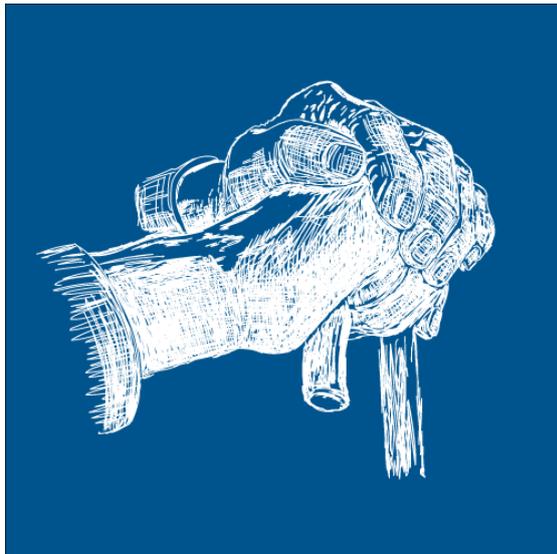




The Old Age Psychiatrist

Issue 73, January 2019

Old Age Psychiatry faculty
newsletter



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Update from the Editorial Team

by

Helen McCormack

Editor, Old Age Psychiatrists, Royal College of Psychiatrists

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We are pleased to start 2019 in a reflective frame of mind.

In this edition there is plenty to think about, both in terms of the policies and evidence that provide the framework in which we work, but also in reflecting on what it is to be a psychiatrist, a member of a profession, and a person experiencing mental illness.

Firstly, we are launching a trainees' corner in the newsletter and you will find more information below. Take a look and encourage your trainees to write for us, or if you are a trainee, we would love to hear from you.

Alongside the update from the Chair of our Faculty, Amanda Thompsell, we have a fantastic invited piece from Nigerian Psychiatrist, Olufisayo Elugbadebo. She came to the Faculty Conference in March 2018 to give a paper about her research into Psychogeriatric services in Nigeria. Her article is a fascinating and thought-provoking account of his experiences with us and the impact it has had on her and her working life. I would thoroughly recommend it.

The faculty is pleased to announce that it has awarded the Phillip Davis Prize 2018 to Dr Gavin Tucker, Foundation Doctor, for a thoughtful and challenging essay on the topic of assisted dying.

There are a number of updates on Policy and practice, including the New guidelines for driving with Dementia, the latest on the Mental Capacity Bill amendment, and a brief summary of the college report, CR 217: Young-onset dementia in mental health services. We have an article on the Choosing Wisely Programme and our usual Cochrane and Research updates. There is plenty here to ensure you start the new year up to date with advances in our profession. By way of contrast we wind up the newsletter with a great selection of book reviews, and, for the first time, two poems. We hope that these will give you the opportunity to reflect on life with mental illness for older adults and that you feel prepared and galvanised for the year ahead.

As always, we love to receive articles for us to consider for future newsletters, and if you have any feedback on what you read, please let us know.

View from the Chair

by

Dr Amanda Thompsell

Chair of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists

Looking back over the last few months yet again I am amazed about how much has been going on. As ever there has been a need to respond to issues as they arise.

We have been active in feeding into the official College response to the 10 Year Forward View. You can see the numerous references to older adults in the final document.



□ The APPG for mental health review of the FYFV was launched. Despite our detailed response to the draft, there was only one mention of older people and that was in relation to IAPT. I raised my concerns about this at the launch and we are following this up with an email to the MP who chairs the All-Party Parliamentary Group.

□ Following our strongly expressed reservations about HEE's initial proposals for the development of the core competencies for health and social care staff in older adult mental health I am pleased to say that HEE has had a rethink. We are contributing to a new core competencies framework which is now being developed. If anyone else wants to help, please let me know.

□ The Mental Capacity Act Amendment Bill was presented to the House of Lords. We have made numerous submissions and liaised with Department of Health and Social Care, Baroness Murphy and the College over our concerns about various aspects of this Bill. We have repeatedly requested to be involved in writing The Code of Practice. This is still a work in progress, but whilst some things that have improved (e.g. removal of the term "unsound mind" and a willingness to develop a definition of deprivation of liberty) other areas remain a real worry.

□ The issues concerning the interface between the Mental Capacity Act and that Mental Health Act (MHA) have also been reviewed as part of the review of the MHA and the Faculty have provided a comprehensive explanation of what issues could arise for teams on the ground with the various options suggested. By the time you read this we should know what the final recommendations will be.

Meanwhile we have carried on beavering away in promoting our published strategic aims.

1. To enhance the National and International Profile of the Faculty of Old Age Psychiatry on matters relating to Mental Health of Older People of all ethnicities

Once again, we as a Faculty have had the opportunity, and need, to weigh in on potential changes to ICD 11, this time in relation to the classification grouping of vascular dementia. Thanks to our response and those of other groups that we are working with across the globe, the proposed change will not be brought into effect. This ability to work collaboratively across countries is also evidenced in our work with the Global Council on Brain Health into the Council's Report on Mental Well-Being.

We are talking to the Association of British Neurologists and the Neurological Alliance about closer collaboration.

We now have a place at the Older People's Health Forum which is a wide group of Stakeholders developing the long-term conditions and frailty plan. We will continue to push for the important need to address older people's mental health alongside their physical health issues.

Along with the Faculty Chairs of the devolved nations we all have continued to champion the importance of older adults' mental health needs with government and the assemblies.

We have had input into an update on Psychological treatments in primary care, the College report on Autism and into the College review of Cannabis.

2. To attract and retain within Old Age Psychiatry the best doctors at every level of their professional career

Thanks to Dr Krishnan and our excellent speakers, we held a successful conference in October.

We have put together a really interesting programme for the Faculty Conference in March. We will be having masterclasses on topics you are unlikely to find in other conferences and on the last day, as well as a care home /liaison master class there will be opportunities for the trainees to be involved in an interactive learning café event.

Omolade Longe ,Chloe Pickup and Helen Thomson (all trainees) have been working on the website. This has been a significant commitment but thanks to their hard work we have seen a definitive improvement in the attractiveness, readability and content available on the site. Please encourage people to look at it and if you have any other suggestions please let us know.

We have been working on a document articulating the vision of the future of old age psychiatry which we will be completing in the near future so that we can articulate to commissioners and the wider public what skills we bring to the table.

3. To focus on our Membership engagement

Claire Murdoch asked for a response for suggestions for the NHS priorities for the next 10 years. Following an email to all members, I drafted a response to her based on the responses from members.

The issue of section 49 reports has been raised by the College in context of Mental Capacity Act Amendment Bill and we can feel reassured that everything that can be done is being done.

The Annual Members survey is completed and on the website. Thank you to all those who responded.

Concerns by members and the executive around the 6 week “*Target*” of referral to treatment for people with dementia on the NCCMH Pathway have been discussed with Alistair Burns and he has made clear both that this should not be viewed as a target as such but rather an aspiration and that treatment could mean the development of a care plan. On the website (under resources) we have put some guidance produced on neuroimaging (to reduce variation) and another document offering suggestions for streamlining service pathways, whilst maintaining or improving quality of care. All the recommendations made in these documents are a result of current memory service practice in London.

We put in suggestions for the NICE dementia quality standards.

We have been liaising with NHS digital on data on older people and we are feeding back on its usefulness in the hope that we can get data for colleagues that will help them in their negotiations with commissioners.

We are continuing to work with the Young Onset Dementia Network and a new meeting is being planned to focus on how to build on the excellent report which was launched in October and is on the website.

We are continuing to liaise with Alzheimer’s Research UK to look at what the future therapies look like and how it will impact on the services so we are at the heart of these discussions.

4. To increase awareness of mental health conditions of older people of all ethnicities

We have had success in getting publicity (in the newspapers and radio) on the issue of age discrimination in older people’s mental health when we launched our report in November alongside a YouGov poll commissioned by Independent Age

on the issue of older people's mental health. Our comments on the lack of referrals for older people who self-harm has also been picked up by *The Times*.

A lot of this has been covered under some of the other strategic aims as there is overlap. Here however are some areas specifically relating to mental health issues.

We continue to promote MINDED and I presented about it at The Dementia Congress to get more awareness.

We are organising a roundtable next year with the BGS to follow up the depression in care homes report

We supported the BGS's successful bid to host the European Geriatric Medicine conference in 2021 and I have asked that there be old age psychiatry input at that conference.

Looking forward

There is still so much going on and I am not talking about Brexit. The 10 Year forward plan by NHSE and MHA review could have a profound impact as could the Mental Capacity Act Amendment Bill.

Frailty and Integration are key areas of focus and we need to be able to articulate what value we bring as old age psychiatrists to these issues. Thank you to all who have contributed examples to us and we plan to develop a brief report based on your experiences in these areas. Please contact us if you have examples to share.

The feedback from the annual members' survey gives food for thought on issues of retention which we will need to use wisely to influence change.

My experience at the Faculty of Old Age Psychiatry Annual Conference 2018

by

Olufisayo Elugbadebo

Chief Tony Anenih Geriatric Centre, University College Hospital, Ibadan, Nigeria

Overview

Significant moments in life and career are not easily forgotten, they are priceless and recounting them can be filled with effusive exuberances. Attending the Faculty of Old Age Psychiatrist Conference at Gateshead Hotel Newcastle, United Kingdom was an interesting experience which I believe will linger in my consciousness. I find it exhilarating, reminiscing my time at the conference.

The meeting, which lasted for three days, (7th-9th March 2018), was filled with moments of discovery which I found enlightening and resourceful to my field. The experience was quite exotic and the adventure absorbing, as it was totally filled with informative sessions and a cheerful dinner. I will provide a succinct report about my experiences and lessons at the conference.

The participants

One would expect that a conference related to old age mental health would attract a ridiculously low number of participants, considering previous experiences in my country and their reticent responses to old age-related disciplines. I cannot express how bewildered I became at my entrance into the hall to find such number of people seated with interest in issues bordering on old age mental health. Indeed, that sight was compelling, positively intimidating and highly motivating. My bewilderment was protracted at the fact that it was not just only a Psychiatrists' affair; other related professionals in the field of geriatrics and service users were also represented at the meeting.

Meeting other participants

Naturally, I enjoy meeting people, but this conference was exceptional. During the breaks, there was always someone new I had to meet; everyone was curious to learn more about other people and what they are doing. Not just that, they were willing to share their experiences with others and offer their assistance in their best of ways. It was as though they all found purpose doing this and that made the difference.

I met with quite a number of people interested in the state of old age mental care in my country. I found it amusing seeing the expressions on their respective faces when told that we have a formally organised old age mental psychiatry service in Nigeria.

In addition to the various interesting sessions at the conference was the dinner, it was another flavor which was mixed with the awesome informal lectures. My table was surrounded with great female psychiatrists - among whom were Amanda Thompsell from the UK and Karen Sparring from Sweden, who are successful women in this field. They were very warm and generous with their wealth of experiences. I had one on one interaction with them and they shared with me their experiences as professionals in this field as well as their accomplishments. This dinner moment, for me, was explosive; the experiences and achievements were highly motivational. I was inspired, as well as challenged by their experiences and I already pictured myself attaining such giant feats in this field in the nearest decade as I tenaciously take my steps higher, I know I'm all the way up!

We had a swell time as we danced to some traditional Scottish beats and I went ahead to meet other colleagues who made the night memorable for me.

Content of the program

The content of the program was robust with various sessions addressing important issues in old age mental health. It was a great task choosing which workshop to attend taking into consideration the various interesting topics highlighted. The ones I eventually attended were enlightening. Going through the various posters, the rapid-fire presentations and the new science presentations where various project topics were discussed was very stimulating. It opened my mind to the areas where there are knowledge gaps in my local community and a need for research into such. Furthermore, the level of advocacy being done by the group to foster things pertaining to old age psychiatry in the UK was a major take home lesson. Efforts being made on how to encourage students in medical school to pick interest in old age psychiatry was eye opening.

This was a major issue considering the fact that back home old age psychiatry is not one of the choice areas where people want to specialize and little attention is given to it. I saw how systems can be put in place to encourage more people to pick this topic as an interest in the field. Also, the use of video clips to depict some of the mental health problems in old age and reason to choose psychiatry was very innovative.

My Presentation

It was a great opportunity to stand before an international community to discuss my research and findings on reasons for partial non-attendance and drop out

from psychogeriatric services in Nigeria. Feedbacks after the presentation were very encouraging. Prior to the presentation, some people were not aware of the existence of old age mental health services in Nigeria.

Materials

Another exciting privilege was that I had access to some information booklets on dementia which were displayed during the conference and I took quite a reasonable number back home.

Sharing my experience back at home

At the next peer review meeting of the geriatric unit of my department, after my return from the conference, I had the opportunity to share extensively with other colleagues my experience, coupled with the fact that I returned to Nigeria with so much enthusiasm and huge motivation to see that we also had such kind of meeting.

Luckily, the president of the geriatric unit of the Association of Psychiatrists in Nigeria happens to be my direct supervisor, so it was easy to narrate my experience. Furthermore, immediately I returned, I worked tenaciously as the local organizing chair of the regional meeting of the geriatric arm of the Association of Psychiatrists in Nigeria, in organizing a faculty meeting in May 2018.

During the meeting, I used the platform to talk about my experiences at the meeting in the United Kingdom and how we could improve as a group and issues pertaining to advocacy. I played some of the video clips displayed during the conference.

Furthermore, I returned with some booklets displayed during the conference in Newcastle on dementia. This further motivated me to work hard with other members of my team to ensure that the first information booklet for caregivers of dementia which we had been working on was launched during the regional meeting. I showcased the booklets I brought from the annual meeting as a means of motivating the group towards having more of such booklets. Also, I have started exploring the possibility of making short video clips which can serve as an advocacy tool that suit my local community.

Conclusion

Finally, I'm grateful to the Faculty of Old Age Psychiatry for giving me the opportunity to attend the annual meeting and I must admit that this conference has left a lasting, indelible impact in my career. The experience is already part of the old age psychiatrist in me and it is something that cannot be expunged. It was indeed a great experience and I enjoyed every moment I spent there.

Trainee Corner



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We are very excited to introduce this new addition to our faculty newsletter!

We encourage trainees (from foundation doctors to higher trainees) to submit articles outlining their achievements and involvement in any of the following areas:

- Teaching
- Quality Improvement
- Research
- Leadership & Management

We hope this corner will serve as a platform to learn from each other, share ideas and foster an environment of peer support amongst trainees in old age psychiatry and those planning to join our wonderful specialty, while also giving you an opportunity to proudly showcase your accomplishments!

The submissions should be between 500 to 1000 words.

The *Trainee Corner* will be officially launched in our May newsletter. We are currently accepting submissions, and we hope to see a lot of interest from our trainees!

New Royal College of Psychiatrists Website

by

Dr Helen Hopwood and Dr Chloe Pickup (trainee reps to the faculty) and Dr Omolade Longe (specialist registrar)

We would like to let members know about the **new** and improved RCPsych website, alongside the revised Faculty pages.



Faculty of Old Age Psychiatry

We aim to promote and protect the rights and wellbeing of older people and their families by supporting and educating old age psychiatrists and trainees and sharing best practice.



The website is now even more useful and usable and has lots of resources for trainees, clinicians, researchers, trainers, and all others working in old age psychiatry.

We have listed some examples here to give you a flavour of what's available:

- Guidance on job planning – a template suggesting a minimum standard for running safe services
- Careers leaflet for Foundation doctors – a leaflet to explain the speciality
- Joint report on depression in care homes – examples of good practice and analysis of the issues
- New report *Suffering in Silence* – age inequality in older people's mental health care and other resources for challenging ageless services
- #icanpreventdelirium and other videos
- The under-used Felix Post prize and others
- Trainee pages for support, stories and how to get involved in the Faculty

Coming soon to the website: The Faculty's vision for OA services in coming years, the integration agenda in frailty, a recruitment video for early careers doctors and a blog for trainees.

In particular, we would like to highlight the **research pages**. Dr Charlotte Allan has gathered together a summary of Old Age research active sites and their activities, and there are examples of career vignettes from early career researchers. This provides practical advice and signposting for those wishing to develop their research interests, to help them make connections with established academics.

We were **involved** in the redesign of the website and would like to encourage others to do the same. We worked closely with the web team to improve the website's appearance and presentation of up-to-date, easy to understand information that matters to members of the faculty.

Integrated Care Services – please share your experiences!

by

Kate Jefferies

Consultant Old Age Psychiatrist, Surrey & The Borders NHS Trust

We need your help!

As a faculty we are keen to share old age psychiatrist's experiences of working within integrated care systems.

The Old Age Faculty want to learn from all your experiences with STPs and to share it with other members. Up until now we have had no idea of who has been involved with their local STPs / ICSs and this is a unique chance for us to start to seize the initiative in the world of integration.

We want to compile old age psychiatrists' experiences into a paper which we could then share with Faculty members about working in integrated care system. If you can help us all learn from your experiences and share good practice, we have a few key questions which we would like to ask you.

These include the following:

- How did you get an invitation to the meetings with the STPs/ ICSs?
- What do you think were the drivers for them to include you?
- Were there any barriers you had to overcome to get involved?
- What tips would you give to colleagues on how to get involved/be effectively involved?
- What things would you tell them to be aware of /avoid?
- How much of your time does it take?
- Do you think it would be worth developing a professional network of old age psychiatrists who are involved with STPs/ICSs so that they can share their experiences?

Surrey Heath CMHT for Older People recently won the Royal College of Psychiatrists Older Adults Team of the year award.

Surrey Heath CMHT-OP is at the forefront of the national drive towards integration of community services. Since 2016 the team has been part of a

joined up system that includes colleagues in community services, social care, primary care and the voluntary sector and provides seamless support to older Surrey Heath residents.

There is a single point of access from 8am to 8pm for all community services so that 'no door is the wrong door'. Placing mental health staff at the heart of the system ensures that mental health needs are considered for all older adults in the locality, preventative work can occur and identified problems can be managed promptly.

The team prioritises continuity of care and accepts referrals for patients with both functional and organic presentations. Waiting times are 2 weeks on average. Urgent referrals can be seen within 2 hours. Patients can choose to be seen in a number of settings including their own home, a modern accessible clinic or in their GP surgery. The service offers a comprehensive programme of group and individual therapeutic interventions to cater for different levels of need.

The team also offers specialist care home input to assess and manage behaviour that challenges; including joint GP/Old Age Psychiatry wards rounds & detailed formulations using the Newcastle model. It accepts YOD referrals for diagnosis and multidisciplinary support and runs a monthly YOD support group.

Dr Rebecca Davis, Consultant Old Age Psychiatrist, Surrey Heath CMHT-OP describes working in an integrated care system:

'I feel very lucky to be working in a part of the country where mental health services are seen as equal & valued partners in the care of older people with complex needs.

The commissioners recognised that we needed to expand our CMHT-OP to be able to deliver shorter waiting times, extend our hours and to be able to work flexibly across the primary & secondary care interface without strict referral criteria. This was resourced by doubling the allocated CMHTOP budget.

We are able to work with all our community health, social care and voluntary sector partners to develop joint care plans built around the patient's needs. The most complex patients are discussed at our community MDT and we are delighted that we now have data to show that these meetings are leading to a reduction in unplanned admissions to the local acute hospital.

Mental health team members also provide input to an innovative frailty panel that meets weekly to offer preventative and anticipatory interventions to those residents screened as being high risk.

It is really rewarding to be involved in preventative work for all older Surrey Heath residents, rather than just the patients we see face to face. As services become more stretched, we will need to equip all staff working with older adults

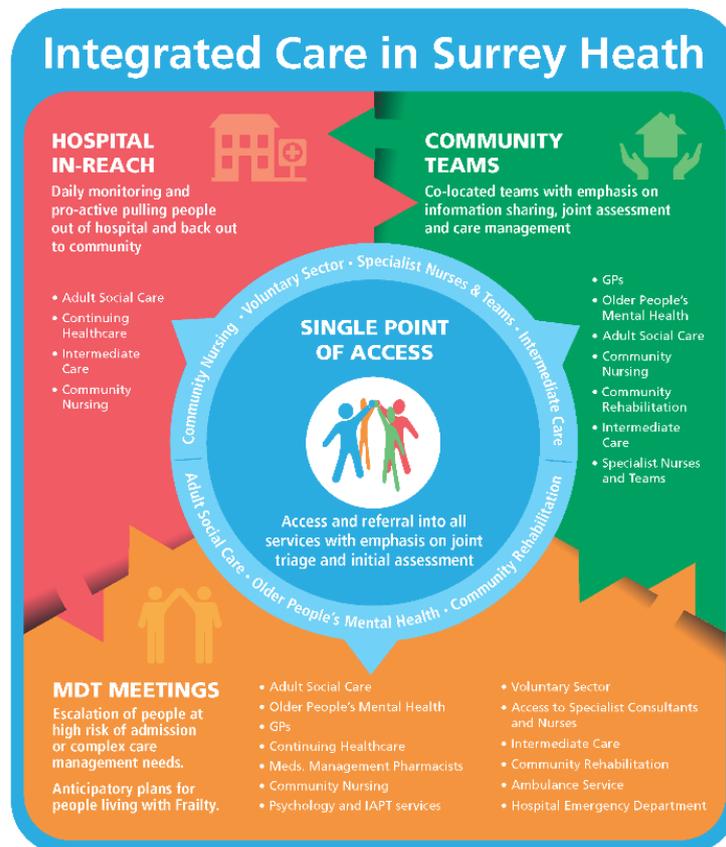
with key skills in the assessment and management of common mental health problems. By working alongside community colleagues, we have built up their confidence in screening for common mental health problems and helping to support patients with complex comorbidities.

We have focused on keeping all mental health staff within the CMHT-OP structure, rather than stand-alone memory services or primary care outreach workers. I think this 'critical mass' of staff enables the team to be efficient and responsive as well as providing good peer support and robust supervision.

Our integrated care model is now being replicated in other parts of the ICS within the Frimley footprint and has been attracting national interest. We were really pleased that the college named us 'Team of the Year' in the Older Adults category at the RCPsych awards this year.

I hope commissioners in other parts of the country will be able to look at what we have achieved in Surrey Heath and see the value in investing in mental health services for older adults.'

Please get in contact with Kate Jefferies, Kapila Sachdev and Joanne Rodda at oldage@rcpsych.ac.uk. Let us know your thoughts and experiences, and if you would be willing to get involved with this project.



New guidelines for driving with dementia or mild cognitive impairment

by

Paul Donaghy, ST6 Academic Clinical Lecturer in Old Age Psychiatry, Newcastle University and Gateshead Health NHS Foundation Trust

Kirsty Olsen, Research Assistant, Newcastle University

John-Paul Taylor, Senior Clinical Lecturer and Honorary Consultant in Old Age Psychiatry, Newcastle University and Northumberland, Tyne and Wear NHS Foundation Trust

The assessment and management of driving safety in people with dementia and cognitive impairment is a difficult issue for patients, their loved-ones and their clinicians. The role of clinicians is made more difficult by the lack of good research evidence in this area.

New guidelines have been developed by a working group including representatives from diverse backgrounds such as old age psychiatry, general practice, occupational therapy, Driving Mobility, lay members, the DVLA and the Alzheimer's Society. The purpose of the guidelines is to provide clinicians with an understanding of their legal and clinical responsibilities, as well as a framework on which to base appropriate management of those who drive with a diagnosis of dementia or mild cognitive impairment. The guidelines have been designed to provide assistance to clinicians rather than be prescriptive and can be adapted for local use.

The guidelines have been endorsed by Alzheimer's Society, the Royal Colleges of Psychiatrists, General Practitioners and Occupational Therapists, the Memory Services National Accreditation Programme, Driving Mobility and the British Psychological Society. Copies of the guidelines will be sent to Memory Services across the UK supported by a dissemination grant from Alzheimer's Society. An electronic version is available from <https://research.ncl.ac.uk/driving-and-dementia>.

Mental Capacity Bill amendment and Mental Health Act / interface update

by

Sharmi Bhattacharyya, Consultant Old Age Psychiatrist, and Clinical Lead, North Wales

Mental Capacity Bill amendment update

The Government published its Mental Capacity (Amendment) Bill with the first and second reading in Parliament on 3rd and 16th July 2018. The Bill amends the process for authorising deprivation of liberty. It focuses upon a version of the Law Commission's Liberty Protection Safeguards and attempts to reduce the bureaucracy and confusion associated with DOLS.

This update follows the previous update in September 2018 Faculty Newsletter (<https://www.rcpsych.ac.uk/pdf/Old-Age-Faculty-newsletter-September-2018.pdf>)

On the 5th September the House of Lords debated the first day of the Committee Stage of the Mental Capacity (amendments) Bill. The RCPsych briefed Peers about concerns focused on five areas of the Bill mainly about 16- and 17-year olds and about the use of the term unsound mind were discussed while amendments on 'registered medical practitioners', Section 49 and fluctuating conditions were likely to be discussed on the second day of Committee on the 15th October.

The Bill had its second day of Committee stage in the Lords on 15 October. There continues to remain increasing concerns around the Bill weakening safeguards for patients and not being fit for purpose. It appears that the government is keen for the bill to "move at pace" and for the next stage (Lords report stage, the final Lords debate) to take place within a few weeks.

Although no amendments were made, the Government indicated an intention to make a number of changes.

The Government has announced that it will be bringing forward amendments to the following:

- Extend the scheme to 16- and 17-year olds which the College had campaigned for.
- The term "unsound mind;" would be replaced.
- Government will work to introduce a statutory definition of deprivation of liberty.

Particularly important to our Faculty has been the concerns with regards to Sec 49 reports and the College had suggested an amendment on removing power under section 49 to call for reports to be written by NHS bodies. This was debated and Health minister has committed to speaking to Ministry of Justice about improving the situation but without removing the provision of Sec 49 reports.

With fluctuating capacity Government declined to legislate to allow a deprivation of liberty to continue if capacity regained for a short period of time where foreseen but did commit to include in Code of Practice and to consult on its development.

Importantly Government also acknowledged the importance of considering patients' wishes and feelings and changed approach here, after continued and varied concerns from a range of peers and stakeholders and so has committed to ensure that the patient should be consulted on.

The parliamentary Joint Committee on Human Rights issued a special report on the Bill. The committee is very clear that the Bill requires further changes to protect human rights of vulnerable people, reiterates its recommendation on clarifying the definition of deprivation of liberty and incorporating advance consent, calls for changes to prevent conflict of interest re. role of care home managers and rights to advocacy and access to information to improve (<https://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/news-parliament-2017/mental-capacity-bill-report-published-17-19/>).

Hence although some aspects of the debate on the bill is positive there continues to remain concerns about other aspects and our Faculty continues to stress the importance of our involvement in developing the Code of Practice for the Bill.

Mental Health Act/Mental Capacity Act interface update

The Faculty has been actively involved in providing case examples of difficulties in managing those who fall on the MHA/ MCA interface as well as responding to the options proposed by the interface topic group established by the independent Mental Health Act Review. In August 2018, initially 5 options were explored and then the interface topic group identified three possible options for drawing the line between the use of the MHA and the MCA to authorise deprivation of liberty in hospital for purposes of assessment and treatment for mental disorder and to set out how an 'objecting' patient would be treated under each of the three options under consideration by the topic group. The three options explored were

- maintaining status quo,

- maintaining the status quo, but, where the patient lacking capacity is not objecting, provide that only the MCA may be used
- providing a best interests test for determining which regime to use

Although we are unaware of the outcome, the faculty was involved and responded with detailed reasons for the pros and cons of each of the options suggested to ensure our Faculty voice was heard.

Choosing Wisely Programme

by

Dr Kate Jefferies, Consultant Old Age Psychiatrist, Surrey & Borders Partnership Foundation NHS Trust

I was very excited to assist Dr Daniel Maughan (Associate Registrar for Sustainability) and Dr Gianetta Rands launch the Old Age Psychiatry recommendations for the Choosing Wisely Programme at the Royal College of Psychiatrists International Congress in Birmingham in June 2018.

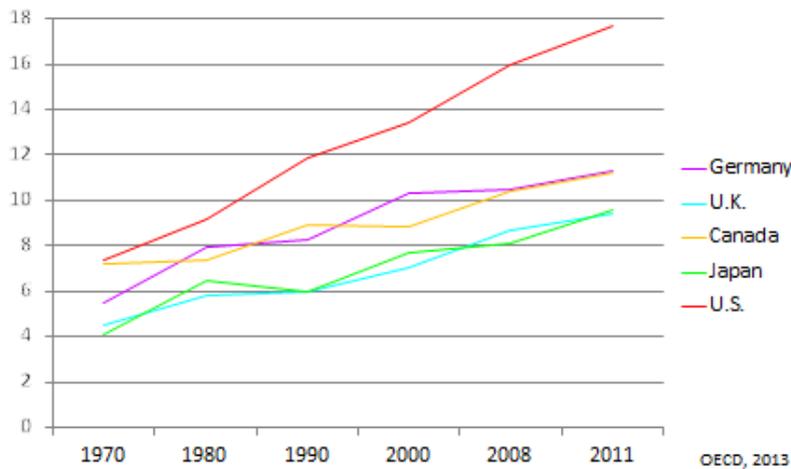
Choosing Wisely is a campaign that aims to help doctors and patients engage in conversations about unnecessary interventions and also to help doctors and patients make effective choices to ensure high-quality care.

Being based on the principles of being doctor-led, patient focused, evidence-based, multi-professional and transparent, this is a campaign that aims to minimise over-diagnosis and over-treatment. As Old Age Psychiatrists we are often in a position of reducing medication burden for our patients and ensuring treatments are not causing more harm than good. Thus, these principles are close to the hearts of Old Age Psychiatrists.

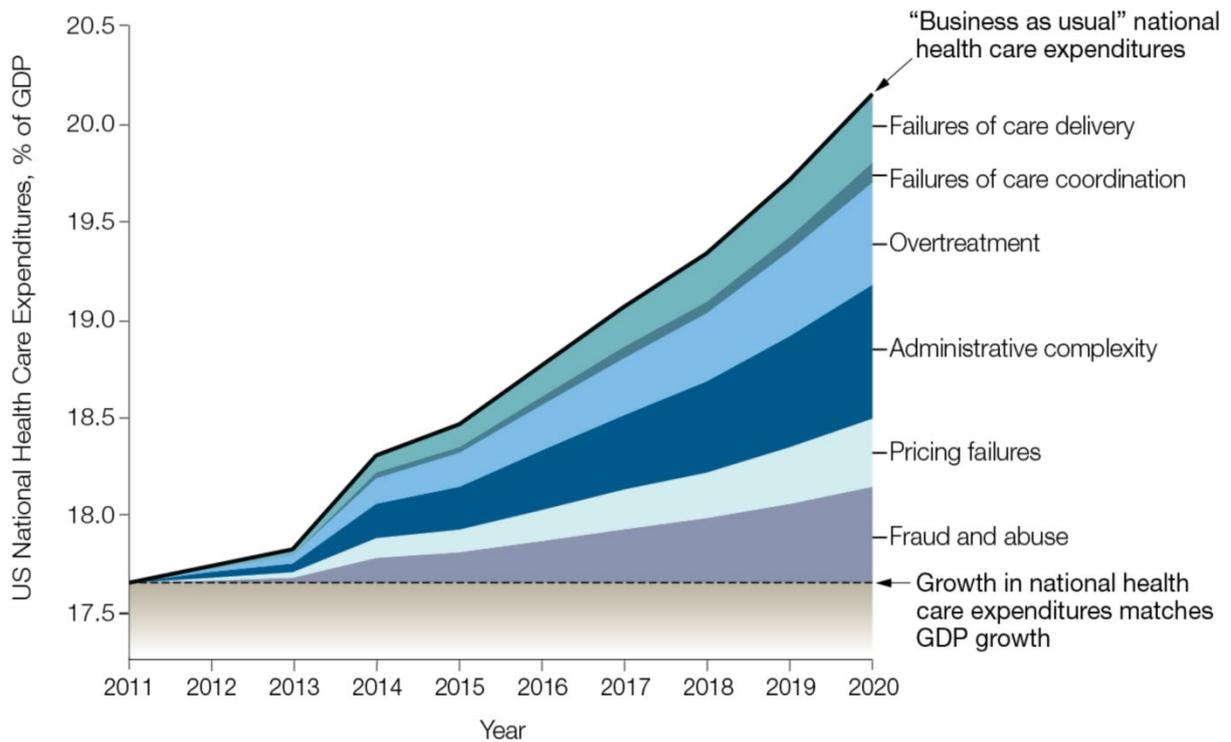
In addition to minimising the burden of excessive investigation and unnecessary treatments for our patients, Choosing Wisely will help us reduce unnecessary expenditure and hence ensure our limited finances are spent where they are most needed.

Total health expenditure has been rising year on year, see figure 1:

Fig 1 Total health expenditures as percentage of GDP (1970-2011)



Over-treatment contributes to these rising costs (see figure 2):



It's really exciting for our faculty to be leading the way on this international programme. There are also plans for the other faculties to compile their own lists of recommendations.

The Choosing Wisely Programme is led by the Academy of Medical Royal Colleges. The first lists were launched 2016 and the second round of lists in May 2018.

In 2017, the Old Age Faculty pulled together an initial list of 21 suggestions, and following a vote from the faculty members a final list of 10 recommendations was agreed, and these were the recommendations launched at the Congress (see box below).

RCPsych Choosing Wisely List – 2018
Recommendation 1 - Cognitive testing alone does not diagnose dementia. In order to establish an accurate diagnosis of dementia it is recommended to obtain a full history, collateral information from key family members and a cognitive assessment.
Recommendation 2 - Aim to use non-drug treatments for the management of behavioural and psychological symptoms of dementia.
Recommendation 3 - Do not forget pain as a common cause of agitation in patients with dementia.
Recommendation 4 - Antipsychotics can cause serious side effects in patients with Lewy Body Dementia. They should only be used under expert guidance.
Recommendation 5 - Careful consideration of the risks to patients, including the use of an anticholinergic burden scale, should be undertaken prior to initiation of anticholinergic medication
Recommendation 6 - Do not refuse patients access to a service, investigation or treatment solely on the basis of their age. Decisions should be based on need
Recommendation 7 - Management of older adults with mental problems should be guided by Old Age specialists , who are able to manage the complex needs of this population.
Recommendation 8 - The care of frail older adults with complex needs who need an inpatient admission, is best managed in an older person's specialist ward environment .
Recommendation 9 - Do not use physical restraints in older adults in hospital settings with delirium except as a last resort.
Recommendation 10 - If benzodiazepines or antipsychotics drugs have been initiated during an acute care hospital admission, make sure there is a clear plan to review their use, ideally tapering and discontinuing prior to discharge.

The recommendations encapsulate the principles of Old Age Psychiatry and I think you will agree are sensible and pragmatic.

There are many reasons why doctors have historically over-investigated, over-diagnosed and over-treated patients ranging from a belief it is what the patient or the referring doctor wants, a fear of being negligent or of being sued, a feeling that doing something is better than doing nothing, financial incentives or having always done so.

We are hopeful that this programme and the recommendations chosen by us will open the way for us to start having frank conversations with our patients about the pros and cons of investigations and treatments. We are also hopeful that this framework will support us as clinicians to not always offer every possible test and treatment, but to work with our patients to deliver the best care to them.

A Brief Summary - CR217: Young-onset dementia in mental health services

by

Dr Anitha Howard, Consultant Psychiatrist, Benham Hospital, Gateshead, NE8 4YL

There are 42,000 people living with Young-onset dementia (YOD) or early onset dementia, defined as the onset of dementia before the age of 65, in the United Kingdom. In 2016, joint guidance was produced by the Royal college of psychiatrists and the Alzheimer's society on the provision of services for YOD(CR135). CR 135 needed revision given the significant changes in mental health services as well as the evidence base underpinning the diagnosis and management of dementia, recent policy developments to improve better care and treatment as well as the increased public awareness of dementia. The revised report aims to complement the important work of the [Young dementia network](#) and key partners, such as the Alzheimer's society.

The report highlights that dementia in younger people has a different impact than in older people for a number of reasons including clinical, genetic, psychological, financial, social issues and can often have dependent children. People with YOD can present atypically or with distinct clinical phenotypes as well as have less common forms of dementia. Dementia in younger adults can often be misdiagnosed, under recognised and inadequately managed.¹

Most people with YOD receive their care from old age psychiatrists, predominantly in mental health trusts and while the report focuses on this setting, its core messages are equally applicable to psychiatrists based in acute trusts, or other psychiatric sub-specialties who may be involved in the care of people with YOD such as neuropsychiatry, intellectual disability, general adult and liaison psychiatry. The working group comprised a mix of professionals from different backgrounds including old age psychiatry, neurology, neuropsychiatry, intellectual disability as well as the Alzheimer's society and the Young Onset Dementia network. The report was also reviewed by people living with young-onset dementia (YOD). The report aims to cover the whole of the UK, but these issues are not unique to the UK.

The key message of the report is "*the needs of patients with YOD in the care of mental health trusts are best met by a dedicated specialised service*¹." The report recognises that people with YOD and their families can have complex

diagnostic, management and personal needs which require specialist services to make active links with other specialities and services.

The report hopes to inform the dialogue between commissioners, clinicians and managers regarding the unique needs of people with YOD and how to deliver services.

The report has summarised its recommendations under four headings:

1. Access to a specialised service with expertise to provide assessment and treatment to facilitate support.
2. Job planning for psychiatrists
3. Continuing professional development of consultants and trainees
4. Future research and strategic developments

Access to a specialised service

The report highlights the current level of provision of YOD specialist services in the country and why specialist services for people with YOD are required particularly given the complexity in diagnosing YOD. The report recommends services be person-centred and age appropriate, with clear referral pathways. Patients should be able to access a full range of appropriately trained multidisciplinary professionals with the right combination of expertise and training, but psychiatrists have a key role in diagnosing and managing the mental health of younger people with dementia. Specialist teams should work collaboratively with the patient, families primary care, statutory and voluntary/third sector providers as people with YOD will require support with employment, finances, driving etc. The report also discusses the core clinical functions of a specialised team as well how trusts can facilitate integration and collaboration by naming a senior manager as well as a named local clinical lead.

Job planning, continuing professional development, resources and training

The report offers advice to psychiatrists on job planning, continuing professional development (CPD) and training relevant to working in this area.

Diagnosing YOD can be complex especially given the cognitive symptoms that can arise in enduring mental health problems, sleep disorders, neurological disorder etc. CPD for psychiatrists working with YOD will need to include training in rarer dementias, neuroimaging, genetic testing as well as new diagnostic markers.

An important recommendation is the development of networks between psychiatrists and other colleagues in other specialities as well as other professionals working with YOD in the region. There are suggestions in the report on how training in YOD can be improved for trainees

The report signposts the reader to various resources, including the [Young Dementia Network](#), that are available to professionals and people with dementia.

Research and strategic developments

Research in YOD can offer key insights into the nature and potential treatment of dementia for all ages but research in YOD remains underdeveloped. The gaps in research are highlighted in the report and recommendations are made on how this can be addressed on a local, regional and national level by working with strategic clinical networks and other key stakeholders.

Looking forward, the report suggests greater integration and collaboration between key stakeholders could offer much needed strategic leverage to improve the quality and scope of services for people with YOD across the UK.

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Dr Howard was part of the working group involved in producing this report and would like to acknowledge Dr Robert Barber's help with this summary.

The latest evidence on older people's mental health: a quick update

by

Rugiyya Saeed, Trainee Editor, ST5 Old Age Psychiatry, Cardiff

"Research is to see what everybody else has seen, and to think what nobody else has thought."

Albert Szent-Gyorgyi

This update aims to highlight recent research in older people's mental health. The papers discussed below have been published in journals or online since our previous newsletter.

Adjunctive brexpiprazole for elderly patients with major depressive disorder: An open-label, long-term safety and tolerability study

Ulla Lepola, Nanco Hefting, Doris Zhang, Mary Hobart. *International Journal of Geriatric Psychiatry*. July 2018 (online first)

A 26-week interventional, open-label study that recruited 132 patients (≥ 65 years) with major depressive disorder and inadequate response to ≥ 1 antidepressant treatment from USA and Europe outpatient centers, to study the long-term safety and tolerability of flexible-dose brexpiprazole as an adjunctive treatment. Overall, 77.3% experienced ≥ 1 treatment-emergent adverse events of mild to moderate degree, with fatigue (15.2%) and restlessness (12.9%) having the highest incidence. Movement disorder scales and standard safety assessment (vital signs, laboratory tests, echocardiogram, physical examination) did not show any consistent clinically relevant findings. The Montgomery-Åsberg Depression Rating Scale showed a mean (standard error) efficacy change of -14.5 (0.9) from baseline. The authors concluded that long-term brexpiprazole adjunctive treatment was well-tolerated in elderly patients, with improvements in depressive symptoms and social functioning.

Anxiety as a risk factor of Alzheimer's disease and vascular dementia

Eva Becker, Claudia Lorena Orellana Rios, Claas Lahmann et al. *The British Journal of Psychiatry*. 2018. 213, 654-660

This meta-analysis explored the association between anxiety and dementia. It included longitudinal studies with a follow-up of at least 2 years that were published before January 2018, if trait or state anxiety was assessed at baseline, and excluding those where cognitive impairment was noted at baseline. Using a

random-effects model, the pooled time to Alzheimer's disease and incidence of vascular dementia was calculated, which showed a positive association between anxiety and Alzheimer's disease (hazard ratio 1.53, 95% CI 1.18-2.01, $p < 0.01$) and vascular dementia (odds ratio 1.88 95% CI 1.05-3.36, $p < 0.01$). Although, only two included studies explored the association between anxiety and vascular dementia, hence this result has to be interpreted with caution. Other limitations identified by the authors include a remarkable amount of heterogeneity and methodological limitations across studies.

Donepezil treatment in patients with depression and cognitive impairment on stable antidepressant treatment: A randomized controlled trial

Davangere P. Devanand, Gregory H. Pelton, Kristina D'Antonio et al. *The American Journal of Geriatric Psychiatry*. 2018. 26 (10), 1050-1060

This randomised, double-blind, placebo-controlled trial looked at the use of adjunctive donepezil for 79 patients with comorbid depression and cognitive impairment who were on stable antidepressant medication for 16 weeks (initially with citalopram, and then with venlafaxine if required). This was followed by the addition of donepezil or placebo for another 62 weeks. There was an improvement in depression in 63.93% with antidepressant medication within the first 16 weeks, but there was no treatment group differences between donepezil and placebo on dementia conversion rates (measured by Alzheimer's Disease Assessment Scale, Selective Reminding Test total immediate recall and Functional Activities Questionnaire). The addition of donepezil was associated with more adverse effects. Hence the adjunctive use of cholinesterase inhibitors in this patient group is not supported by this study.

Risk of dementia in long-term benzodiazepine users: evidence from a meta-analysis of observation studies

Q. He, X. Chen, T. Wu, L. Li & X. Fei. *Journal of Clinical Neurology*. October 2018 (online first).

A literature search of the publications on PubMed and Embase up to September 2017 identified 10 studies (six case-control and four cohort studies) that analysed the relationship between long-term benzodiazepine (BDZ) use and the risk of dementia. Using a random-effects model, the pooled rate ratio for developing dementia in older adults taking BDZ was found to be 1.51 (95% CI 1.17-1.95, $p = 0.002$). This risk was increased in those taking BDZ with a longer half-life (> 20 hours) and for a longer time (> 3 years). Hence, this meta-analysis concludes that long-term BDZ use is associated with an increased risk of dementia in the elderly population.

Cochrane Corner Winter 2018

by

Dr Jenny McCleery, Consultant Old Age Psychiatrist, Oxford Health NHS Foundation Trust, and Joint Co-ordinating Editor, Cochrane Dementia and Cognitive Improvement Group

Dr Ciaran Abbey, Consultant Old Age Psychiatrist, Oxford Health NHS Foundation Trust

This newsletter's Cochrane Corner covers two updated reviews. One, of general interest to Old Age Psychiatrists, is about polypharmacy in older people; the other asks whether anti-depressants are an effective and safe way to treat depressive symptoms in people with dementia.

Appropriate polypharmacy for older people

The population we care for is living longer, often with multiple co-morbidities and long lists of medication. Polypharmacy has been associated with multiple negative outcomes such as increased risk of hospital admissions, adverse drug events and mortality (Cahir 2010). However, polypharmacy may be appropriate for some patients. Potentially inappropriate prescribing (PIP) is a more nuanced concept which incorporates both the prescription of potentially inappropriate medications (PIMs) and potential prescribing omissions (PPOs). PIP is a risk for our group of patients. For example, a large study of community prescribing in Scotland in 2010 found 13% of older adults with prescriptions of more than five medicines and potentially serious drug-drug interactions (Guthrie 2015).

What interventions are available to help to reduce inappropriate prescribing? Cochrane's Effective Practice and Organisation of Care group has updated their review on *Interventions to improve the appropriate use of polypharmacy for older people* (Rankin 2018; <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008165.pub4/full>), last published in 2014. The authors found 20 studies to add to their original 12. Twenty-eight of the 32 studies were RCTs. Thirty-one trials used complex, multi-faceted approaches, referred to as pharmaceutical care. These interventions took place in a variety of settings in high-income countries and involved elements such as medication review, feedback to prescribers, and education for patients and prescribers. The one less complex intervention was a computerised decision support (CDS) system for GPs.

As is often the case, the headline finding was that, due to the low or very low quality evidence, it is not possible to be certain whether or not pharmaceutical care interventions lead to clinically significant benefits. Pooled effect estimates do suggest that there may be some effect on potential prescribing omissions and

inappropriate medications, but there is a high degree of uncertainty associated with all the results. NICE, in their multimorbidity guidelines, highlight the importance of appropriate prescribing (<https://www.nice.org.uk/guidance/ng56>). However, although there is no doubting the importance of the topic, there is no evidence to suggest we should be advocating for any particular approach to the problem currently. Interest in this area of research remains high. The Canadian website <https://deprescribing.org/> includes a number of interesting links and resources related to potentially inappropriate medications in particular, and is worth a visit.

Antidepressants for depression in dementia: appropriate or inappropriate?

To what extent are anti-depressants potentially inappropriate medications for people with dementia? An updated review *Antidepressants for treating depression in dementia* (Dudas 2018; <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003944.pub2/full>) may help to answer this question.

Depression in dementia is complex and not always easy to diagnose. This update of the 2002 review limited inclusion to studies which had used formal diagnostic criteria for depression as well as for dementia. The authors found 10 eligible studies, but were unable to obtain usable efficacy data from 2 of them. Refreshingly, this was a review which found some high quality evidence and hence could draw some conclusions with more certainty than is often the case in Cochrane reviews.

There was little or no difference between the antidepressant and placebo-treated groups in scores on depression symptom rating scales after 6 to 13 weeks (standardised mean difference (SMD) -0.10, 95% confidence interval (CI) -0.26 to 0.06; 614 participants; 8 studies; high quality evidence). This result held in the five studies which used SSRIs and regardless of the rating scale used to measure the outcome. For response rate at 12 weeks, there was an imprecise result and overall less certainty about any effect (antidepressant: 49.1%, placebo: 37.7%; odds ratio (OR) 1.71, 95% CI 0.80 to 3.67; 116 participants; 3 studies; low quality evidence), but the remission rate was probably higher in the antidepressant group than the placebo group (antidepressant: 40%, placebo: 21.7%; OR 2.57, 95% CI 1.44 to 4.59; 240 participants; 4 studies; moderate-quality evidence).

Participants on antidepressants were probably more likely to drop out of treatment than those on placebo over 6 to 13 weeks (OR 1.51, 95% CI 1.07 to 2.14; 836 participants; 9 studies; moderate quality evidence) and were more likely to suffer at least one adverse event (antidepressant: 49.2%, placebo: 38.4%; OR 1.55, 95% CI 1.21 to 1.98, 1073 participants; 3 studies).

What should we make in practice of a conclusion that antidepressants do not improve outcomes on depression rating scales, but that they probably increase short-term remission rates and probably cause more adverse effects than placebo? The review authors call for future research to take a finer-grained approach to the nature and severity of both dementia and affective syndromes to try to work out what – if anything – might work for whom. For now, I suspect it would be premature to consider antidepressants as always inappropriate in dementia, but we should perhaps think of them as potentially inappropriate and should redouble our efforts to ensure that non-pharmacological treatments are made available in our services. (See also our 2014 review on *Psychological treatments for depression and anxiety in mild cognitive impairment and dementia*: Orgeta 2014; <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009125.pub2/full>, currently being updated).

Proposed new research framework for Alzheimer’s disease

Finally, you are probably aware of the Research Framework on Alzheimer’s disease from the National Institute on Aging – Alzheimer’s Association (NIA-AA) (Jack 2018). The proposal made in this framework is that Alzheimer’s disease should be defined by biomarkers alone, without reference to a clinical syndrome. A stated aim is to improve the characterisation of clinical trial participants. In October’s edition of *Age and Ageing*, a group of editors from the Cochrane Dementia Group explain their concerns about possible implications (<https://doi.org/10.1093/ageing/afy167>). Do have a look and join the debate.

Get involved by joining Cochrane: <http://join.cochrane.org/what-you-can-do>. Cochrane Crowd is a great place to start (<http://crowd.cochrane.org/index.html>), or take a look at TaskExchange (<http://taskexchange.cochrane.org/>). Keep in touch through Facebook <https://www.facebook.com/CochraneUK> for updates. Follow the Cochrane Dementia Group on Twitter (@CochraneDCIG).

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Conference Review: Geriatrics 4 Juniors

by

Sophie Gascoigne-Cohen, Speciality Doctor in Old Age Psychiatry

[G4J](#) or 'Geriatrics 4 Juniors' is one-day conference aimed at junior doctors, Nurse Practitioners and Allied Health Professionals. Despite belonging to none of these groups, I thought it would be an informative conference to attend. My hunch was right and I would encourage Old Age Psychiatry colleagues to attend in future years. G4J was organised by the Association for Elderly Medicine Education ([AEME](#), pronounced 'Amy') and supported by the [British Geriatrics Society](#). In addition to delivering G4J annually, AEME produces a range of educational resources including [COTE podcasts](#) and [E-learning](#).



G4J 2018 was held on 24th November in central London and was a packed day of sessions about improving the care of older people in hospital and in the community. It teaches to the level of junior doctors rather than consultants and the organisers make an effort to keep the ticket prices down; it was definitely good value at a flat rate of £55, which included a decent lunch, a few free pens and a wonderfully enthusiastic lanyard with 'I love geriatrics' all over it.

The day was divided into three slots with optional sessions during lunch. There was no obvious theme, which perhaps reflects the generalist nature of geriatrics. The organisers encouraged people to keep their smartphones out to participate in live polls and to pose anonymous questions for the presenters, as well as to 'like' the questions already posted. This proved very effective and is an interesting transition from the roaming microphone.

The morning started with the session, 'CGA – Confusing Giraffe Animations? Crazy Geometric Algebra?', which was an overview of the less exotic but nonetheless important Comprehensive Geriatric Assessment. CGA is an evidence-based process to manage frail and vulnerable older people. It was likened to the geriatricians' stent or scope due to its importance in their toolkit. It sounded similar to a mental health care plan involving the MDT and prompted me to read about it to better understand its use in primary care. We then learnt about Parkinson's disease and common issues for junior doctors tasked with prescribing their medications during afterhours shifts or when there are difficulties with swallowing. Useful pointers included the [Parkinson's disease medications calculator](#) for inpatients who are nil by mouth and a reminder that

delirium can be precipitated by initial high doses of rotigotine. We were encouraged to get involved in research, including via the [Geriatric Medicine Research Collaborative](#), which includes national delirium audits and would be relevant to Old Age Psychiatry trainees.

Throughout the day there were Q&A sessions about training as a geriatric registrar and what it is like to be the 'med reg' on call. While not relevant to those with no such aspirations, it was interesting to hear how trainees manage their challenging roles and their reflections on how they navigated difficult situations on call. These sessions were popular and may be worth replicating at RCPsych conferences to address concerns of junior doctors considering higher training.

At lunch we were encouraged to go to the 'World Café' to view the posters and talk to delegates manning various stalls. It was reassuring to see a mental health presence with a stand about careers in Old Age Psychiatry. Mental health was also an issue raised by the [UK Parkinson's Excellence Network](#). Their report, [Improving management of mental health in people affected by Parkinson's](#), and [free online learning pathways](#), whose target audience includes psychiatrists, were useful discoveries.

There were clinical talks throughout the conference, all of which had useful tips for Old Age Psychiatry. 'My patient won't eat!' covered practical approaches to managing malnutrition, directed us to the guidelines by the European Society of Clinical Nutrition and Metabolism ([ESPEN](#)) and touched on the benefits of communal dining for appetite stimulation. 'Dizziness, which way do I turn?' gave us an overview of key clinical examinations and treatment. There was, of course, a session on delirium, which reinforced that it is common, devastating and needs better management. Some of its many take-home messages included handy screening tools, such as the single question in delirium (SQuID) and the [4AT assessment](#). Common medicolegal issues were covered in the session, 'I've got power of attorney', with a helpful overview of the Lasting Power of Attorney forms as well as consideration of complexities inherent in other legal instruments. All the speakers reinforced that you are not expected to address difficult medicolegal and clinical issues on your own.

The day concluded with 'Polypharmacy the Musical'. We were given 10 tips to improve prescribing practices, all illustrated by a pertinent music clip. If you take nothing else from this review, look at [Bohemian Polypharmacy](#), the music video by James McCormack. A parody of Queen's Bohemian Rhapsody about evidence-based prescribing makes for an unexpected but clever ending to a conference dedicated to caring for older people.

Book review: Hour of The Bees

Author; Lindsay Edgar

ISBN: 978-0-763-691202

Published by: Candlewick 2016

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'Things are only impossible if you stop to think about them ... '

Hour of the Bees is a magical debut novel from Lindsay Eagar in which 12-year-old Carolina enters her grandfather's confused world for the first time. What drew me to review this book is the target demographic: the publisher's recommended reading age is 10-14 years old. I was curious to discover how the author would broach the subject of dementia with a younger generation and the book opened my mind to the challenges this entails. How do families explain the irreversible changes in their loved ones? Possibly more importantly, how do children process this?

As her grandfather Serge requires more family support, Carolina must move with her family to stay with him at his rural New Mexico sheep ranch. Having never encountered Serge's premorbid personality, Carolina and the readers alike explore Serge's mental state through the eyes of a child.

By blurring the lines between Serge's fairytale stories, stories of the past and his delusions, Eagar creates a beautiful ambiguity to her story telling. Will the bees end the 100-year drought? Was there really a magic, life-giving tree? Carolina's attempt to understand this brings her closer to her grandfather than any of her family ever managed.

The book cleverly captures the often tense and complex family dynamics surrounding mental illness. The strains of duty and obligation are felt from the opening chapter. However, instead of the narrator, and hence the audience, being the one grappling with difficult decisions, we are simply observers along with Carolina.

Carolina's approach contrasts with the advice from the professionals. *'Help decrease the chance of triggering negative behavior or outbursts by keeping the environment structured and predictable'*. Seemingly sensible advice. But in the context of the story it seems impersonal and ineffectual. What really works is taking the time to know Serge and understanding what's important to him.

My only problem with the book is the ending, which ties up all loose ends into a convenient, fairytale ending. I would have liked an ambiguous ending that left me with questions to ponder long after I'd turned the final page. We should remember, however, that *Hour of the Bees* is primarily a storybook. If you lost the concrete, fantastical happy ending, you may also lose the connection to the 10-14 year old audience.

This is a lovely, mysterious coming-of-age story that I devoured in 2 days. On reflection I think this book highlights how the medical profession could do more to include the youngest generation in mental health awareness and demystify the dementia diagnosis.

The [Dementia Explained](#) website developed by Alzheimer UK was a runner up in the BMA Patient Information Award last year. It is worth a look for advice and resources that teens can explore at their leisure.

Book review: Living with Dementia; Relations, Responses and agency in everyday life

Edited by; Lars-Christer Hyden and Eleonor Antelius

ISBN: 978-1-137-593740

Published by MacMillan Palgrave and available as an E-book and in print

Dr Anitha Howard, Consultant Psychiatrist, Benham Hospital, Gateshead, NE8 4YL

There are many books about dementia but Living with dementia offers a fresh new view. The contributors come from a range of backgrounds including experts in sociology, interactional analysis and anthropology and uses a variety of sources including media reports, historical accounts as well as research and transcribed conversations of real therapeutic encounters to demonstrate a unique perspective.

Concepts, such as 'Citizenship' to encourage people with dementia in self-determination are well argued and convincing. The effects of migration in people with dementia as well as in BME and its impact are particularly relevant with the changing demographics in society.

The section on communication and collaboration in dementia discusses in depth the way people with dementia with carers and professionals including discussing the diagnosis.

I found the chapter the chapter discussing the perceived loss of self through the real-life suicide of Gillian Bennett who had dementia, thought provoking and relevant with the ongoing debate about euthanasia.

I would recommend this book to anyone working with people with dementia who would like a different view on caring for people living with this illness.

Book review: Somebody I Used to Know

Author: Wendy Mitchell

ISBN: 978-1-4088-9336-4

Published by Bloomsbury Publishing Plc. 2018

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Dementia could affect any of us...

Have you ever asked yourself what it really feels like to have dementia? What the emotions are you would experience?

As I am now in the age group when dementia may affect me this issue has suddenly become more pressing for me.

When I was a junior trainee in psychiatry, seeing patients with dementia seemed something so far removed from my reality. I certainly turned a blind eye to their emotional distress.

Now I find myself wanting to open up my emotional world to my patients and try to understand their reality and what might be my future reality.

Earlier in the year I was listening to Radio Four and heard an extract from this book. I eagerly ordered it and read it over a few days. I found myself in tears at times and certainly think I do have a better understanding now. I urge all old age psychiatrists to also read this book which will give them a better insight into their patients.

Emotions and dementia:

The negative ones...

Wendy Mitchell was diagnosed with young onset dementia at the age of 58 in 2014. The book tells her life story before dementia, leading up to diagnosis, and how she has lived with dementia. She speaks to her former self before dementia and the self she is desperate to hold on to or at least the memories from that time. Her biggest fear is not remembering her two daughters. "When did you decide that I was to live a different life without all the bits that made me me?"

She describes dementia as being "a thief in the night, stealing precious pictures from our lives while we sleep." She worked as an administrator and team leader

in the NHS and prided herself on her good memory. Yet, this was now the thing that was letting her down.

She grieves her losses: running, baking, driving, cycling, working, social contacts. She grieves her future losses: "not remembering loved ones."

She describes many emotions with her dementia: sadness, frustration, anger, visceral grief. She describes fear of a "blank", "black hole", "confusion" – "Fear seemed so far away like tiny dots on the horizon that once I would have to squint to see. Dementia sent me hurtling towards them."

She talks about the guilt of what dementia does to relatives and what it "takes from them."

Wendy describes also the helplessness and the sadness. The impotence, lack of control. Then the hopelessness and dark feelings. She questions herself "Can I go on?"

The most vivid part of the book for me was when she describes being at work and suddenly "my brain was cloudy, a fog had descended, like the peak of Scafell Pike on a clear day where one minute I could see for miles, and then suddenly a chill in the air indicated the clouds were forming." She describes this day as "the moment you left." She walks around unable to recognise her surroundings, her office, her own name on her office door. The fear and panic she describes is palpable and a glimpse into this world we perhaps would rather not know.

The positive ones...

For Wendy, she finds many positive emotions with her dementia diagnosis.

As her concrete memories are eroded, she still has her emotions and therefore her connections with others. This is particularly so for her daughters with her love for them.

She enters research trials and gives her brain for research. As parts of her are taken away by dementia, this part of her will keep going.

She is active with her local dementia support group. She gives lectures about living with dementia and bravely travels the country to do so.

She appears on the Victoria Derbyshire show; "another opportunity thanks to dementia diagnosis." She makes lists of the advantages of having Alzheimer's.

I was humbled by her bravery and comforted by her positivity in so many ways.

Is the NHS letting patients with dementia down?

What I found most sad as a psychiatrist working in the NHS assessing, diagnosing and treating patients with dementia is her experience as a patient in the NHS of doctors.

She says "I feel broken and abandoned , discarded by an NHS that I worked in for twenty years." "I feel abandoned by the doctors who diagnosed me." She describes medical professionals: "they just didn't get it", "...health care professionals whose ignorant responses distress us."

Most memory clinics now diagnose patients and give minimal support before discharging them back to the GP. This is what Wendy experienced.

Like the service I work in, Wendy found that the people who were left to support her and understand her emotions were the Alzheimer's society.

In our climate of financial constraints, are we being lead down the dark path to nowhere with our patients that leaves them feeling lost? I hear myself saying to patients "Your GP can always refer you back in to our service", "You can always call the dementia helpline." Yet the word "discharge" is heard certainly by Wendy as "abandoned" or "discarded."

If you are prescribed medication for your dementia you may be one of the lucky ones who has ongoing support.

When I read Wendy's experience I was left having to face the emotional reality for patients of the service we provide. I feel ashamed to be part of this.

Can we as a profession change and learn from this book?

What I have learnt from this book is that I should not be afraid to be aware of patients' emotions even if they are difficult and painful.

In our current economic climate we need to be more creative with how we offer ongoing support to patients with dementia after diagnosis that leaves them feeling supported in an ongoing way in a system that responds to all of their needs. So perhaps we need to continue seeing them not just to change their medication or because they have been challenging for their relatives but because they need our ongoing emotional support too.

Let us together change the way our NHS treats patients with dementia and improve their futures. After all, this may be our future being treated for our dementia.

The Indelible Fade

By Dr Mohammed Khan, CT2, General Psychiatry
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My heart did pierce the sedated sky,
Like screeching lightning, at night;
My heart did storm the parched lands,
Like tempestuous rivers, with might!

My vision did trespass distant dreams,
Relentlessly, astride my boundless sight;
My strength did pervade engulfing jaws,
Effortlessly, winning each suffocating fight!

Remains now, the ageing last lap,
Withered body with its crumbling height;
Tearful eyes, mourning the long forgotten,
And unstable feet nervous to set right!

Age did turn the storm, into a silent drizzle,
Neglected and vulnerable, buried in the plight;
Though not all that's buried is dead,
Seeds do sprout again, when it gets bright!

So let not this darkened masquerade,
Make you ignore, my raging light;
My singing soul, my yearning heart,
Spread wings, awaiting another flight!

The Dementia Poem

By Asha Dhandapani, CT1, Psychiatry trainee, Wrexham Maelor Hospital, Wrexham

I know I cannot remember!!

I know I ask you to repeat again and again,

I know I had just toppled over again.

I know I am fidgety, and broke something dear to you

I know I am clumsy which could dishearten you

Please don't despise me for that!!

Am I the one to be blamed?

See me not as old and wrinkled skin,

But, as the strong one who toiled every day.

See me not with pitiful eyes,

But, with love and affection alone.

See me not as an ever demanding soul,

But, as the one who wants to be heard

Am I the one to be blamed?

All that I pray is for a loving hug,

A loving hug to keep me warm.

All that I pray is for a helping hand,

A helping hand to guide me, as I am lost.

All that I pray is some more of your time,
As I want you to be to the end of my life



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