

Old Age Psychiatrist (64)2016

Old Age Psychiatrist Newsletter of the Old Age Faculty of the Royal College of Psychiatrists

January 2016 Issue 64

Editorial Team: Helen McCormack, Sharmi Bhattacharyya, Anitha Howard

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Introduction to the new Editorial Team.

Helen McCormack, helenjmcormack@hotmail.co.uk

We are pleased to be able to introduce to you a new editorial team for the Faculty Newsletter. We would like firstly to extend our thanks to Claire Hilton , who has so ably edited the newsletter for the last three years. It is a testament to what she has done that it is taking three of us to take on the role in her place! We would also like to thank Dave Rigby, Trainee Editor, who is also standing down. We will be looking to recruit a new trainee to the team; more of that in a moment!

In the first year as a team, Helen McCormack will take on the role as Lead Editor, and we will rotate this position in future years.

Helen McCormack is a newly retired Old Age Psychiatrist, and has worked as a Consultant for twenty one years, initially solely in Clinical practice, but in the last decade as a Clinical Director for Older People Mental Health, and latterly Medical Director. She also works for the Mental Health Tribunal Service, the General Medical Council as a fitness to practice panellist, and the CQC as a specialist adviser. She is particularly interested in Integration of care and its impact on older adults, and the leadership role that we as Old Age Psychiatrists have.

Dr Sharmi Bhattacharyya has been an Old Age Psychiatrist in Wrexham, North Wales since 2013, having previously worked as a Consultant in Wolverhampton since 2007 both jobs having a specialist role in Young Onset dementias. She has a Masters in Medical Ethics and Law and is an Honorary Senior Lecturer at University of Chester. Her interests are mainly in mental health in BME communities, Young Onset Dementias and legislation around the Mental Health Act and Mental Capacity Act.

Dr Anitha Howard is an 'old fashioned' sector Psychiatrist and has a special interest in Young Onset Dementia. She has been a Consultant with the Gateshead NHS Foundation Trust since 2006, after completing training in psychiatry in the North-East of England. She is the lead Consultant for the Young Onset Dementia in Gateshead and enjoys working with one of the few comprehensive services for Young Onset dementia. She would particularly like to encourage trainees and Consultants who normally would shy away from writing to contribute to the newsletter. She would like to broaden our book reviews to include fiction and nonfiction books that touch upon the common issues dealt with in old age psychiatry.

The new editorial team wishes to build on the success of the newsletter to date, and would welcome suggestions as to what we might cover in future issues, and submissions from across our profession and beyond. We have been discussing the following ideas:

- To run a series of articles and interviews with retiring or retired Old Age Psychiatrists. This will include high profile colleagues, and 'jobbing ' psychiatrists, as both can be inspirational to people considering Old Age Psychiatry and those early on in their careers. We are undertaking a joint piece of work which has been initiated across the College with a senior Trainee, Dr Kuljit Bhojal who would conduct interviews with retiring Psychiatrists for publication in the newsletter.

- To run a series of features on subjects of particular interest, such as DOLs, Integrated care, Young onset dementia. Suggestions for other topics would also be welcomed.
- To encourage more trainees to write for the newsletter and encourage non academic minded Consultants to write articles and book reviews.
- To encourage professionals from other disciplines to write about their experiences of working with Older adults
- To open the book reviews to include fiction and popular non -fiction as long there is a link or theme to psychiatry particularly old age e.g. Elizabeth is Missing.
- To strengthen links with the British Geriatric Society, and to commission articles that can be published in their newsletter and vice versa.

As a new team we are fortunate to be geographically spread, and to have worked in a variety of different services. In order to complete the team, we are looking to recruit a new trainee editor. We are interested in hearing from any trainee who would like to become a member of the editorial team. Trainees usually serve for a period of a year, and we welcome people from any geography, with us meeting in person when possible, but virtually on a regular basis. If you are interested please contact me at helenjmccormack@hotmail.co.uk.

Integration of Care for Older Adults with Mental Illness. Does it matter, and do we need to be leading it?

Helen McCormack, Mark Rickenbach

'The bomb shell dropped quietly, amidst a rag tag integrated care team meeting, as a throwaway comment. "You might want to employ me as your mental healthcare nurse to do dementia reviews" "Why I asked?" "Because they are planning to discharge all follow up of dementia care". I laughed nervously, slightly incredulous. Our mental health services had changed over the last few years, but patients could still rely on occasional contact with a mental health nurse to pick up on problems. They were able to pick out when our at risk elderly patients, struggling on their own, crossed the self-care barrier into decline.

As GPs, we had already noted the diminution of consultant contact. In the past we could call our trusted, named, and known consultant lead, who could advise on drug management, with the familiarity of past patient contact. Like us, as GPs, they had a backroom store of knowledge built up from occasional contact with their local list of patients. They did not manage every patient, but were supported by a team who knew them well. This consultant arrangement has gone now with staff changes, part time work and shift cover. We had come to rely more on our experienced mental health nurses. More of a group than a named individual, but none the less well informed and working well as a communicating team. Reliable and experienced. Suddenly this was also being taken away.

Now the at-risk isolated elderly at home could lose their point of contact for co-ordinated social and mental health care issues. The GP in the seven working minutes of a ten minute consultation will be left to sort out the care issues of both the patient with mental illness and their stressed, often elderly carers.'

There are the words of my long time friend, GP colleague, and professor of education, Mark Rickenbach. They are a personal perspective, but it breaks my heart that this is how some of our colleagues see integration in practice. Mark is currently attempting to address his local issues with a multi-speciality care provider (MCP) application for an integrated care clinic. It is hoped this will bring mental health nurses, consultants, GPs, social services and the voluntary sector together for a shared clinic each week.

I am interested in integration of care and the impact it is having on the wellbeing of older people who have mental illness. Many of you will have responded to a questionnaire I sent out some months ago, the purpose of which was to understand better what integration means around the UK, what is in place in different areas, and what the impact is. I found a hugely mixed response, with some people telling me of really good, innovative, joined up practice, and others reflecting the situation that Mark highlights above.

My anxiety has been that if we leave the future of integration to this evolutionary process, there is a risk that many people around the UK will not have access to the services they need, and it may then be a monumental undertaking to rebuild those services. There is evidence of successful models, but it is currently difficult to find that evidence, either in the literature or from our colleagues.

The Old Age Faculty of the Royal College of Psychiatrists shares my concern about this, and has identified it as a priority area in the months ahead. We are going to write a review of the available national and international literature, and to look at some examples of successful practice around the UK, so that we as Psychiatrists and as a Faculty can have evidence at our fingertips. I believe we have the expertise and the commitment to lead the future for our patients, and I hope this work give us a little more power to our elbow.

I am aware that there is good work going on around the UK, not necessarily written up in the literature. Part of this work, therefore, will be to describe a sample of those services to supplement the literature review. Many people have been in touch with me already, but if you have a burning desire to tell me about your service, please contact me on helenjmccormack@hotmail.co.uk.

Mark Rickenbach, FRCP FRCGP PhD FHEA, Visiting Professor Healthcare and Education Quality, Winchester University, General Practitioner and GP Trainer and Appraiser, Hampshire.

Helen McCormack, Consultant Old Age Psychiatrist, Executive member, Old Age Faculty, Royal college of Psychiatrists.

**Medical Psychotherapy faculty conference 2016 sponsored by the Old Age Faculty
'Attachment theory across the life cycle'**

We would like to welcome you to the annual Medical Psychotherapy faculty conference which this year will be held in Weetwood Hall in Leeds on the 13th to 15th April 2016. This is an open conference for medical psychotherapists, Old age, general and perinatal psychiatrists and will also be of interest to non-medical psychotherapists. The conference title is **'Attachment theory across the life cycle'** and is being run in conjunction with the Old Age faculty and sponsored by BPC, UKCP and APP. Invited speakers will address new research paradigms and new ways of working in psychiatry and psychotherapy focusing on the application of attachment theory.

On the first day, internationally renowned speakers on Attachment theory (Professor Peter Fonagy, UK; Dr Steve Suomi, USA; Jeremy Holmes, UK) discuss the clinical challenges and opportunities thrown up by recent advances in Attachment theory. On day two, applications of attachment theory across the life cycle will be discussed. Presenters include Dr Andrew Balfour and Dr Sandra Evans (applications in older adults) and Dr Amanda Jones (applications in the perinatal period). We are looking forward to an exciting and interactive programme.

2016 Conference organising committee

Update from Alistair Burns, NHS England's National Clinical Director for Dementia and Older People's Mental Health.

There have been some developments in the last few months which I think will be of interest to readers of the newsletter.

The Mental Health Task Force is due to publish its findings in the next few weeks (by the time you read this, it should have been published) and the work of the Task Force has explicitly been across the life course. The Mental Health Task Force reports for all Arm's Length Bodies and so not only includes NHS England but also Health Education England, Public Health England, NHS Improvement and the Care Quality Commission.

There was a wide consultation to the task force's call for comments, with some 20,000 people responding. The generic issues from the consultation will be familiar to everyone and are around things like skills of staff, access to services and equality of provision. Many of the issues raised in terms of general psychiatry, are equally applicable to older people. We await the publication of the report with interest.

Aside from the work of the Task Force, there are three issues which are currently foremost in my mind, and I would consider important for us as a profession to tackle. First, the clinical rationale and evidence base for the recognition and treatment of depression in older people. I think it is fair to reflect that the therapeutic nihilism which often accompanies depression in older people among some professionals is not dissimilar to that which can surround dementia. The assumption that depressive symptoms in the presence of physical ill health or impoverished social circumstances is understandable and, therefore, that they do not merit treatment is still prevalent. Identifying

people with depression is crucial and there has been a suggestion that there be an older person's depression CQUIN in general hospitals similar to the dementia CQUIN. Even its critics would acknowledge that this has garnered support and has raised the profile of Dementia. It could be that a similar three stage approach of identifying depression, assessment and then treatment and referral could be helpful.

Second, loneliness. We all know that loneliness and isolation, although strongly associated, are not the same; the former referring to separation from contact, with the latter representing the subjective experience (1). Around 10% of older people feel lonely but up to three times that figure will experience loneliness some of the time. It has been said that loneliness has the same effect on your health as smoking 15 cigarettes a day. Loneliness increases with age and to have children but no contact with them makes you feel more lonely than having no children at all.

Third, the issue of ageless mental health services for older people. James Warner and I have suggested that this is an important issue and have recently written something (2) and quoted some of the facts about mental health in older people.

- In a 500 bed general hospital, on an average day, 330 beds will be occupied by older people of whom 220 will have a mental disorder, 100 each will have dementia and depression and 66 will have delirium.
- For every 1,000 people over the age of 65, 250 will have a mental illness, 135 will have depression, of which 115 will have no treatment.
- 85% of older people with depression receive no help from the NHS, and older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication.
- The number of older people being treated in the improving access to psychological therapies (IAPT) programme rose from 4% to 6.5% (2008/9-2013/14), still short of the articulated goal.
- While 50% of younger people with depression are referred to mental health services, only 6% of older people are.
- Around 10% of older people experience loneliness which can be a symptom course of depression – loneliness has the same health effects as smoking 15 cigarettes a day.
- 20% of men and 10% of women are drinking alcohol in harmful amounts – the latter is a 100% increase over the past twenty years.

We have addressed the recent study which showed that older people's needs are not met as well in generic services making the case for a specialist old age provision (3).

In terms of dementia, we have now, to all intents and purposes, achieved the two thirds diagnosis admission nationally, which is great news (the current figure is 66.5%). Thank you to everyone who has contributed to this significant piece of work. It allows us now to adapt the conversations about dementia towards looking at diagnostic support and the benefits that brings. I am sure everyone would agree that should be a priority for us and that post-diagnostic support makes the big difference to people with dementia and their carers.

Along with that we have the opportunity to look in a slightly different way at what we are doing in dementia and we have begun to socialise the idea of the wellbeing pathway i.e. if we started with one of the five things we could do with dementia and their carer's we have developed the ideas of:

- preventing well
- diagnosing well
- supporting well
- living well
- dying well

These align neatly with the dementia 'I' statements and the various NICE guidelines and quality standards and also the Prime Minister's challenge on dementia and the OECD (The Organisation for Economic Co-operation and Development) which has taken an international interest in dementia.

Finally, I am a bit short of pictures these days (for a number of reasons) but found this one on my phone. It is clearly from a country railway station in a place that I was visiting but I have forgotten where. Does anyone recognise it or has the pictorial forensic skills to identify it?



So, interesting times as always and I look forward to any thoughts or comments you have at Alistair.burns@nhs.net.

Alistair Burns, National Clinical Director for Dementia and Older People's Mental Health

References;

1. http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true
2. <https://www.england.nhs.uk/2015/10/09/mh-better-access/>
3. <http://bjp.rcpsych.org/content/early/2015/09/10/bjp.bp.114.145706>

Update from James Warner, Faculty Chair.

I am delighted that the faculty continues to go from strength to strength and has been busy tackling a number of important issues. A huge amount of work has gone into the comprehensive faculty response to the **Law Commission consultation about deprivation of Liberty Safeguards**. Led by Gianetta Rands and Adrian Treloar, I think the faculty produced a cracking, well-argued and comprehensive report.

Thanks to our friend in the House of Lords, Baroness Elaine Murphy, (who has just been awarded the faculty Lifetime Achievement Award- well done Elaine!), we also have a second meeting with the Law Commission in early December to hammer home our points.

Of all the emails I get from faculty members (and I do try to respond to each one personally) concerns about **ageless services** remains the most common issue raised. Over the last couple of months we have seen publication of new research in the BJPsych (with an accompanying editorial setting out our arguments against agelessness) and have written to all CEOs urging them to abandon ageless services. Alistair Burns and I co-wrote a blog published on the NHSE website, so we have implied backing there too. You can see the blog here: <https://www.england.nhs.uk/2015/10/09/mh-better-access/>

We are conducting a follow up **national survey on the state of services** in November 2015. With the help of two trainees, Krish Vedavanam and Bart Matras and a medical student, Seb Zaidman, we have designed a questionnaire that is much shorter than the 2012 initial survey, but will identify the current state of play and impacts of ageless services. Results will be presented at the next annual conference. If you have not completed the survey yet, please do it now: <https://www.surveymonkey.com/r/35PCQZ7>

Together with Alistair Burns I have continued to advocate for a strong representation of old age psychiatry in the **Mental Health Task Force report** through our own submission and informing other stakeholders of our opposition to ageless services. This will be published soon.

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The executive Delphi exercise earlier this year identified **recruitment to the specialty** as the top priority for the faculty. Our FECC co-chairs, Alex Bailey and Victor Aziz have held a meeting to develop a strategy to improve recruitment. Latest figures are disappointing across the whole of psychiatry- old age does not fare worse than the other major specialties. But of course, it should be the most popular specialty by a country mile. You and I know that; we just need to communicate it to our trainees.

Following our representations to the **Centre for Workforce Intelligence** in the summer, Old Age psychiatry has retained its status with the UK government as a “shortage occupation” where the projected shortfall is so large it allows consultants in this specialty to enter the UK workforce from outside the EU/EEA. Only three consultant specialties meet these criteria: emergency medicine, radiology and old age psychiatry. Sadly, a straw poll of the executive suggests we are not recruiting talented people from overseas to fill posts. If we continue to wear such a big shortfall that is just another reason for commissioners and providers to ditch the specialty!

We should be optimistic. I was at the OA trainees annual residential conference this month and the enthusiasm and atmosphere in the room (about 40 trainees!) was palpable. We just need more of them!

You may recall that we have been fighting the discriminatory practice whereby a trainee in an adult liaison post will receive **endorsement in liaison** but a trainee in an OA liaison post does not. The curriculum has been re-written and submitted to the GMC. I had anticipated that would be the end of the matter but the GMC has requested changes. We will continue to fight this battle until our trainees are treated equally.

Finally, remember the elections are coming for the faculty executive and Chair/Vice Chair. Please make sure you vote and give your new representatives a clear mandate!

Best wishes, James

Faculty of Old Age Psychiatry Annual Conference 2016

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| Date | Wednesday 9 - Friday 11 March 2016 |
| Type | Conference |
| Venue | East Midlands Conference Centre, Nottingham |
| CPD | Up to 6 CPD hours per day, subject to peer group approval |
| Audience | Any medical health professional with an interest in old age psychiatry |

Directions | Programme (tbc)

[Register your interest](#) - An email will be sent to you once booking is open

The Faculty of Old Age Psychiatry of the Royal College of Psychiatrists looks forward to welcoming delegates to the 2016 Annual Scientific Meeting in Nottingham.

Competition: Careers in old age psychiatry: senescent or vintage? My reflections on choosing a speciality.

Dave Rigby and Claire Hilton

The September 2015 issue of *Old Age Psychiatrist*¹ included winning and shortlisted entries for the creative writing competition

Senescent or Vintage? My reflections on choosing a speciality

In this issue we include a selection of the others, excluding any we have been asked not to publish or which did not seem to us to fit the theme of the competition in any way.

Recruitment into old age psychiatry is an issue of increasing concern for the Faculty: the executive recently voted it the most important issue for the speciality's future. We asked you to write about your experience of working in the field, to help us explore the reasons why people are drawn into working in old age psychiatry, as well as some of the preconceptions that may deter people from pursuing such a career. We asked you to write about your thoughts about the speciality before working in it and how this changed with experience during the job. Creative and original writing was encouraged, up to a maximum of 800 words.

We were delighted and impressed with the high standard and variety of submissions, poetry and prose. We received 30 entries, from medical students to consultants. Much thought must have gone into writing them. Some people's personal journeys into the speciality were very moving. We both rated every entry, on criteria of originality, standard of writing, relevance and overall impression. We then asked our three judges – Tamar Hodes, David Jolley and James Warner (see September 2015 issue) – to select the best three of twelve shortlisted. We are now qualitatively analysing all the submissions to see if we can draw conclusions to help improve recruitment into the speciality. Because these are creative pieces, we have edited them only minimally, less than for more formal articles.

We have an apology to make. We have lost the contact details of the author who submitted an entry after the competition closing date (hence he/she was not included in our other e-mails). The entry comprised two parts: 'Teachings from phlebotomy' and 'The solitary figure'. We have not included it here as we do not have the author's agreement to do so. *But if you are reading this, please email claire.hilton@nhs.net if you would like it in the next issue.*

We would also like to thank James Warner, Chair of the Faculty, for letting us publish his poem although it was not included in the competition.

1

<http://www.rcpsych.ac.uk/workinpsychiatry/faculties/oldage/aboutthefaculty/newsletters/enewsletterseptember2015.aspx>

.....by James Warner

I always wanted to be a psych
Nothing else crossed my mind
But old age? well get on your bike
You wouldn't go far to find
Smelly wards, sad old staff
It sounded such a grind

My second job at Liverpool Royal
Robin Philpott's crew
Acute old age psychiatry
It chilled me through and through
My first day there; oh what a joy
The rumours just weren't true

I recall one tortured German soul
He was so very low
Parkinson's Diabetes and AF
Did not help his woe
But nurturing staff (and ECT)
Helped the depression go!

In those days there no forms to fill
Bureaucracy now is bad
Today's tsunami of admin
Simply drives me mad
But if we put our patients first

Work does not seem that bad

So what's so good about old age?

Well first, there was no smell

Everyone was just lovely and

Had great stories to tell

The staff were very caring;

The patients got so well!

So down with ageless services

They drive me round the bend!

Get every person in the land

To help reverse the trend

Our patients need our specialism

To get them on the mend

Essay

Andrew Aziz

As a 10 year old, my lasting memory of my grandmother's Alzheimer's disease was, during one visit to her house, that of her repeatedly asking my mother every 10 minutes 'Where is Nagui?' Despite being informed that Nagui, my Dad was back working in the UK my grandmother could not recall it and we went through that question nearly 30 times in a 3 hour visit. In her last year of life, I remember the toll that it placed on my father, auntie and cousins. She didn't remember their names, where she was and at times accused them of poisoning her, and she had a constant desire to leave the house. I also recall my father ringing different UK psychiatrists asking for their opinion on what could be done and finding it difficult to be told that it was too advanced and that there was very little that could be done now. I remember how frustrating he found it, having to watch his mother decline in that way.

My grandmother lived in Egypt and so obviously the healthcare/welfare system is very different to the UK. As a well-off family in Egypt we were fortunate enough to be able to afford diagnostic tests such as an MRI to enable us to diagnose the Alzheimer's. Numerous poverty stricken families in the developing world will not be sure what is going on, and do not have access to psychiatrists or

medical help. The cost of seeking medical help will be too much for them and so they will rely on lay beliefs and their own knowledge to help them work through their own situations.

So when I started Elderly Psychiatry I was really worried about the sad stories that I was going to see. In Egypt there are very rarely things like care homes/respice-care or care co-ordinators. These are all luxuries that sometimes we take for granted in the UK. For all its criticism following the Mid Staffordshire Enquiry or the recent scandal in obstetrics in Morecambe we are incredibly lucky to have a NHS which is free at the point of delivery. We must always remember that in the USA, a country we see as our aspiration, that the number one cause for bankruptcy is healthcare. In the year 2014, 2 million people in the USA, that is equivalent to 1 in 4 people in London, became bankrupt due to needing healthcare intervention.

Supportive measures such as care co-ordinators and care homes may not be the elusive cure we are looking for in dementia, but they support families and help them with coping through these difficult issues. They enable families to feel a bit more in control of their relatives' condition and make a very difficult burden seem more manageable.

In many foreign lands, families are both legally and culturally obligated to look after their relatives but in the UK we have a welfare system. I am always thankful for this welfare system as they have a duty to look after people who may have illness and no family to help them with these issues. I dare to imagine what would happen to these people who have no one to look after them if the state did not intervene.

Another topic is mental health awareness regarding elderly people, which is not commonly discussed. All the time now we see TV shows showing dementia - a mainstream show like *Grey's Anatomy* where a doctor's mother suffers with Alzheimer's or films like *Still Alice* showing the heart-breaking cognitive decline in a well-educated professor. This awareness is something we must keep promoting as it is essential in helping the general public gain more understanding. On mainstream news now as well, we are getting almost weekly updates on research and evidence. With smartphones being so popular, with an app like the BBC News, people are becoming better informed and have a greater understanding of the conditions.

There is much more open dialogue about mental health problems and this is very helpful for us, for instance, we saw that the political leaders in the lead up to the recent general election were discussing mental health separately from the acute medical sector.

In my time I have seen that families of patients with dementia now are googling the medications we start and discussing side effect. As doctors in elderly psychiatry, I do feel we are empowering the patients/relatives much more by being more open about anti-dementia medications and offering options. We are teaching them about the condition and explaining what can be done in terms of diagnosis and medication and about the non-curative element of dementia and the limitations that unfortunately we still have.

Prior to being a medical student, I can remember always thinking of depression and suicide as something that mainly happens to young males. I can recall very vividly as a younger person the suicide stories of Nirvana lead singer Kurt Cobain, and, a personal idol of mine, former Wales and Newcastle United footballer Gary Speed. What I did not realise was the high incidence of depression

and suicide in the elderly population. This is one thing I think needs to be better understood by the general public. There is much more awareness of suicide at younger ages, I believe, as it is seen as a waste of life, and physical health problems being more paramount in the elderly. One fact that will always stick in my mind is that, in a care home, 2 in 5 would qualify as being depressed.

We must educate and help recognise mental illness in the elderly quicker to help both patients and their family deal with mental illness more effectively.

Some personal reflections on old age psychiatry

Manorama Bhattarai

'Oh Mrs P, could you please tell me where you are going?' I said.

'I want to see Mark' 'Why has he left me like this? We need to go down to the picnic together', she said.

'Do you know where you are?' I said. Getting very annoyed Mrs P answers 'Now, what you getting at, we are in town.'

'If I were to say you are in a hospital, what do you think to that Mrs P?' I said.

'You must be silly, I am absolutely fine, thank you', she answers.

'Could you tell me who I am, Mrs P?' I said.

'Oh you are...you are...ohhhh... Why should I care?', she says getting irritated.

Here I was (actually emotionally) with someone who suffered from dementia and for the first time I felt as though I was beginning to be patient and learn from the interaction, having thought previously of dementia as being something too challenging to even think about whilst a foundation doctor. I had worked in the ortho-geriatric ward where there had been much exposure to patients with co-morbid dementia. The sense we had then was that we just deal with the medico-surgical issues as we didn't have time to deal with dementia, or rather even understand it.

A typical round in ortho-geriatrics (example of post op round):

'Bloods check; infection screen check; fluids check; wound check!!...hmm but not communicative...ohhhhhhhh she has dementia...seems we can't do much more for her... no life for her really!!!'

It was after the conversation with Mrs P on an old age psychiatry ward and reflecting on that which had sparked some feeling inside of me, to conclude that this speciality was made for me. I was beginning to appreciate the privilege of not only having the opportunity to observe the real dementia experience but also being able to learn from someone else's life experiences. It was true that Mrs P had lost her sense of orientation but inherent within her was the sense of deep attachment to her belated husband. To her, he was still alive.....within her heart and mind Mark was with her, giving her hope. This had touched me rather deeply. The reality came to sink in that

dementia is not about the forgetting but actually about the remembering!!! It was then the most important aspect of Mrs P had come out; one of the reasons that made her feel alive and there she was in her presentation desperately seeking that lost companionship.

Sometimes it is easy to think that one cannot learn from dementia patients, particularly the moderately severe (as in Mrs P's case) but the more patients I saw, the more I knew that they were the ultimate source of knowledge. Discovering the subtle ways of communication, the various expressions of fear, anticipation, and anxiety/worry and most importantly the smiles of friendships within the wards was rather fascinating. Mrs P had that sense of hope that kept her going; everyday she would walk in the corridor waiting for Mark to take her to the picnic. That sense of strong attachment had kept her away from the negative spiral of depression or other functional illnesses.

Thus I see a point in reminiscence; looking back at the pleasant memories in life keeps us going. In old age, there is this opportunity to look at the beautiful life stories of the patients and gain inspiration from them. We just need to look beyond the 'oh she didn't remember she had the tablets', 'oh no, she keeps putting her clothes wrong way around', 'Gosh, how many times do I have to tell her?' to 'I really wonder, what this experience must be like for her, Mrs P wants to see Mark; why is she so angry at the wait? What were they planning to do?' 'I am just so curious about her personality and her reactions; I'm really curious to see what her best moments in life were; I'm really edging to know how she made it so far; how she coped with her adversities; how she influenced others.' She sure influenced me as I got hooked into wanting to know more about her life story.

On the other hand, however, perhaps Mrs P could have gained even more hope and strength from having that personal insight that the power of her relationship with Mark was so strong, that he remained alive with her even when he could not be with her physically and nothing, even death could take that him away from her. That is the bit that I feel old age psychiatry is about; let's break the amyloid plaques and generate insight for our patients. Let's enable our patients to recognise that they can indeed be stronger and cope with physical loss; that they can BEAT their BRAIN.

My reflections on choosing a speciality

Stephanie Campbell

I had never considered a career in old age psychiatry before I was rostered to work on a dementia behavioural science ward during my first placement as a CT1. My initial reactions on discovering that I was to be placed there for six months were dread and uncertainty. I had little experience in an old age placement and wasn't sure what to expect in terms of roles and responsibilities. I had always thought that I would go into training in general adult psychiatry and was unclear how learning about non-pharmacological methods of treating patients with dementia was going to be of benefit.

When I began my placement, the consultant who would have been supervising me had just retired, and a replacement had yet to be found. For the initial few weeks my educational supervisor, who also worked in old age psychiatry, took it upon herself to step in and became my supervising consultant. She arranged to meet with me every week so that clinical issues that arose could be discussed and appropriate management plans put in place. Given that I had so little experience with psychiatry in general and in old age psychiatry in particular, with its often complex and challenging

group of patients and their care needs, I found this an invaluable help. The consultant was always able to offer helpful, guided advice and I felt supported as a trainee. She herself had been responsible for setting up an old age psychiatry liaison service in the adjacent acute hospital and allowed me to accompany her during several liaison assessments. By observing someone who had many years' experience in dealing with people with dementia I was able to learn effective means of communication with these patients, as well as gaining insight into the types of issues faced by both patients and their families. I had the opportunity to carry out several assessments myself under her supervision, which I received subsequent feedback for. I was able to learn about important areas, to ensure they were discussed during history taking, and memory assessments, and by doing so improve my own clinical practice.

Over time I gained more confidence in assessing and managing patients with dementia in various settings such as in the ward, clinic or on home visits, and began to realise the impact that could be made to both patients and their families lives by the addition of helpful medication and practical support. I found the cohort of patients endlessly fascinating to talk to as I enquired about their life history and found myself more and more rethinking my plans for a career in general adult psychiatry. I was fortunate to have a very helpful community team and ward staff who gave me expert advice (and at times a much needed cup of tea) when required, and made the placement a valuable learning experience.

When the time came to move on I had come to the realisation that I had found my calling. That was several years ago now and despite rotating through multiple subspecialties I am still firmly resolved to apply for a career in old age psychiatry.

The specialty of old age was once described to me by a consultant as 'the hidden gem of psychiatry', and I have come over time to appreciate the truth behind this statement. Whilst there are elements to the speciality that are at times challenging, being able to make even a small difference to the lives of the people we are treating and their families, who are generally always very thankful for the help, is very rewarding for me. I look forward to the future of this dynamic complex specialty and the potential advances which are being made. I will always be grateful for the initial support of my educational supervisor during my old age placement, without whose input I may never have realised what a rewarding career I was missing out on.

My reflections on choosing a speciality

Kate Day

Old age psychiatry services in Bristol are in the midst of massive change, and we are not alone. As they say, 'no one likes change' so what should I expect to find in my six month attachment in old age psychiatry but exhausted and over-worked staff working in teams fraught with low morale who feel as though they are fighting a losing battle? Or so you might think.

Without getting too involved in the political and managerial back story, modernising mental health reports led to the re-tendering of mental health services in Bristol with the aim of providing this large and multi-cultural city with a more focused yet flexible service including a separate pathway

for dementia care. This inevitably resulted in a large shake-up of services and concurrently the people working within them.

Being a psychiatry trainee and previously a foundation doctor I have had the pleasure of working within many diverse teams in a variety of environments each facing their own pressures; but never have I been involved with a team undergoing such extensive change as this. And whilst I, and the rest of the team, are fully aware that my time will end after my allocated six months and I will move on to pastures new, my colleagues are stuck with this change and evolution for the long term. They have seen the effects first hand, of a service many felt didn't need changing. A service where many have worked for years. A service where some great therapeutic relationships had been built through hard work and perseverance. But all this was being taken away.

So I was a little surprised to see the resilience displayed amongst the team, now huddled in an undersized room without enough chairs for us all to sit. The advent of mobile working you see has been used as an excuse not to provide the team with enough office space, risking effective and quality team working. So whilst we come together once a week for the team meeting, we otherwise are scattered across various locations, anywhere equipped with a chair and Wi-Fi! Perhaps inevitably there is a background grumble, discussion over being unable to leave your desk in case someone else 'steals' the seat where you were sitting, but the over-riding tone is one of hope and compassion. Compassion towards the service users who are experiencing this change with us, and compassion towards each other.

Whilst the team sometimes appears overcome with challenges it seems they are unaware of the strengths they harness. The flexibility to maintain a working service despite their woes is not easy and at no point have I seen this affect patient care. Many have used this time of change as an opportunity to reflect both personally and professionally in order to contribute to a developing service, shaping the future of the region's mental health care. For a leader, it seems that acknowledging the difficulties goes a long way in placating the problems, and providing a forum for sharing challenges in a productive way is key. For most it seems all they want is understanding and reassurance that the struggle is not theirs alone; perhaps then, not dissimilar to the daily struggle of our service users. With the exception of a disgruntled few, most people are aware that the change is short-lived and once the dust settles it will all be forgotten. As many colleagues have said this is not the first and will not be the last time the service is restructured and you just have to roll with the punches.

Perhaps with a title such as this it was not expected I would write a piece so indirectly concerning patient care, however, something more encompassing has been my experience of old age psychiatry; and something increasingly important in these times of restructure. It is clear that the process of change is never simple but often it is necessary and usually outside of our control. It is far too easy to get caught in the negativities without reflecting on the strengths demonstrated in such times and the overarching goal becomes forgotten. And perhaps Maslow has a good point in his hierarchy of needs – the simplest environmental requirements have to be met before anything more complex can be achieved.

Reflections on choosing a specialty

Stephanie Dhadwar

I have never yet tired of telling my story to those who did not know me before psychiatry became my chosen medical career. I feel proud to now be working as an ST4 for the very same consultants that inspired me when my epiphany and conversion to psychiatry occurred. I admit this is tinged with a hint of shame at my retrospective view of psychiatry.

A then keen to impress and equally impressionable FY2, fresh from the clutches of demanding and opinionated surgeons, I too, shared the notion that psychiatry was a specialty centred on loose theories where patients did not get better. On my arrival, my supervising consultant psychiatrist, with the full knowledge that I was a would-be breast surgeon, a fact of which I had emphatically informed her, more than once, admirably justified why spending time on a dementia ward would be helpful to me. 'Now you will know how to deal with the ladies with brain metastases and challenging behaviour'. I smiled politely, whilst the commentary in my head dictated, 'Oh no, we would not be operating on those patients'. I take this opportunity to publicly apologise!

How far I have come and how that latter anecdote leaves me cringing quietly inside at my ignorance and inexperience. In my defence, with the advent of specialty training, one felt urged to make a decision about a chosen specialty very early on in a medical career, a notion, which I'm sure many identify with.

It was early in my placement in older adult psychiatry that it slowly dawned on me that, actually, I didn't mind going to work in the morning; more so, I rather looked forward to touching base with my patients whom I had had the pleasure to come to know so well. My naive impression of psychiatry floundered in the path of patients being admitted with new, or enduring mental illness, who, with time and the right treatment, got better. The extension of this to patient's families made it all the more worthwhile. I came to learn that in fact, there are very few illnesses that can be completely cured, but I found profound personal and professional fulfilment from seeing patients' quality of life improve and that of those around them.

With that I was converted. I have not looked back since my decision to pursue a career in older adult psychiatry. Given my change of career choice, I was invited to speak to medical students about why I chose psychiatry as a career and most of what I mention here seems to spark interest, provoke thought, and I hope to an extent a little inspiration.

Now I have fully embraced the role of psychiatrist and identify myself as a doctor of 'medical treatment of the soul', I am keen not to leave behind the medical knowledge I set out to attain when I embarked upon my medical degree. Higher training has provided me with the outlets to pursue the areas of psychiatry and medicine that interest me and enables me to raise the profile of psychiatry among our colleagues. I stand my ground in maintaining that being a psychiatrist does not absolve us of using our general medical knowledge to aid diagnosis and treatment of our patients. In the meantime, my research has further enabled me to investigate the interface of physical and mental health in corroboration with our local cardiology department. My next consideration is embarking upon a Diploma in Geriatric Medicine! Who said psychiatry wasn't scientific! In conjunction with

MRCPsych, I think it will stand me in good stead to do well by my elderly patients.

The down sides? Quite simply there are not enough days in the week! The balance between training obligations and clinical need can be difficult. Perhaps too strong to brand a necessary evil per se, but paperwork and documentation can also be difficult to factor in and I dare say, perhaps not prioritised often enough, as I embark upon the approach to ARCP² trying to ensure that all the experience I have accumulated is clearly stated in my portfolio!

Psychiatry for me addresses the fascinating aspects of science and humanity of human life and I am delighted that training continues to nurture this. It is everything I expected for the good. I suppose having studied Science and Philosophy to 'A' level I should have realised psychiatry was for me from day one!

.....**Richard Harris**

Preconceptions

As an FY1 doctor, starting my job on a care of the elderly ward in a district general hospital, I did not have high hopes for the mental health experience I would gain. I have an interest in psychiatry but I thought that the mainstay of my work would be the identification of dementia and delirium. On reflection, this was an important part of my role on the ward, but by no means all I did during my time there. My preconceptions of older adult psychiatry were of an 'awfully nice' subspecialty of psychiatry where not much really happens. These preconceptions were challenged in a way I was not expecting. I don't think I realised that I had negative preconceptions of older adult psychiatry; but looking back the stigma definitely exists amongst clinicians.

The unexpected...

I did not expect to observe the diversity of psychiatric presentations I saw during my time on the ward. It was definitely more than just dementia and delirium. It surprised me how many of the patients' psychiatric presentations were not addressed as they had been admitted through A&E and the acute medical ward before coming to the geriatric ward. More often than not it seems a patient's psychological wellbeing is not a priority when compared to their physical health. There is definitely still a great deal of work to be done in redressing this balance in the acute hospital setting. Most of the patients on the ward had multiple medical co-morbidities; the job showed me the interaction between physical and mental health more clearly than I've ever seen it before.

'Doctor social worker'

The individual difference that can be made to a person by addressing their mental health needs was also surprising to me. One case in particular has shown me how we can empower individuals when we address their psychological, physical and social needs simultaneously. The patient that made the biggest impression upon me was an 82 year old Scottish lady who was admitted to the ward after a fall in her home. On admission she was profoundly depressed, bed bound, not eating or drinking and refusing all medication and rehabilitation. When I met her, she had already been referred to the liaison psychiatry team for 'probable dementia'. On her last day on the ward - after much planning alongside occupational therapy, physiotherapy, liaison psychiatry and the doctors on the ward, she was able to recite a Robert Burns poem to me (from memory) and offered me a chance to join her in partaking in the highland fling, a dance she tells me she was particularly proficient at in during her

² Annual Review of Competence Progression

youth. She gave me the nickname 'doctor social worker'. I think many of my colleagues would see this blurring of professional boundaries as borderline insulting, but I am proud that she gave me this name, as, after all, I think all doctors have a responsibility for considering biological, social and psychological wellbeing for each of our patients. The change in this lady was dramatic, it showed me the difference we can make to individuals when things go well. Older age psychiatry is definitely a specialty where a difference can be made.

The importance of teamwork

I was empowered in my role as the ward FY1 by a fantastic liaison psychiatry team. The team showed me the role I had in being the patient's advocate and the voice of the patient. There were multiple situations I can think of where we were able to act in a person's best interests to enable them to maintain their autonomy and make their own decisions regarding their future - often in the face of pressure from bed managers, social care services and surprisingly, patients own families. All of these groups I found had agendas which were sometimes at odds with the patient's wishes. The liaison team are a valuable asset. The time they can provide to spend with patients to explore their psychological distress and help to monitor their progress whilst on the ward made a difference to each individual. They also taught me, and the other members of the ward multidisciplinary team, a great deal about older adult mental health.

Conclusions

I've surprised myself. Now I see older adult mental health in a totally different way; interesting, dynamic, challenging, surprising and satisfying. I have a newfound appreciation for the older adult psychiatry team. I am looking forward to gaining more experience in this area during my core training. I have a feeling this may be the area of psychiatry for me.

My reflections on choosing a speciality

Gareth Howel

In 2013 Channel 4 screened a documentary entitled 'Bedlam'. For the first time the worlds' oldest psychiatric institution opened its doors to the prying public in an attempt to challenge the myths, taboos and stigma that enshrines mental health. The final episode of the series depicted a patient over the age of 65 who had spent months in a catatonic state. It was as if multiple botox injections had been applied to her body, giving her an expression as if derived from plasticine. This was my first appreciation of old age psychiatry, and it acted as a 'watershed' moment.

At the time I had recently applied to become a core trainee in psychiatry. After watching the series I had several intriguing questions about the specialty. Was the scope of mental illness and its diagnosis different in old age psychiatry? Did treatments alter significantly? Were all patients housed in in-patient facilities like this older lady with catatonia? Were these observations about people with dementia true? These questions warranted answers and further exploration.

Upon commencing a recent 6-month training post in older peoples' services stationed in the community I experienced trepidation, indifference and some scepticism about the role of older peoples' services. Comparisons can be made with general practice in some aspects: several scheduled clinics and home visits made up the bulk of my work as a core trainee. After 2 weeks of shadowing clinics and home visits generally led by my consultant I encountered many diagnoses already familiar to me – schizophrenia-like diseases, affective disorders and anxiety, yet somehow

there were subtle variations in their presentation. As an example, consider the case of an older person with depression. The somatic underpinnings seen in the working age population are much less pronounced, leaving the affective component dominant. Even in an older person encountered in clinic with schizoaffective disorder, symptoms were milder, and I could converse with some clarity with the patient. The original questions still remained unanswered.

Two patients were to transform my outlook of the specialty forever.

The first was a gentleman, accompanied by his daughter, whom I saw in an outpatient clinic. I was tasked with delivering the destructive and life-altering diagnosis of 'Mixed dementia', as demonstrated by previous investigative findings. Was I capable, skilled and experienced enough to do this? Apprehension coursing through my veins I explained the findings to both relatives, and what was to follow I was wholly unprepared for. All the gentleman could think about was the impact of the diagnosis on his social life. He repeatedly expressed concern about seeing friends, the changes to his ability to drive and whether he could continue to use his narrow boat. His daughter, meanwhile looked monumentally relieved, becoming tearful but overcome with gratitude that an explanation had been found for her father's memory difficulties. I realised the diagnosis meant little; that knowledge about the condition and wider impacts upon his functioning was at the fulcrum.

Second was a lady whom I saw alone at her home. A small, slender lady with immediately evident mobility concerns from osteoporosis and kyphosis answered the door after a lengthy wait. I entered her home, relatively unkempt and full of cats. She proceeded to inform me of her difficulties remembering people's names, places and objects she had mislaid around the house. It transpired she had a background of anxiety and depression, and at the epicentre of her concerns was not her memory difficulties. Several ongoing familial stressors were immediately evidence and the tale of a recently deceased pet. The consultation was as much about company, considering the impact of these stressors and her chronic medical conditions on her mood, and allaying her fears that she was not, in fact, developing Alzheimer's dementia.

Both circumstances broadened my understanding of what it means to be a psychiatrist specialising in older people. A diagnostician is but a minor function, with reassurance, education and protection forming the majority of the role.

The public profile of Alzheimer's dementia has risen significantly in recent years. People of stature such as Sir Terry Pratchett have acted as ambassadors for the disease, divulging their personal stories and tales of its progression. However, this does neglect the other dementias and psychiatric conditions in older people. With an impending General Election³ the NHS landscape is malleable but uncertain. The commitment by all political parties to place further resources at the door of mental health services, older people's services is now an exciting expansive area of psychiatry. This clinical unpredictability, yet flexibility is appealing whilst there is an expanding academic component as society seeks to understand the psychopathology behind Alzheimer's disease and other dementias. To be at the forefront of such developments in the future is an exciting and enthralling prospect.

³ This was written before the election in 2015

My reflections on choosing a speciality

Saeed Humera

My first experience working with older people was during my junior training few years ago. Currently I am working as a speciality doctor in old age psychiatry and young onset dementia.

The images we have of old age carried in our conscious and unconscious lives are for the most part negative.

And so the general impression during my junior years amongst the trainees was that it's a relaxed rotation and to do more with physical stuff than actually mental health.

My experience from the outset was quite different and didn't agree with the general impression about old age psychiatry. And this perception was changed by a patient whom I looked after during my first ever contact with older people. A gentle and kind gentleman, who was physically quite unwell and whose eyes used to light up whenever I went to see him. He was lonely and isolated, and felt ignored by his family. He died eventually due to his failing physical health, but he left a huge impact on me. I believe when he died, he was less depressed, more contented and I felt satisfied that I was able to instil a little positiveness during his last days.

His smile, his little praising remarks and gratitude gave me huge confidence at that time and still remains with me.

Many issues for older adults are similar to those of younger adults and they generally respond to the appropriate treatments. However, some mental health problems may be more prevalent among older adults than younger adults and symptoms may manifest differently (e.g., anxiety, depression), thus requiring modifications to treatment approaches.

I feel shared and unique factors to consider when providing mental health treatment to older adults make the field highly rewarding and challenging.

When I initially came to this country, everything was new for me. During my years of experience, I've come across wonderful people including staff, patients and doctors that had a lot of impact on me and to this day I cherish my experience. I remember getting to know the English sense of humour, the immense pride the staff took in their work. I learned a lot about values and professionalism that are important when working with people. I especially remember one of the nurses on an elderly ward, who set a very good example for other colleagues and was one of those who always went that extra mile. She was the most hard working and selfless person I've ever met, who showed love, empathy and respect for all and made the environment around her joyful and lively.

There are many inaccurate stereotypes of older adults that can contribute to negative biases and adversely affect the delivery of care. Older adults themselves can also harbour negative age stereotypes, which contribute to adverse outcomes (e.g., poor physical and memory performance and reduced survival). Furthermore, these negative stereotypes can adversely affect health care providers' attitudes and behaviours toward older adult patients.

For me, working with older adults has encouraged me to understand the normal biological changes that accompany ageing.

During my home visits, the love and gratitude showed by the elderly people and a 'cup of tea', which I was always offered and they insisted upon.

Disease accelerates age-related decline in sensory, motor, and cognitive functioning, whereas lifestyle factors may mitigate or moderate the effects of ageing on functioning. Over the years I have learned that it is useful for a psychiatrist to distinguish between what is a normal pattern of change from non-normative changes, and to determine the extent to which an older adult's problems are symptoms of physical illness, or due to medication.

Some mental health disorders have unique presentations e.g., late-life depression may have a relative emphasis on somatic rather than emotional symptoms. Anxiety symptoms are typically similar to those of young adults, but the content of older adults' fears and worries tends to be age related (e.g., health). In such situations, I've always found it helpful to sit down and chat with my elderly patients to try to remove some of their fears.

Familiarity with the prevalence of mental disorders in elderly people, their symptom presentation and relationship with physical health problems facilitates accurate diagnosis and appropriate management.

In my current job as a liaison psychiatrist, whenever I have been asked to review someone for their anxiety and / or depression secondary to a health issue, I've discovered that most of the time, just sitting down and listening to them makes an immense difference and the gratitude you get in return is heart-warming.

Last, but not least I've worked with some wonderful consultants who have remained pivotal with regards to my decision to remain in this speciality and to this day I don't regret choosing old age psychiatry as my speciality.

Marmite, You Either Love It Or Hate It

Fawzia Huq

Have you seen that Marmite advert, when the breastfeeding baby projectile vomits all over his mother when he sees her eating Marmite on toast? I cannot recall such bodily emissions erupting from anyone when I've said I wanted to go into old age psychiatry, but a subtler reaction, like in the form of wrinkled noses.

I was a wrinkled nose type of gal (about psychiatry in general, actually) in the days when I was a burgeoning medic. That changed when I met a patient who overdosed on beta-blockers. It was quite normal to ignore her as we peered at her ECG and talked amongst ourselves. I only went back to find out her 'story', so I could request an urgent psychiatric assessment the next day to potentially discharge her (bed pressures, you see). Turned out her 'story' captivated me 2 hours after my shift and left me a burgeoning medic no more.

Fast forward time, and I request an old age psychiatry core training post. I had always enjoyed my geriatric medical patients; listening to their life stories, working with their families and having difficult discussions such as end of life care. It was therefore quite a reality shock when I started my

post in CT1 as I expected the patients to fit the stereotype of being frail, dependent on others and wanting a paternalistic doctor. I was pleasantly surprised with my diverse patient caseload; one of them being a very feisty 86 year old who attended for a dementia assessment.

She would have been an egregious character to some; arriving in her cashmere sweater and lips framed with fuchsia pink lipstick, which every so often parted to allow an eruption of giggles. She spoke of her scandalous elope with a Catholic priest, inter-speckled with too-rude-to-print-here jokes followed by cheeky winks and more giggles. I couldn't help but chuckle along with her. She was still very independent and it was joyful hearing that she was attending university and karate classes. She also was still driving, *'with no problems doctor'*, she reassured me with a wink. Her son rather gently chimed in at this point. *'Well, there was that time mum when you were lost for ten hours on the motorway and the police had to escort you home'*. Cue more jokes and gaiety, and it was then that I thought perhaps her humour was a ruse to cover up the truth. As the assessment continued, her memory deficits became glaringly obvious. I knew it wasn't going to be an easy consultation.

She peered at me over her glasses. *'I do not see how forgetting a silly made up name and address means that I have a memory problem'* she told me indignantly. It was more than that of course. I prayed she would allow me to effortlessly discuss notifying the DVLA. Alas, the conversation was more like a struggling antelope surfacing for water, in the grips of a crocodile death roll. No prizes for guessing who was the antelope and who was the crocodile. She conceded eventually, perhaps because she was tiring. *'Okay, I will stop driving, even though it is taking away a huge part of my independence. But only because you (cue wagging of the finger) have forbidden me, not because I believe I need to'*.

This wasn't your typical 'breaking bad news' scenario, where tissues are gently handed out and after grief and anger, the patient and family thank you for all your hard work. This was about giving a diagnosis which can take years for its viciousness to manifest. It can take one's independence over time, has no cure and any current medical management in reality only has a modest outcome. Yet I was robotically churning out diagnoses and medications in the memory clinic, not stopping to think about the impact it had on my patients. I did however reach the targets of how many patients were required to be seen, you'll be pleased to know.

I concede that I was caught up in those dreaded words we hear about; targets, CQUINs, discharges. These elements or similar, will always be there, and to a certain degree outside of our control. However, my patient compelled me to take a look at my own individual practice, and remember all the reasons why I initially wanted to go into the specialty. Since then, I have changed my practice. I know I cannot ignore the managerial aspects to the job, but it does not mean I have to ignore the patient.

As it so happens, my patient and her son did leave my room thanking me for all my hard work. There were no wrinkled noses that day.

My reflections on choosing a specialty

Linda Irwin

My first glimpse into the specialty of psychiatry began when I selected a foundation year 2 job which included a four month psychiatry rotation. It was on my first day of the job that I found out I would be the one based in the inpatient ward of psychiatry of old age!

Initially my heart sank - I had just come from working in medical wards where there were usually a number of confused, frail, elderly patients who were pulling out their IV lines and shouting obscenities from their hospital beds. I imagined this would be another four months of dodging punches whilst trying to take bloods and feeling saddened by the inability of the patients to adequately communicate their feelings or even recognise their loved ones.

There were 2 wards where I would work. One ward was for the more confused patients, who were usually suffering from behavioural and psychological symptoms of dementia. The other ward was for the functional patients who might have been suffering from depression, or psychosis. The two wards were noticeably very different.

On the dementia ward there was a slight sense of chaos, with patients wandering around the wards, and nurses frantically trying to keep up or move out of their way in some cases! One patient enjoyed pushing a chair up and down the corridor, shouting 'beep beep' as he went past, letting me know in his own way that I should move!! I soon got to know the patients and their families, and although it was sad in a way, I found it interesting to hear their families talk about their lives and what hobbies they had and where they worked. It allowed us to think about ways in which to engage the patients in activities too, with music therapy being useful – it's amazing that some patients with dementia can remember songs and sing along word for word! I could see that the consultants enjoyed their jobs too, although recognised it could be tough. I remember one case where a patient held a grudge against a consultant as he wasn't allowed to drive any more due to his dementia. There were also the physical health problems which came along with being an older person with dementia.

Sometimes there were a few funny moments. On one occasion I thought I had left my new coat safely locked away in another room, only to find half an hour later that a male patient was walking around with it on. I tried to bargain with him to get it back but I had to admit defeat and let him walk around with it until he decided he didn't want it any more - if he was content I wasn't going to upset him! Each patient, despite being confused, had their own personalities and their own ways. I noticed that although it was hard work for them, the nurses enjoyed their jobs and cared passionately for their patients - perhaps sometimes they worried a bit too much.... One morning I was asked to listen to four patient's chests as they sounded 'chesty'. I did the usual task of explaining to the patients that I wanted to listen to their chests, but they soon lost interest and it turned into me auscultating 'on the go' as I ran around the ward after them with a stethoscope to their backs - I don't think they had a chest infection somehow as I could just about keep up!! There was also the time when I was bleeped during an on-call by a worried nurse who was concerned that her 90 year old patient had a severe headache and abdominal pain and didn't look well at all. When I arrived the gentleman smiled at me and when I asked if he was sore anywhere he shook his head and smiled again - he was joking with the nurses! He then reached out and shook my hand whilst the nurse standing beside him couldn't believe how well he suddenly looked! They laughed that he had wound them up

making them believe he was unwell, when he was just wanting a bit of attention! He proceeded to go to his bed and sleep soundly.

The functional ward was a bit more organised, and had the advantage that the patients could usually understand things a bit better. This ward had its moments too though! A 75 year old female patient on the functional ward, with some cognitive decline had become confused and had symptoms of a urinary tract infection. The patient became quite animated and whispered to staff 'I think I am pregnant!' The situation itself was quite comical and the staff were able to deal with things by pretending that they were doing a pregnancy test with her urine, when in fact they were testing it for evidence of infection. She was told that her urine showed she wasn't pregnant and was promptly started on some antibiotics!

Thankfully my four months turned out to be much better than I had expected, and I didn't get punched once! It even led me to apply for a training post in psychiatry. It was my experiences during my time in the psychiatry of old age job which helped me through my interviews and into my current job as a CT1 psychiatry trainee. When I have to choose my specialty in the future, I think I will remember back to the memories of my psychiatry of old age job!

Old Age Psychiatry as a medical student

Jane Leadbetter

I am currently a final year medical student at the University of Liverpool. As part of the final year of our studies we have two seven week placements called SAMPs - 'Specially Allocated Medical Placements'. These are in areas we have self-selected in order to gain more experience and help with future career planning. To pick these placements there is an online catalogue detailing where the placement is, and what the seven weeks will entail, and from this you rank your top five choices. There are naturally more popular placements that are over-subscribed, such as paediatrics at Alder Hey etc. However most of the psychiatry options are pretty much a guarantee if you rank them anywhere on your list, due unfortunately to their unpopularity.

As I am interested in psychiatry, my choices were psychiatry based. I listed CAMHS as my top choice and forensic psychiatry at Ashworth Hospital as my second. For my final three options I chose psychiatry placements based on their proximity to where I live - two in rehabilitation psychiatry and my last choice at an old age psychiatry hospital only around the corner from my house. I got a placement on CAMHS, and also my last option of old age psychiatry.

I was quite unexcited about seven weeks in old age psychiatry - the only appealing part being the short walk commute, meaning no early wake up calls! I imagined finding the wards to be quite sad places and thought the specialty would not be as interesting and diverse as other areas of psychiatry.

There were two wards in the hospital, one for patients with organic and the other for functional disorders. I separated my time between the two wards and shadowing the psychiatry trainees in the community.

During the placement I was able to complete an audit on the use of memantine at the hospital. I found it interesting to learn more about the pharmacology of the drug, and to familiarise myself with the NICE guidelines regarding dementia treatment.

During my time in old age psychiatry it was however the functional mental disorders that I found most interesting. There were many patients with depression, and I met a few male patients who were hospitalized following suicide attempts. This led to the idea for a report I wrote during my placement. Reading the literature surrounding depression and suicide in older people was worrying. The problem is set to increase in the future, particularly in high risk males, and at present there are limited strategies in place to stop it from escalating. With the numbers of older people increasing, by 2020 suicide is predicted to be the tenth most common cause of death in older people. This research highlighted the importance of old age psychiatry now, and even more so in the future.

I very much enjoyed spending time with the older age group. I think working in old age psychiatry gives you a real opportunity to make a worthwhile difference to patients, and also to their families, who are facing very difficult times. The trainees I spent time with were really enthusiastic about their time in old age psychiatry and spoke very highly of the specialty. I also like how, particularly as a trainee, there is a big medical component to old age psychiatry.

All in all I was very pleasantly surprised by what a rewarding and enjoyable experience I had during my old age psychiatry placement. It is probably too early to say what specialty I would choose but I would look forward to an old age psychiatry post either during my foundation years, or later as a psychiatry trainee.

My reflections on choosing a speciality

Priyanka Palimar

As I was about to start my first rotation in older adult psychiatry I heard from my peers that it would be an especially busy job but I would be surrounded by a welcoming and supportive multi-disciplinary team. I was, on the other hand, warned that the inevitable deterioration of dementia and the possible chronic nature of functional conditions in the elderly would be disheartening. With this bleak picture I was led to believe that the work would be monotonous with dementia assessments and breaking bad news. As a trainee in my post I did see a greater proportion of patients with dementia but was lucky to be working both on the dementia ward and in the community. Personally I was apprehensive about the considerable medical overlap in this speciality particularly as I had come straight into psychiatry from my foundation years, doing mostly surgical jobs. I was grateful to my consultant however as I was made to shadow her for the first month, meaning I had few duties of my own. It soon transpired that this speciality had a lot more to offer for my clinical, academic and personal experience.

Deep down I knew that keeping busy is usually the best way to familiarise myself with the discipline and I started enjoying the steady pace. I loved the mix of environments in which I visited patients: the dementia ward, the general practice units, the medical ward, patient homes and care homes. The liaison work was for me the most rewarding; I felt I was using my new found knowledge to advise on the management of the patient but also inform colleagues about the legal framework and differences in care needed in this age group.

The interface between physical health and psychiatry was apparent in many situations and it came to my surprise that I was able to use it more confidently than I had thought. I also was able to re-acquire skills like interpreting an ECG, assessing a patient after a head injury, and for a hip fracture. This experience also made me more confident at assessing delirium on general hospital wards and on our dementia unit.

The neuropsychiatric aspects of all dementias were fascinating and made brain dysfunction more tangible. It was also evident in a patient referred by his GP presenting with symptoms of anxiety and very intrusive thoughts of suicide. The history and cognitive testing by the consultant psychiatrist however turned out to be suspicious and an urgent CT head was done. Regrettably the patient had a large brain tumour and this was immediately relayed to the GP and a referral was done to the neurosurgeons to be seen the next day. I realised a good relationship with the local GPs and hospital colleagues was extremely important and this relationship was seen and emphasised whilst I was in the job.

The wider team of nurses and social workers were truly fantastic in working together and for the patient. I felt they had more capacity to talk to carers and relatives than in general adult teams. This I see as having a great effect on patients' quality of life and care, addressing some of the issues described in the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). I had the opportunity to engage with families helping them in understanding the sometimes strange, challenging or upsetting behaviour they saw. I realised this was holistic care that was being offered and practiced.

Although a cliché now, I found older adult patients were often very grateful for any help. In fact this was surprisingly the case when a patient and his wife I saw in clinic refuted the diagnosis of Alzheimer's dementia that the previous trainee had given. This was despite evidence gathered at the last appointments and I asked him to repeat a MMSE. He declined this offer and the couple became somewhat defensive, stating they did not have any serious concerns about his memory. However the atmosphere in the room remained calm and they were certainly not rude. As there was not a lot more that could be done I discussed the case with the consultant at supervision. She contacted the patient and gave them the option to have a new assessment with her: I was surprised and pleased to hear the patient specifically said they were very happy with my approach and care. I thought this was a highly unusual scenario in other specialities!

I knew that this time for this couple was a confusing and scary one, for them and others, and I came to see this speciality as dealing with the transition into the next stage of life with or without a mental illness. It has broadened my understanding of this complex process and I will be applying for higher specialist training next year to continue my journey into old age psychiatry.

My reflections on choosing a speciality

Sandra Reyes-Beaman

I was born in Mexico City at the time in which it was common for multiple generations to live together. Living in the same house and, for many years, sharing the bedroom with my paternal grandmother was a real blessing. My father always struggled to keep our home going, so my three siblings and me always had only the basics in everything, and with great effort, we were also blessed with the best inheritance we could have received: education. However, grandma was always there, contributing with a little bit extra. With her limited savings generated by a fairly low pension she provided me with trips that allowed me to appreciate not only my country and its history, but also how lucky I was compared with the rest of the population in having a family, the basics to live, education and especially my grandma. It was at that time, before my teens that I decided that I was going to become a medical doctor. My final aim was contributing to changing the health conditions of the population. Ambitious I know, but when you hold a dream everything is possible.

When I graduated, my grandmother was still present, but one year later she died of cancer. Her tiny body consumed by all the metastases slipped away slowly, without pain, and surrounded by her loved ones. In particular, she departed peacefully holding my hand as if providing me with her final instructions.

Life took me to the practice of public health, and with many people's support in the Mexican Health System, I grew as a professional medical doctor and in five years I was already a policy maker in my country. With older people still at the centre of my heart, I was helped financially to create the first medical research unit on ageing. I became the head of the unit and with it, my dream came true. I was going to start influencing not only clinical practice, but the way in which services were organized for older people in my country. At that time I published papers and book.

In 2001 I needed to make the hardest decision in my life. My family wanted to come back to England for good. So, with my heart sinking and many people's expectations down, I moved to re-start my career in this country.

Naturally, I wanted to continue working in a position that would allow me to teach, do research and practice clinically with older people. Unfortunately, those integrated positions did not seem to be readily available at that time. So I started working in academic public health, later in the practice of public health, until I realised that both pathways were completely unsatisfactory. They were not compatible with the dream of being a medical doctor.

So I had a career break that would allow me to reflect upon and reconsider my path. After that career break, I approached the person in charge of revalidations in my Trust, Dr Steve Frost. Dr Frost is a wise kind gentleman and psychiatrist who supported me and showed me that it is never too late to come back to pursue a dream. I spoke with him about my interest of going back to work with older people and without any words, but with a warm sigh and a handshake he directed me to psychiatry.

I applied for my first job as a locum in old age psychiatry. Of course I am sure that I failed all the questions that were asked regarding the MHA, but a lovely lady consultant psychiatrist, Dr Hamer, viewed potential in my previous experience working with older people and also in my genuine interest for this population. So I started working in old age psychiatry along with other trainees. Ten months later, I officially started my formal training in psychiatry as a core trainee.

As I am older, sicker and more disabled than my junior colleagues, people have tried to discourage me from starting and continuing this training. However, I have a dream, several guardian angels including my grandmother and Dr Frost, older people with psychiatry problems and Dr Hamer.

Struggling with portfolios and professional exams, going through core training, reducing the family time, frustrations, and setbacks they are all a worthy investment to go back to old age psychiatry and see how a simple word, a small action, reduction in pain, identifying and preventing complications, etc., can bring a little bit of light in an older person's day.

Practicing alongside Dr Hamer and all the old age psychiatry teams has reminded me that medicine and in particular old age psychiatry is not a profession but a ministry. That place in which you can fall in love and find meaning to your life in the service that you provide to older people in the most vulnerable of human beings' states.

My professional life has been fulfilled by a sigh, a thank you card, a lovely word, a hand shake, all of them coming from patients that confirm that I am in the right path.

Being born in a low class family in Mexico and many decades later finding myself practicing in this specialty in England had no place even in my wildest dreams. However, I know that God has facilitated my life, has given me dreams and direction, and has always put me close to the right people at the right time. My responsibility is to devote my life to his calling, working in mental health services for older people no matter the conditions that I need to satisfy and how long my ministry is going to last.

.....by Shalini Sharma

I am not sure where to start but one thing is sure that had it not been for working in old age psychiatry, I would have been a very different person. Working in psychiatry and old age psychiatry in particular has given a new meaning to my life.

Frankly speaking if you had met me seven years ago and asked me whether I would like to do old age psychiatry, my answer would have been totally different to what it is now. I always knew I wanted to do psychiatry but never in million years thought I would do old age psychiatry. It is not until my first placement as a CT1 trainee in old age inpatient unit, my perception of old age psychiatry totally changed and to date it has not shifted a bit.

I was pregnant when I started my CT training and was dreading my first day at work thinking and planning ways to survive an old age placement. But to my surprise right from day one, I started loving my job. The elderly patients made me feel so welcome; patients were so appreciative for the tiniest support offered which in turn gave me immense satisfaction in what I was doing. The stoic nature of this patient group taught me so much about life which in turn motivated me to find ways to further help them and be their voice. During my placement, I had to go on maternity leave but the love and care shown by patients on my return back was overwhelming. It further strengthened my belief to take old age psychiatry as a career. My consultant at that time had a major impact on me wanting to consider old age in higher training. I think old age consultants are the nicest group of people who are quite down to earth with a good sense of humour, immense love for their patients and with great respect for colleagues.

Another thing which I admire about old age psychiatry is the complexity of this patient group. The psychiatric conditions modified by physical illness and the coexistence of organic and functional illness and complexities of legal frameworks I find very challenging and thought provoking. Working in old age has given me an opportunity to work as part of a multi-departmental-team in a real sense along with an opportunity to work with patients and their families over a long period of time. I think this is one speciality where you get to see how a holistic approach can make significant changes in someone's life in a true sense. Another positive aspect of older adult services is that it has enabled me to have a work/life balance which being a woman and mom is very important for me.

My journey so far in this speciality has been a blessing although I had to struggle a lot to get where I am at the moment as there were not that many old age training jobs. When I initially applied for the training post in old age psychiatry, more than half of the advertised old age training posts got converted to dual training. I ended up having to either choose to go somewhere away from home or apply next year. Not only that, my own colleagues and seniors discouraged me to join old age psychiatry stating things like 'You are digging your own grave, there is no future in this speciality' which is very disappointing to hear. Fortunately enough, none of those views changed my passion to work with older people who I think are the loveliest cohort of the population. I don't regret my decision and am very hopeful that somehow things will work out and I will get where I am meant to be. This might mean that I have to work harder, probably more than my contemporaries in other specialities but I am prepared to do that for the amount of satisfaction I get in working in old age.

My worry is, despite it being such a unique speciality, this patient population is undervalued and in need of advocacy. It is heart breaking to see lack of empathy for the patients while changes are being suggested and policies being made.

I think it is very important for people to know that although this speciality might not look glamorous like other popular specialities, it is a very challenging and interesting branch and has the true flavour of psychiatry. I feel, even in this time of uncertainty, we should not leave hope and we should think about ways to promote this beautiful speciality by raising awareness around trainees and medical students. At the same time it is very important for us to work together to stop the spread of discouraging myths about the speciality and instil some hope among people interested in working in this speciality.

Poetic Analogy

Mishra Shirin

And so from one side of the coin,
To the next
A vortex, I jumped into
Oh, I had done geriatrics!
But no psychiatric experience had I had...
At aged twenty and four
In my heart of hearts,
In the four chambers part,
What I had always held was the Old

I'd always known
That once we grow and grow we shrink and willow
(And possibly bellow)
But that beauty lies within
A transformation
A move in time
The striking stories
And to hell with recent memories!
So I began my journey immersed in this new life
(Or was it Old?)
Don't fret, don't fuss, don't fight the nurses told
I soaked it all in and became the patron
Checking, chiding, befriending,
Nursing at times
A secretary for her or for him
An advocate when threats to my precious patients came in
Their small achievements
My source of pride became
I wanted the best for them
And the best would be gained!
The little things would make me smile
I would grin at news of discharging Elizabeth or Joan (not real names, but of course that should be known)
I worked hard to get these patients home
I did more than others in my position I am sure
After all, they could be my Grandmother in years
Their happiness drove me
As for their illness, there was no definitive cure
Their bodies in my keeping
But their minds on an adventure
Sometimes scary
Sometimes sad
But sometimes it was so good to be young again

This poem explains that through my post on an acute geriatric ward, I developed a love for working with older adults. I learned that older people's lives are a rich and fascinating tapestry woven with years of experience and complex emotions. I observed beauty in the ageing process as I recognised the wonderful changes that often come with age including wisdom, being comfortable with one's body and the vanishing of vanity.

Indeed, of my foundation year rotations, this post was undoubtedly my favourite. As a result, though I was looking forward to my first psychiatric rotation being an older adults post, I felt unsure if I would enjoy it to the same extent. I felt apprehensive about whether I would be able to properly manage my patients' physical health problems as I was aware that the facilities and staff background would be different to that of an acute trust. Nevertheless, I believed I owed my patients high quality holistic care and so entered psychiatric training with the best intention of providing it.

As my sixth months in old age psychiatry ticked by, I felt happy following small achievements such as when I managed to successfully arrange home leave for a certain patient on Boxing Day and when I was able to correct another patient's hypotension by altering medication. They now seemed like greater achievements to me as I did not have any senior medical staff helping me and I was working

relatively independently on a daily basis. Furthermore, I was working with limited physical health investigations at my fingertips and had to personally take the bloods and perform the ECGs whereas the nursing staff had helped with these tasks in my previous line of work.

Frustration passed quickly as I recognised the need to adapt to workplace changes and to rise to the challenge in order to give patients high quality care. I became a better clinician overall as I became more thoughtful and thorough in my management plans than when I previously had a team to fall back on.

I also became very reflective in my practice which felt wonderful. This is perhaps because I had the time to look back upon events. In my previous job as a busy medical doctor, this opportunity had not arisen. I reflected that, from the choice of music to the pace of life that was set by the collective, the older people changed the landscape of the ward. This was not a conscious, controlled manipulation of the surroundings - it just happened. The ward changed as a result of the patients' preferences and natural way of life. The surroundings seemed to adapt to meet the patients rather than the other way around. This felt so powerful and demonstrated to me just how strong and persuasive age and experience can be.

Looking back, it is now impossible for me to determine which job I enjoyed most, as on the acute ward I loved the tasks I was required to complete and that I had a team to work with, but on the other hand, through my psychiatric rotation I have developed invaluable personal qualities of patience, resilience and reflective ability. It is beautiful that I have seen both sides of the coin.

Reflections on choosing a speciality

Samuel T Romans

Before commencing my placements in old age psychiatry as a foundation doctor and later as a core trainee, I had a much different view of the speciality. During my undergraduate training, I observed a prevalent sense of therapeutic nihilism regarding elderly patients amongst my peers and medical professionals alike, where some felt successful outcomes were often unachievable. However, I endeavoured to put such experiences to one side and approach the speciality with an open mind. This essay describes just a couple of my many notable experiences whilst working in old age psychiatry.

One of the major changes occurring in later life is retirement, and the consequences of this can be overwhelming. In an outpatient clinic as a foundation trainee, I met a gentleman who, whilst having maintained reasonable mental health throughout his working life, had become profoundly depressed since retiring following a myocardial infarction. He had operated his own business for thirty years, and prided himself on providing for his family. In our further consultations over subsequent months, I appreciated just how much ageing and mental health were interconnected phenomena. The very process of ageing and its associated rites of passage had stripped him of his identity and sense of purpose – his daily existence had fundamentally changed forever. I reflected on how I pride myself on my work, and indeed how as medical professionals, we commit to 'lifelong learning'; how will we cope when we arrive at this chapter in our lives?

One factor contributing to his low mood was the degree of fatigue his cardiac medication regime was causing him, and careful adjustments had to be made. This helped me understand how much physical health was at the forefront of old age psychiatry, and the need for one to maintain a thorough understanding of both mental health and the clinical medicine of other bodily systems. Old age psychiatrists are instrumental in bridging the gap between complex mental health conditions and (often multiple) physical comorbidities.

Whilst many elderly people continue to enjoy a good quality of life, there are those who are isolated, vulnerable and in need of support. In my first month as a core psychiatry trainee returning to old age psychiatry, I admitted a pleasant elderly woman with progressive cognitive deterioration and type 2 diabetes, who had been living alone for almost two years since the passing of her husband. They had been married for over fifty years, and when first discussing her life with him, she burst into tears. It cannot ever be underestimated how profound a loss this must have been, to have had her closest friend's love and support for so long, only to now find herself unsupported and alone, living a mere semblance of her previous existence. For months, she had been housebound with declining mobility, barely eating and with poor blood sugar control.

Following her admission, we needed to both characterise the likely cause and nature of her cognitive deterioration as well as optimizing her physical health and functioning. Over subsequent weeks, what struck me more than anything was the importance of a team-based approach in achieving a good outcome for her. Of course, this is true in all specialties, but perhaps no more so than in old age psychiatry, where patients frequently have complex psychiatric needs, physical comorbidities, and diverse forms of functional impairment. Though her life would never be quite the same as in years past, I felt a sense of immense satisfaction seeing her no longer frightened, vulnerable and alone, but mobilizing more comfortably, having her mental and physical health optimized, as well as receiving support with regards to dietary intake, communication skills, and social reintegration. Many of the victims of poor care outlined in the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) were frail older people with dementia, and it is essential that we collectively learn from these lessons to provide excellent quality person-centred care. Achieving this can be challenging in frontline NHS services, and requires the dedicated input of many different professionals, each with a specific set of skills.

Some of my preconceptions about old age psychiatry were rooted in observing the sense of helplessness that many medical professionals encounter when caring for older people. I feel this comes from a combination of the immense challenge of treating the myriad of clinical problems that older people can present with, as well as having an overly narrow definition of a successful patient outcome (i.e. that anything but complete resolution of symptoms is unsatisfactory). However, following my experiences of working in old age psychiatry I feel infinitely more optimistic; the complexity of treating older patients should be seen as a clinical challenge to be embraced, rather than avoided, and there are few, if any, specialities more reliant on effective multidisciplinary team working.

FEATURES

DoLS Drums

David Jolley

This is an extraordinary business. It started with a botched use of existing law in 1999. This was followed by consideration in the courts and House of Lords and eventually to a ruling of the European Court. This asked us to tidy up our act so that similar fiascos might be avoided.

The consequence has been a view that there was something wrong with the laws of the time. Could it be that the problem was in the botched interpretation and application of those laws rather than the laws?

The Mental Capacity Act is broadly welcomed, though it brought into formal legislation areas of life and its complexities which had previously been coped with within the flexibility of The Common Law. Common Law – Common Sense – how we grieve the loss of old fashioned values. We find ourselves swept along in accepting and even championing each new, preferably computer-based, move to proscribed rules, regulations and accountability via tick boxes.

Deprivation of Liberty Standards (DoLS) are described as ‘bolted on’ to the Mental Capacity Act – portraying a crude and makeshift excretion. They were accepted as an inescapable consequence of the European Court’s ruling. I wonder now whether this was not the first mistake. Perhaps a better response would have been to examine how we were using existing law: what has followed is law modification after law modification. We have a toxic overdose of law where there could be, should be better practice in the application of understood best health and welfare practice.

There were rumblings in high places that DoLS were not fit for purpose, having been written rather quickly and lacking the elegance of the Mental Health Act and Mental Capacity Act. Their perverse potential has been realised through judgements given in response to key cases, usually involving younger people with Learning Disability and/or Autism. These have widened the application of DoLS to anyone in 24 hour care who lacks capacity and would not be allowed to go away from their safe residence should they happen to wander. Lady Hale’s wonderfully memorable: ‘A gilded cage is still a gilded cage’ immediately evokes the tune of the tearjerker song: ‘Only a bird in a gilded cage’. But that was about a woman who chose to marry for wealth, rather than love – a cage of her own choosing made with full capacity. She may have had regrets. For most people now being deemed ‘Detained by the State’ they and their families may have sadness that they have come to need care away from home, but on balance they are grateful for the safety it now provides. The regrets they have are few.

Designated ‘Lacking Capacity’, being registered under DoLS, being declared ‘Detained by the State’ all add to the stigma of living with dementia. They also mean your death must be processed by the Coroner. Locally this means that you will be taken from your care home to await the deliberations of the Coroner in the mortuary of a hospital you have probably never entered when alive.

The numbers involved are already enormous – 137,540 DoLS applications 2014-15, a tenfold increase over 2013-14. Eighty percent relate to people 65 and older, 51% have a diagnosis of dementia which is a recognised terminal illness <http://www.hscic.gov.uk/catalogue/PUB18577/dols-eng-1415-rep.pdf>

The majority will die and come to the Coroner within a matter of months. The personal and financial costs are enormous, the benefits for most are virtual rather than substantial.

The Law Commission has offered a consultation in which an alternative system of 'Protective Care' is presented for consideration and this has been subject to an 'Impact Appraisal': http://www.lawcom.gov.uk/wp-content/uploads/2015/08/cp222_mental_capacity_impact_assessment.pdf

I fear Protective Care, though well intentioned, well thought through and described, will prove to be at least as costly and stigmatising and so economically and ethically unacceptable. **The estimates of costs** given look to be detailed but are only rough estimates with multiple assumptions which are questionable. **The anticipated benefits/savings** are at best questionable.

Let us learn from other European countries and **formulate a law which ensures good standards without undue formality.**

One immediate approach might be to agree that where people have given Lasting Power of Attorney to include Health and Welfare, if the donor agrees with a placement, then is no need for DoLS.

An immediate solution to the Coroners dilemma is to ask that people on the end of life register – expected to die of natural causes - are not referred to the Coroner unless something unexpected has happened. The Chief Coroner is asking for a modification of the law. This is surely to be supported and achieved asap.

This is a matter where members of our Faculty are probably better placed than anyone to understand the issues and to argue the case/bang the drum to change the course of history from one which is trapped in non-productive legalisation toward sensible and sensitive use of resources to care. We need to speak with humility but without fear to people who can make the necessary changes. One place to start will be our local MPs.

David Jolley, PSSRU, The University of Manchester; Willow Wood Hospice Ashton under Lyne and Wythenshawe Hospital Memory Service.

David.Jolley@manchester.ac.uk

Dementia, rights, and the social model of disability

Dr Rupali Guleria, Dr Martin Curtice

A new direction for policy and practice?

['Dementia, rights and the social model of disability'](#) is a policy discussion paper published in September 2015 by the Mental Health Foundation in a project funded by the Joseph Rowntree Foundation¹. The paper was produced in consultation with an expert advisory group and a round table event in March 2015 involving 35 participants including people with dementia, carers, disability activists, legal experts and academics, and representatives from government and third sector organisations. The project was assisted by Innovations in Dementia (iD), a community interest company to ensure the involvement of people with dementia. This article provides a review of this important paper.

The paper looked closely at the recent shift in the discourse of dementia from a medical disease to a condition having a rights based dimension addressing some key questions:

- Is there merit in viewing dementia as a disability by using the social model of disability, and what are the issues to consider?
- What are the possible implications for dementia policy discourse and service provision?
- What are the implications for people living with dementia and their human rights?
- What is the role of national and international law?

Historically, the paper notes, dementia discourse has been dominated by the 'highly medicalised notion of dementia' – a disease associated only with irreversible decline and where 'nothing can be done'. The paper considers there has already been a shift such that dementia is increasingly being viewed as having a rights-based dimension. People living with dementia have a range of impairments and face a variety of disabling barriers leading to their marginalisation, exclusion and oppression. However, the paper observes the human rights of people with dementia is not debated in the mainstream in the same way as other marginalised and oppressed groups.

National and international law and dementia

The rights enshrined in national and international human rights law are 'diagnosis neutral' and instead use the term 'disability' for physical, psychological and cognitive impairments that arise from health conditions and direct individuals and organisations to ensure that people with these impairments are not excluded and accommodated in the same way as non-disabled people. The paper closely examines national and international law which guarantees and protects the rights of people with dementia from discrimination. The European Convention of Human Rights (ECHR) and the Human Rights Act 1998 (HRA – as the ECHR is enacted in the UK) applies equally to everyone. The report identifies five ECHR/HRA Articles which are relevant in upholding the rights of people with dementia, namely Articles 2 (the right to life), 3 (the prohibition of inhuman or degrading treatment), 5 (the right to liberty and security), 8 (the right to a private and family life) and 14 (freedom from discrimination)². According to the definition of disability under the Equality Act 2010,

mid-late stage dementia falls within the scope of this act, providing protection against all forms of discrimination³. The Mental Capacity Act 2005 (in force in England and Wales) has a role in enforcing rights of people with disabilities who are cognitively impaired. However, it has also been reported the MCA has been used in ways that can paradoxically undermine autonomous decision-making and self-determination as noted in 2014 by the House of Lords Select Committee report on the MCA. This report suggested the MCA has been used in ways that reinforced overly protective and risk-averse cultures in health and social care. The Care Act 2014 (which came into force April 2015) outlines the domains of wellbeing that it is concerned with, including personal dignity, protection from abuse, control over day-to-day life, physical health, mental health, emotional wellbeing and an individual's contribution to society. It obliges local authorities to enable the individual to participate as fully as possible in decisions about themselves and to be provided with support necessary to do this.⁴ The UN Convention on the Rights of Persons with Disabilities (CRPD), an international treaty passed by the UN in 2006, calls for fundamental changes in society's response to disability to ultimately eradicate any sense of difference between disabled and non-disabled people (the CRPD has been ratified by the UK which means national laws and government policies should be compliant with it). Hence, the CRPD uses a social model of disability affording key rights and protection to people living with dementia. The paper observes that the use of a rights-based approach incorporating human rights principles can drive change in dementia policy and practice. An example of this is the current drive to establish Dementia Friendly Communities (DFC), towns (e.g. Motherwell) and cities (e.g. York) which are implementing the social model driven by dementia activism and third sector organisations.

Human rights based approach

The 'social model of disability' is described in the paper as having arisen out of the disability rights movement which originated in USA in the 1970s and has become a global movement. The medical model results in power and control lying with stakeholders ('medical paternalism') while the person with dementia is seen as a passive dependent – the paper also considers the medical model 'maintains oppression, exclusion and passive dependency of the person'. The social model seeks to address the societal and attitudinal barriers so that the person with dementia is at the centre of decision-making process. The Human Rights Based Approach (HRBA) is a framework tool used in social justice work and can be used to examine whether human rights are being considered in practice. In order to deliver a HRBA in practice, five 'PANEL' principles were developed. These refer to:

1. **Participation**
2. **Accountability**
3. **Non-discrimination and equality**
4. **Empowerment**
5. **Legality of rights**

These principles can be used in developing policy and practice for people with dementia at the macro (systemic) and micro (organisational/stakeholder/individual) levels. One of the main action points from the paper was for organisations to explicitly apply (and be evaluated/audited against) HRBA and PANEL principles in:

- a. National and local dementia policy/strategy development.

- b. Dementia service development and commissioning activities.
- c. Professional education and training for dementia.
- d. Age-friendly cities and integration activities.

Rethinking and reshaping dementia

The social model of disability was noted as having the potential to lead dementia discourse in a new and exciting direction. It reshapes how dementia is talked about and critically who does the talking – the social model of disability ‘forces’ a rethink the use of negative language and barriers used to describe dementia e.g. ‘living death’, ‘the demented patient’, the dementia ‘tsunami’ or ‘ticking time bomb’. It also notes that viewing dementia as a disability, also provides an alternative framework to rethink dementia as a rights, social justice and equality issue – which in turn opens up the policy focus beyond the narrow health and social care framework.

The paper considers using a social model approach would bring a shift away from deficit-based thinking where the policy approach is generally to keep people with dementia safe resulting in more oppressive structures and cultures and exclusion such as inappropriate premature institutionalisation. The paper also suggests that applying the social model of disability to dementia may lead to an increased focus on community based solutions with more personalised services. Another proposed advantage of the social model of disability is that it would support advocates to challenge any lack of investment in services and support for people with dementia. However, to date, dementia is not framed as a disability in national dementia policies. The social/rights based model provides an opportunity for people with dementia to become both a catalyst and collective voice to bring about change.

Organisational and paradigm shifts needed

The paper notes it can and will be challenging for organisations to implement a shift to a social model of dementia in reality and practice. Organisations and stakeholders will need support to facilitate change in strategies, leadership and culture. The paper considers that universally accepted and agreed principles and the social model are the cornerstones of the success of the disability rights movement but there is still a gap in terms of an explicit set of agreed principles. Dementia activism which is in its infancy, has adopted the tagline ‘nothing about us, without us’ pushing for further discourse whereby people with dementia can be more autonomous and active agents within their own lives.

The paper advises the application of the social model of disability to people with dementia requires a transformational change which includes policy and practice development at various levels. It also acknowledges that a paradigm shift in dementia towards a social/rights based model of disability would require large scale societal and cultural changes at both micro and macro levels that ‘must be sustained, valued and nurtured’ – this is the classic conundrum of being able to put rhetoric into reality on a national and international scale.

Cautiously exciting future

The paper recognises that viewing dementia as a disability is a relatively new but exciting debate which is in its early stages but that the 'jury is still out'. Overall the paper is cautious, but realistic, in its appraisal of how the social model of disability can change dementia to be viewed as a rights-based disability rather than a predominantly medicalised notion with inherent negative connotations. Hopefully this paper can be a meaningful catalyst by pushing forward holistic approaches and improvements in dementia care.

Dr Rupali Guleria – ST5 old age psychiatry, Worcestershire Health and Care NHS Trust, Athelon Ward, Elgar Unit, Newtown Hospital, Newtown Road, Worcester WR5 1JG

Dr Martin Curtice – Consultant in old age psychiatry, Worcestershire Health and Care NHS Trust, New Haven, Princess of Wales Community Hospital, Stourbridge Road, Bromsgrove, WR61 0BB

References.

1. Mental Health Foundation (2015) [‘Dementia, rights and the social model of disability,’](#) A new direction for policy and practice?
2. Human Rights Act 1998 – <http://www.legislation.gov.uk/ukpga/1998/42/contents>, (accessed 27th November 2015) .
3. Equality Act 2010 – <http://www.legislation.gov.uk/ukpga/2010/15/contents>, (accessed 26th November 2015).
4. Care Act 2014 – <http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm>, (accessed November 2015).

End of life Care in a Psychiatric Hospital

Lauren Z Waterman, David Denton, Ollie Minton

First published online ahead of print in BJPsych Bulletin:

<http://pb.rcpsych.org/content/early/2015/09/23/pb.bp.114.049833>

needs to be pasted in

CAREERS

"Retirees: Do you have *Wise Words* to share?"

Are you approaching the end of your career? Do you wish you could pass on some of the insights that you have learned?

The e-newsletter team is looking for soon to be or just retired members to take part in our new feature **Wise Words**. We would like to interview you about your reflections on your career and to capture any advice you have for those who have just started their careers in psychiatry.

The interview format will be similar to the fifteen-minute interview articles that have been published in recent e-newsletters.

If you are interested in taking part or know someone that might be interested, please contact Kathryn.Stillman@rcpsych.ac.uk for further information."

Old Age Psychiatry or Psychotherapy: both-and

Susan Mary Benbow

Visiting Professor of Mental Health and Ageing, University of Chester, systemic therapist, old age psychiatrist, and Director of Older Mind Matters Ltd

I took early retirement from my NHS consultant post in 2009 and now enjoy a portfolio career with a Limited Company, Older Mind Matters Ltd: it has been an interesting ongoing evolution and confirms my support for the view expressed by the poet Antonio Machado:

"Traveller, there is no path

You make the path as you walk..."

“By walking you make a path”

The path I've taken was formed by opportunities seized. When I was undertaking my higher training in psychiatry (as a senior registrar at that time), I was given the choice of 12 months in psychotherapy or 12 months in old age psychiatry. Tricky. I spoke with my colleagues in both specialties. As I remember it, the trainee old age psychiatrist said 'it's so difficult. The patients shout at you, the relatives shout at you and the staff constantly make demands on you'. I couldn't resist the challenge, opted for old age psychiatry, and found I loved it. Along the way I discovered that by showing interest and enthusiasm you risk becoming an expert; that sometimes you need to take a risk and do something new; and that skills and experiences you accumulate translate into future settings. Learning is never wasted. So it was that I worked for an ECT consultant in an early training post and have only just managed to extricate myself from an interest and involvement in ECT that persisted throughout my NHS career and beyond.

“And turning, you look back”

The most enjoyable aspect of old age psychiatry is the patients⁴. Every one is fascinating. They have life stories that captivate and enthrall, even (or perhaps especially) those who have been somewhat wicked at times and led colourful lives. I could listen for hours. We have the opportunity to make a difference to people's lives, often at a time that they desperately need someone to stand by them. What a humbling experience to be welcomed into people's homes and allowed to get a glimpse of how people live and have lived and to learn the art of old age psychiatry from the people who are living it. If I missed anything when I left my NHS consultant job it was the patients.

Families offer challenges at times (how can one family have so many different points of view?), and, having opted to train in old age psychiatry, I then worked in old age psychiatry consultant posts, first in Manchester and later in Wolverhampton. Alongside this I found time to train as a family/ systemic therapist at the Cardiff Institute of Family Therapy. That training gave me strength and confidence in working with families to try to help them find ways to deal with their difficulties. So psychotherapy and old age psychiatry proved not to be alternatives - instead they're complementary!

The third area of old age psychiatry that I love is its complexity. Medical knowledge remains important and relevant, given the admixture of physical and psychological problems our patients present. Community working is critical as our patients are more accurately assessed and understood in their own surroundings. Liaison with everyone is tricky but necessary in order to plan and deliver good treatment/ management. Social care may be even more important than health care – I would never have guessed that in my naivety as a trainee. I found a downside to the system, however, when changes started to be imposed that I believed were not in the interests of our patients and families, and that was a major factor in my early retirement.

Colleagues were another sustaining aspect of the specialty for me. Psychiatrists with dedication, energy and vision; psychologists who saw patients at length, offered careful detailed opinions, and worked tirelessly with the rest of the team; social workers who would go the extra mile and work the system for their clients; nurses who made themselves invaluable to everyone and drew no

⁴ The Royal College of Psychiatrists is reverting to the term patients in the interests of equity between mental and physical health.

boundaries around their commitment to patient and family. I am still in touch with some of the amazing people I met along the way. Thank you to you all.

“At a way you will never tread again”

But, who would have guessed this? Early retirement proved not to be an end but a beginning. I completed a PhD by publication and went on to develop a portfolio of work that is mainly, but not exclusively, within the umbrella of old age psychiatry. Skills developed in NHS consultant practice are valued in other areas. I work now mainly in therapy (with families and couples); in teaching and training (often in relation to dementia); in an area I describe broadly as safeguarding (which includes domestic homicide reviews and work with carers who have experienced adverse care); in research (mainly with colleagues at the University of Chester – could I use the term independent scholar to describe this?); and, to a limited extent, in clinical practice (here a highpoint is the Gnosall primary care memory clinic). Along the way I get asked to do intriguing things and, if it sounds interesting, I’ll probably do it.

“Traveller, there is no road ☒

Only wakes in the sea.”

Looking to the future, I like to think that those of us who are well into their journeys may continue to contribute and perhaps can step out in new directions, freed from the constraints of substantive consultant roles. At the same time we need trainees and consultants in old age psychiatry who are not afraid to hold fast to their patients’ interests by making new paths and going in new, perhaps unexpected, directions.

Correspondence to:

Dr Susan Mary Benbow,

Visiting Professor of Mental Health and Ageing,

Centre for Ageing Studies☒Room CRV210,

University of Chester,

Faculty of Health and Social Care,

Riverside Campus, Chester, ☒CH1 1SL.

Telephone: 00 44 1244 512249

Mobile: 00 44 7789 485435

Email: drsmbenbow@gmail.com

Tips on writing for *Old Age Psychiatrist*

The comments here are based on the combined experience of current and previous editors of *Old Age Psychiatrist (OAP)*. We receive many articles on important subjects, but some are badly written. In particular, they are too repetitive, are poorly structured, and grammar is often incorrect. Others have no direct relevance for psychiatrists working with older people.



Suggested types of article:

- Innovations / interventions which have or have not worked.
- 'The spice of life'
- 'How to survive the current round of NHS changes'
- 'The best thing I've done in the last month' (work related!)
- Case studies: they are not accepted by many journals, but for some people they can be thought provoking and a good way to learn. Case studies must be accompanied by a statement of consent from the patient or their representative and must be anonymised.
- Reviews of relevant clinical and research topics not readily found in text books or academic journals.
- Reviews of books, films and websites.
- Someone who has inspired you.
- Recent experiences and papers read recently: what has inspired, angered or influenced you which other people should know about?

What we do not want:

- Clinical research
- Papers with masses of statistics
- Audits

These should be published in peer reviewed journals.

Please do not send articles to more than one College newsletter! If an article is relevant in more than one Faculty, we can include a link.

Word length

500 to 1,500 words is good.

Illustrations are welcome, provided they do not infringe copyright.

Submission

Please use Microsoft Word and e-mail the article to us.

Include

Title

Names of all authors

Contact details

Page numbers

Style

We can be flexible about style, but **please be consistent**, including with capitalisation, referencing and punctuation.

Tips on writing

- Use language which shows you are passionate about your subject.
- Most of us have to put time into our writing. Regard your writing as a piece of art which has to be perfected to have the right impact.
- Sometimes finding the right words is a bit like pulling teeth. On line or Microsoft Word synonym finders can be very useful.
- Use a word processing package which automatically checks grammar and has a spell-checker set to UK English.
- Is your argument crystal clear and logical? Readers will want your message 'up-front' and will not have the patience or time to search for your meaning. Use headings to help structure your argument.
- Do not send an article to us it to us the second you have written a first draft! Put it away for a day or so, re-read it, and think about the style, the argument and the message you are trying to put across and improve it. Do that a few times. Get someone else to read it through and give you feedback. You may know what you are trying to say, but that does not always come across.
- Avoid words like 'obviously', 'certainly', 'clear' etc – if it was all so obvious there would be no need for the article.
- Weigh up the pros and cons of using 'patient', 'client' or 'user' in the specific context of your article. They are not synonymous!
- Define all abbreviations and acronyms: *Old Age Psychiatrist (OAP)* is read by old age psychiatrists abroad and by people in other disciplines.
- Write concisely e.g.
 - 'He was' rather than 'He appeared to be'
 - 'He walked' rather than 'It was also reported that he walked'

- 'He described' or 'He told us' rather than 'He also gave further details regarding'
- Use positives rather than negatives: they convey more information and are less wordy e.g.
 - 'They had little contact' better than 'They had not had much contact'

If you are writing a book (or other) review:

- Please give full details of the book including author, title, publisher, page length and cost, if not available free on line. Please give website if it downloadable.
- Try to make the first couple of sentences engaging for your reader.
- Say what the book is about and who it is for. There is **no need to summarise the whole book.**
- Point out strengths and weaknesses, things you liked or disliked.
- Give examples to back up your comments, both positive and negative.
- Does it fulfil its stated objectives? Is it targeted at the right audience? If so, why? If not, why not?
- Who would you recommend to read / buy it?
- Would you re-read it? Dip into it again?

References

Not all articles need references.

Consider if they will add to your article. If so, a little bit of effort in referencing to substantiate your arguments is well worth the time.

Please ensure that you have read and understand the article cited, not just the abstract!

Your style of referencing must be internally consistent. That includes layout, punctuation, abbreviations, use of italics. If you need a format to follow, then use the style of the *Psychiatric Bulletin* <http://pb.rcpsych.org/site/misc/ifora.xhtml>

Revising your article

Some of the articles we receive are sent for peer review, others are just read by the editors. Most will require some revisions, once or twice.

Most people regard their writing as good and hate making revisions, but please make the changes the editors suggest. Don't just skip over them!

If you disagree with our suggestions then tell us.

Please ensure that the up-dated, corrected version is e-mailed to us.

Useful reference about writing

For some good, brief tips, see Tim Albert, Getting published: 10 things to do before you sit down to write, *BMJ* (13th October 2012) <http://careers.bmj.com/careers/advice/view-article.html?id=20009242>

Mind your language ... or 'Let's abolish "the elderly"'

As Professor Bernard Isaacs wrote in 1982: 'Let's abolish "the elderly"' *BMJ* (1982) 284: 112
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495641/>

Introducing a heterogeneous group of people with a homogenising definitive article is unacceptable!

Dementia words matter: Guidelines on language about dementia, produced by people with dementia in the Dementia Engagement and Empowerment Project (DEEP).

<http://dementivoices.org.uk/wp-content/uploads/2015/03/DEEP-Guide-Language.pdf>

This is an excellent, highly recommended, brief resource on writing about dementia.

The journal *Age and Ageing* gives relevant guidelines on language:

'Try to avoid language that might be deemed unacceptable or inappropriate (e.g. 'older people' is preferred to 'the elderly', the word 'senile' is best avoided). Take care with wording that might cause offence to ethnic or cultural groups.'

http://www.oxfordjournals.org/our_journals/ageing/for_authors/index.html

We hope you will find these tips useful, and by all means give us your views.....

Helen McCormack, Anitha Howard, Sharmi Bhattacharyya

Editorial Team, Old Age Psychiatrist.