patients in our group were able to give detailed answers to the questions.

**Importance of past experiences**

Why is it important to take detailed histories of childhood experiences from older patients? By understanding experiences our patients have had in their childhoods, not only does it give us an understanding of their psychopathology, but it enables us to have a greater understanding of their relationships with us and our colleagues, and any feelings that are aroused within ourselves (transference and countertransference relationships).

Martindale discusses the developmental stages older people must negotiate to come to terms with their dependent states. In old age there is a need to mourn one’s youth and accept the inevitability of approaching death. How our older patients deal with ill health and dependency relies on how their dependent state in childhood was dealt with by the caregivers or parents. So a patient who has experienced abuse in childhood may react badly to becoming unwell and being in hospital. It is important to understand this as they may be part of a group that we call ‘treatment resistant’ or label as ‘difficult patients’. A patient who has experienced abuse in childhood may not trust that as doctors we are going to help them, but instead believe in their dependent state that we are going to abuse them in some way. Indeed, if we do not make sense of these complex feelings in our patients and ourselves then we may become the abuser acting out feelings of anger or hate towards the patient.

Winnicott describes the ‘good-enough mother’ who can contain and interpret the projected feelings from the baby in their dependent state. If this does not occur, then instead of feeling safe and understood the baby will be left with feelings of terror and destruction. In the dependent state of old age, these destructive feelings may surface again in the form of a depressive illness.

This was the case in one of the patients I interviewed. She had experienced extreme physical and psychological abuse from her mother as well as sexual abuse from a neighbour. She was physically now in a very dependent state being housebound and reliant on carers. From my interview she was also clearly very depressed and left me feeling quite desperate. She had not had caregivers in childhood who could provide containment and consistency for her, and now in the final stages of her life there was a feeling of disintegration and despair.

**Making the time**

As busy clinicians, how can we take detailed histories from our patients and have time to reflect and make sense of the information? The CeCA is too long to carry out routinely. Bifulco et al have developed a self-report questionnaire to mirror the CeCA (CECA-Q). This takes about 20 minutes to complete.

I suppose there is no easy shortcut, but I would urge clinicians to try to make time both to take full personal histories and to make sense of their patient’s early experiences. This in turn will give a greater understanding of their psychiatric presentation and their relationship with us. If this information is not gathered, it may be lost forever if our patients develop dementia or become more physically or mentally unwell. A friendly consultant psychotherapist, I have found, is invaluable to give supervision individually or in a Balint group with other colleagues. If we can...
feel contained with our feelings then so will our patients. Then we will be ‘good-enough doctors’.

Acknowledgements
This is a shortened version of a paper written with Dr S. O’Connor, Consultant Old Age Psychiatrist, Goodmayes Hospital London, in conjunction with Dr M. Blanchard, Consultant Old Age Psychiatrist and Senior Lecturer, Royal Free Hospital, University College London, and Dr A. Bifulco, Lifespan Research Group, Department of Health and Social Care, Royal Holloway College, University of London. The research project was approved by the ethics committee of the Royal Free Hampstead NHS Trust. This work has not been published elsewhere.

References

FORTHCOMING CONFERENCES

COMING OF AGE: DEMENTIA IN THE 21ST CENTURY

CALL FOR PAPERS
The Dementia Services Development Centre has pleasure in inviting you to submit a paper for presentation at our 4th international dementia conference ‘Coming of Age: Dementia in the 21st Century’.

This conference is for everyone involved in supporting people with dementia and their carers, both in the UK and internationally. Delegates will come from a range of sectors including nurses, doctors, social workers, researchers, architects, emergency service personnel, volunteers, people with dementia and their carers.

We are seeking submissions for both oral and poster presentations on a range of themes. The conference will run over 2 days, beginning with an opening event on 19 October 2010. The programme will showcase the latest research alongside best practical guidance on helping improve the lives of people with dementia.

Themes focus on the person, and will address critical issues across the range of professions and organisations that support people with dementia and their carers, specifically addressing the national dementia strategy. If you are uncertain of which theme your paper fits, please contact Jemma Galbraith on jemma.galbraith@stir.ac.uk or 01786 467740.

For further information and to submit a paper, please visit www.dementia.stir.ac.uk/London2010
Deadline for submissions: 10 March 2010.

Late submissions will not be accepted for oral presentations, but may be accepted as poster presentations. Notification of acceptance will be sent out by 24 March 2010.

KEYNOTE SPEAKERS
Professor Sandrine Andrieu
Professor of Epidemiology and Public Health, Toulouse University, School of Medicine, France
Professor Henry Brodaty
Professor of Age Care Mental, Health, University of New South Wales, Australia
Professor Stephen G. Post
Center for Medical Humanities, Compassionate Care, and Bioethics, Stony Brook University, USA
Professor Emma Reynish
Consultant Physician in Internal Medicine, Victoria Hospital, Kirkcaldy, UK

THE 7TH ANNUAL NATIONAL OLD AGE PSYCHIATRY HIGHER TRAINEE CONFERENCE

Venue: Wadham College, Oxford
Date: 15–16 April 2010
Delegates: All old age psychiatry higher trainees and new consultants (less than 18 months in post)
Speakers: Yet to be finalised
Cost: Yet to be finalised (£25–50)

To register your interest, please email: oapconference2010@gmail.com
Formal invitation to follow.