

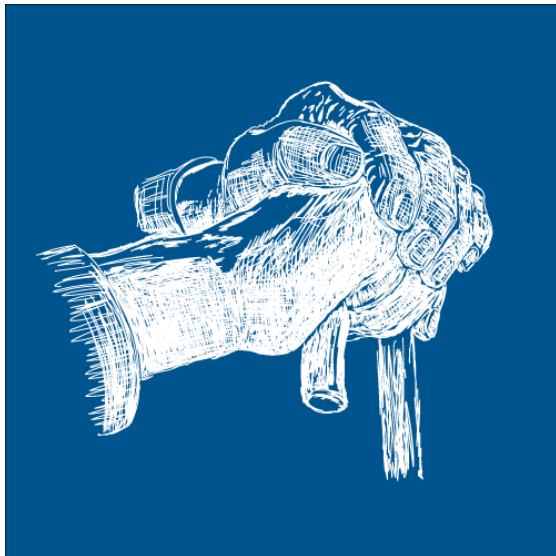


# The Old Age Psychiatrist

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Issue 78, September 2020

Old Age Psychiatry Faculty  
Newsletter



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# Update from the Editorial Team

by

Sharmi Bhattacharyya

Editor, The Old Age Psychiatrist, Royal College of Psychiatrists

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Hello everyone – when I wrote last time I said we would be over the worst and we probably are but I am amazed at the resilience and hard work our colleagues have done in the last few months to keep our patients safe and well both physically and mentally. The challenging times with COVID19 still continue and during these difficult times we hope the articles in the newsletter will provide some food for thought and highlight the great work Old Age Psychiatrists do.

One of the pioneers in our specialty Prof Tom Arie sadly passed away in May this year – our thoughts are with his family. The newsletter has a tribute article to him.

Dr Mani Krishnan took over as Chair of the faculty from July 2020 with a virtual executive committee meeting in July 2020, which was a success. This newsletter has his update with links to great pieces of work done by the executive committee members.

Prof Alistair Burns update as always makes an interesting read. As you know, the faculty Conference was cancelled this year however our new Academic Secretary Dr Mohan Bhatt is leading on this aspect for next year. Watch the space.

The features section is varied with several interesting articles. Dr. James FitzGerald, NIHR Academic Clinical Fellow writes on COVID delirium. The article on Capacity to apply for a Mental Health Tribunal is also thought provoking and relevant to our practice.

Dr Nightingale's article on development of Core Competencies is very relevant to all of us. On the other hand, Dr Hilton's article on 'View from history' is indeed thought provoking. This also links in well to Dr Underwood's article on integrated working and the practical aspects of developing integrated services.

For the more research orientated readers, there are the usual updates such as Cochrane corner and research updates.

As usual we round off with a film review by Dr Howard, which highlights portrayal of dementia in films in different settings and different countries.

COVID 19 is here to stay and services have changed immensely to adjust and adapt to this. For the January edition of the newsletter we are keen to run a

section on **COVID – Opportunities and challenges**. Please feel free to contribute articles on how your services have adapted and what changes have actually improved service delivery and patient care.

Before I end, I must extend a special thank you to Dr Victoria Jones who has had an extended term as a trainee editor due to COVID. Victoria has been a committed and dedicated trainee Editor who has been an asset to the team. Her article on her thoughts and reflections on this role may encourage other trainees to apply in future.

We will miss your enthusiasm and dedication Victoria.

We also welcome our new trainee Editor Nicole Edwards to the team from September 2020. Congratulations Nicole – we look forward to working with you.

As always let us know what you think of the newsletter, and feel free to email me on [drsharmib@gmail.com](mailto:drsharmib@gmail.com) with ideas, suggestions and of course articles for the future newsletter

I hope again that by the time this newsletter is published we would have been over the worst and there is no second surge, meanwhile keep well and stay safe.

# View from the Chair

by

Dr Mani Santhana Krishnan (Krish)

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

@deliriumkrish



## Progression over perfection

Dear colleagues

I am looking forward to working with you all for the next 4 years as Faculty chair. Please join me in thanking our Outgoing Chair Amanda for providing excellent leadership to the faculty over the past 4 years. As academic secretary I have worked closely with her.

I also welcome the newly elected members to the Faculty executive. We have a new vice Chair Dr Josie Jenkinson and Academic Secretary Dr Mohan Bhatt.

Hope you are all keeping well and starting to work in your trusts to gradually build back the services after the pandemic.

We had produced some useful [resources](#) at the beginning of the pandemic and we are adding more resources on the [faculty webpage](#) for our member. I am sure you are also accessing the main [College COVID resources](#) section.

Unfortunately we had to cancel our annual faculty residential conference in March due to the lockdown. The College and Faculty are looking at feasibility of face to face conferences in 2021. However we managed to do two faculty webinars in the last couple of months.

We are also planning to go ahead with our joint one day winter event on 2 December as a webinar. Jo Rodda is collaborating with BGS and will send out the details soon.

You may be aware that Prof. Tom Arie passed away in May. He was one of the founding fathers of Old Age Psychiatry. I had the privilege to interact with him briefly few years ago. He would attend our faculty conferences with his beaming smile. I am hoping to organise an online session to cherish his memories and hear from people who have worked with him closely. Our thoughts and wishes to his family.

I am sure you must have received an email from our Vice Chair Josie Jenkinson regarding joining our informal mailing list through JISCMail. A Jiscmail email distribution list had been set up for our members and allied professionals recently. It can be used to post events, look for help with projects, and disseminate best practice. To join, members can contact Josie Jenkinson / Kitti Kottasz on [Kitti.Kottasz@rcpsych.ac.uk](mailto:Kitti.Kottasz@rcpsych.ac.uk)

### **Faculty Social Media presence**

The Faculty twitter had been set up 2 years ago and has 1841 followers.

The official faculty twitter handle is @rcpsychOldAge. Please follow and contribute.

We had our first faculty executive committee meeting this month remotely and have already started looking at our key faculty priorities for the next year. I will update you in the next edition on various initiatives we are planning to engage over the next few years.

Here are some updates from the Executive committee meeting

- **ARUK Commissioned Survey of Old Age Psychiatrists in UK exploring approaches to the diagnosis of dementia**

I thank Bob Barber for his work on this. The survey had been completed at the end of February 2020 with over 500 responses.

Due to a number of Covid-19 related delays the analysis of the survey had been delayed and the face to face focus groups had been postponed. The CCQI had agreed to undertake the additional analysis for the survey aiming to complete by 22 July. They would also provide the analysis input for the final report. The abstract submitted to AAIC had been cancelled as data analysis was not complete.

The next steps would be:

- ERG to review the findings from the analysis and explore options with ARUK regarding alternatives to focus groups to undertake the qualitative analysis.
- Present findings to the faculty executive.
- Produce final report
- Publication plan to be confirmed.

- **BGS /Loneliness and Neuroscience**

Jo Rodda has worked on the joint report on Loneliness with BGS- this has now been published at

[https://www.bgs.org.uk/sites/default/files/content/attachment/2019-12-16/BGS%20Loneliness%20position%20statement%202019%20FINAL\\_0.pdf](https://www.bgs.org.uk/sites/default/files/content/attachment/2019-12-16/BGS%20Loneliness%20position%20statement%202019%20FINAL_0.pdf)

- **HEE core competencies**

Dr Nightingale reported that the competencies had been published. <https://www.e-lfh.org.uk/wp-content/uploads/2020/04/Older-Peoples-Mental-Health-Competency-Framework-INTERIMV1.2.pdf>

This would be uploaded on the faculty resource page. Please also read her article in this edition of the newsletter.

- **Medical Student Resources**

Jo Rodda has compiled excellent resources for Medical students which will be published as a link in our faculty webpage. The link is <https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/supporting-trainees>

- **Frailty**

I thank Jonathan Richardson and Kapila Sachdeva for their work on the [Frailty report](#).

While we were in the lockdown I worked closely with Amanda to produce a faculty paper for our members. We received good feedback regarding that good practice paper. On the back of that we did our first faculty webinar on memory services during this COVID19 times. We have over 300 delegates with very engaging and passionate members continuing to deliver services in their areas.

We also have been actively involved in the college responses to the pandemic.

It has been 3 weeks since I took over as a chair and therefore still early days to make a detailed report on our faculty priorities going forward. However, a lot of work has already been started behind the scenes by our Executive Committee, and I will provide further updates in the January newsletter.

I would like to thank Sharmi Bhattacharyya and the Editorial team for putting together this edition during these testing times.

I started this report with 'Progression over perfection', taking inspiration from Churchill's quote, "Perfection is the enemy of progression", which I think is quite apt during these pandemic/epidemic times. So, let us work together to continue moving forward as a faculty, and support each other through these challenging times.

Stay well and stay safe.

# Update from Professor Alistair Burns

Professor of Old Age Psychiatry, University of Manchester

National Clinical Director for Dementia, NHS England / NHS Improvement

National Clinical Director for Older People's Mental Health, NHS England / NHS Improvement

Consultant Old Age Psychiatrist, Greater Manchester Mental Health NHS Foundation Trust

Since the last newsletter much has happened in the NHS and in social care. From the beginnings of lockdown as a result of Covid 19 on 23 March, we have seen significant reductions in the number of people diagnosed with dementia, a rise in the amount of antipsychotic medication given to people with dementia, excess deaths in particular in people in care homes (70% of whom have dementia), and a closing of memory clinic services.

This is on the background of all the other changes that have happened to our services as a result of the pandemic. There are a few things which I think it would be appropriate to highlight.

In memory services, we have seen big changes in the way things have been configured. From about mid-March 2020 many closed the doors to new referrals and put on hold those currently undergoing assessments. This resulted inevitably in variability in practice with some clinics endorsing and embracing new ways of working with remote diagnosis and remote assessment while others did less of this work.

In May, a number of us wrote a [paper](#) outlining the aspects that memory services might like to take into consideration when looking at their work. The principles that there should be equity of access for people, that risk assessment should be undertaken and that the service needs to be needs led, underpinned the overarching principle that the quality of the diagnosis and the way it was shared should be paramount.

There were a number of aspects about the diagnostic pathway, from a history taking through to the need for examination, blood tests, and brain scans, which required articulation. Most prominent was the need to discuss which cognitive tests could be undertaken remotely. A number of tests had been validated for use on the telephone and innovative ways were found of developing a mechanism to share pictures over a video link which were key components of traditional tests. There is understandable anxiety about sharing the diagnosis of dementia without the person and their family being present and yet many people embrace this. Non-drug treatments were beginning to be provided online and medication was often prescribed, with some aspects of cardiac being supported by relatives (E.g. by taking a pulse). A prescription of Memantine



could largely be initiated on the strength of a blood test. As the weeks and months go by, more information will come to light about experience with this approach.

Many people described how isolation and loss of structure disproportionately affected people with dementia and their families through a number of mechanisms such as loss of structure leading to a loss of cognitive abilities and even language. At the time of writing, many social care day facilities have yet to open and the mental health effect on people with dementia and their families has yet to be fully quantified. Anecdotally, there is certainly a need for that support to be reintroduced as quickly and as safely as it can.

Many people will remember the Dementia Care Pathway, Preventing Well, Diagnosing Well, Supporting Well, Living Well, and Dying Well and we have rearticulated this to keep up with the Covid pandemic by highlighting areas of each of relevance to Covid as well as adding a sixth - Treating Well.

Preventing Well emphasises the importance of keeping fit and mentally active both in terms, not so much of primary prevention, but secondary and tertiary prevention of harm. Keeping well at home is key and information and leaflets are available from the [IDEAL project](#) lead by the University of Exeter and [Staying Healthy](#) led by the University of Manchester.

In terms of diagnosing Well, with the closure of memory clinics, where the majority of diagnoses are made, there are an estimated 10,000 patients per month not receiving a diagnosis at a time when the NHS was considered to be under particular risk of being overwhelmed, ceasing disease services and redeploying staff was clearly the obvious thing to do. Diagnoses in and of itself in the setting of dementia was a challenge and there was early recognition that many of the symptoms were atypical in older people and people with dementia, communication of those symptoms was even more of a challenge.

Treating Well thought about the importance of delirium and its management and anecdotally people spoke of the severity of the delirium and the fact it was longstanding. ([Coronavirus: Managing delirium in confirmed and suspected cases](#)).

Living well is key and particularly support for carers who often receive less attention.

Finally, Dying Well is the issue, spoken about a number of times in end of life care, and the importance of that aspect of support for people in care homes. Something to be considered is the disproportionate negative effect on care staff many of whom will not have experienced the severity and speed of death and the numbers involved making the quality and quantity of the burden of end of life care seismically different to normal times.

In older people's mental health we have striven to emphasise the need for crisis care and have articulated a number of things which should be highlighted and researched in relation to older people's mental health - reduced contact with family and friends, increased loneliness and isolation, increased anxiety about physical health (fear of Covid), less access to health and care, less access to IAPT, and deterioration of physical health. Also, the emphasis on using digital channels may lead to exclusion of some groups. Areas such as the community mental health teams, the volunteer scheme, crisis and acute services and IAPT were identified as all having bespoke contributions to improving the care of older people during the Covid crisis.

Once again, as I have said before, the commitment and interest to colleagues across the piece in an NHS England and Improvement, plus in the wider sector, to the issue of dementia in older people's mental health is fulsome and I thank everyone for the commitment they have made. At the time of writing we have just advertised for a national specialty advisor in older people's mental health to work alongside the dementia and mental health teams. This will be a significant addition to our armamentarium.

Because there has not been so much contact, I am afraid there is no picture quiz this time but look out for future ones!

## Wales Blog

by

Dr Chineze Ivenso, Welsh Chair of Old Age Faculty, RCPsych

&

Oliver John

RCPsych in Wales Manager

### ***"Do the little things' 'wneud y pethau bychain" – St David***

Wales is often described as having an ageing population with complex needs and the initial impacts of Covid were immediate for some and anticipated for others.

With Gwent providing the 'hotspot' for the outbreak in Wales, Clinicians across health boards quickly established virtual groups; sharing local knowledge, and learning, as well as treatment escalation protocols to help mitigate the impact of the spread.

Deciphering emerging guidance and Welsh Government approaches, we spoke with the Chief Medical Officer. We ensured that testing for symptomatic and asymptomatic patients on admission to an older adult psychiatric inpatient unit was considered as the strategy moved from acute to recovery.

### ***We all have had to get used to webcams, lighting and apologising for not unmuting***

The national response in rolling out video consultation is being led by psychiatrists, with investment and rapid delivery informed by an RCPsych Wales endorsed project in CAMHS.

We are working with the national programme in developing the delivery of virtual older persons psychiatric appointments in the community. The project sees investment in hardware, connectivity, and training (with consultations supported by nursing staff). A pilot in Aneurin Bevan UHB is complimented by a programme in Betsi Cadwaladr UHB in North Wales. We are reviewing the design and implementation, and in joint project evaluation.

Another exciting extension of this work is the parallel UK wide research trial with Prof Rob Howard, providing psychological therapy to people living in their homes with depression and dementia. The project, sponsored by Welsh Government, was put on hold due to Covid, but its planned to restart using video and tele consultation.

We are working with NHS Wales in ensuring this learning is taken forward into national Covid recovery planning; identifying what is effective, sustainable, and how a future service may look.

***Like elsewhere in the UK, Covid hasn't allowed us to detract from our work programme***

We are active contributors to the Welsh Parliaments Cross-Party Group for Dementia, recently meeting to capture some of the unique challenges experienced by carers and by people living with dementia during this time.

We are in discussion with Public Health Wales on hosting a National academic conference.

Additionally, we are responding to the Welsh Health Specialised Services Committee review of effectiveness of PET scanning and advancing our own work in protocols around transitions between services in Wales.

# Tom Arie has died.

## He leaves us to carry on the mission

Obituary for the newsletter of the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists

David Jolley,

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June 2020

Tom died at his home in Kenninghall, Norfolk on Sunday May 24<sup>th</sup> this year. He had been unwell for some time with complications of prostate cancer. Life in his final weeks had been affected for him and his family by restrictions consequent on the Covid-19 crisis, but the family were with him to the end.

When I met him in the early 1970s he had begun to provide a service for old people with mental disorders from a base in Goodmayes Hospital, a run-of-the-mill, large mental hospital on the eastern fringe of London. It was a fabulous time for psychiatry. The benefits of the 1959 Mental Health Act were being realised, better understanding of the nature of mental disorders was emerging from research. Effective physical treatments: ECT, antidepressants and neuroleptics joined with improved psychological therapies to offer hope and expectation of recovery for many, where previously there had been little hope. Clinical studies by Felix Post, Martin Roth and others had confirmed that even old people could recover from serious mental illnesses with appropriate treatment, but the shadow of incurable, progressive dementia hung over late life.

A number of pioneer psychiatrists had begun to offer services for old people with mental disorders. Tom brought to this dispersed and disparate field bright vision and discipline based in a first class intellect, honest and powerful passion, commitment, steely determination and effectiveness. He and his colleagues confronted the shadow of incurability to demonstrate that life could be much improved with existing resources, properly applied. They were successful in combating the fear and stigma associated with mental hospitals by taking good practice to places where people felt at home.

Tom was born in Prague Wednesday August 9<sup>th</sup> 1933. He came to England with his parents 1939 to escape the Nazi regime. They lived in Reading where Tom attended Reading School. He won an Exhibition to Balliol College, Oxford to read Classics in which he was awarded First Class in "Honour Moderations" in 1954; transferring to study medicine, he qualified BA 1956; MA 1959 and BM 1960."

After posts in medicine he trained in psychiatry at the Bethlem and Maudsley Hospitals – gaining the DPM (London) 1964. At the Bethlem he met Felix Post and was influenced by him – maintaining mutual friendship and respect throughout the years which followed. But he told me his decision to leave the combined hospitals to study Social Medicine and psychiatry at the London was influenced in part by the lack of warmth toward patients exhibited by some senior figures at Bethlem/Maudsley. Warmth and respect for all others were enduring characteristics and the essence of Tom.

At the London hospital, his talents were recognised and encouraged especially by Professor Jerry Morris, who again remained a life-long friend and hero. He supported Tom in his decision – wild or reckless as it might have seemed, to move away from the kudos of the teaching hospital circuit, to create a service for older people from Goodmayes.

At Goodmayes hospital Tom inherited seven wards, each with 50 beds – a mix of men and women and a mix of pathologies including shorter term admissions with dementia, depression and other disorders acquired in late life, and long-term admissions ('graduates') with chronic schizophrenia and assorted other problems. Referrals came from a population including 40,000 people aged 65 and above.

Married and with a family which grew to three children, he was not alone. He had vision and a plan. He maintained and developed links with former colleagues. He encouraged students from a number of disciplines to come and work with him, and made a particular point of seeking to support part-time doctors, often women, who were keen to combine a career with family life. Key appointments included Elizabeth Taws who shared responsibility for running the service. Tom Dunn, an experienced and respected local geriatrician, was enthused by the idea of working together – even establishing a small unit with shared beds in Dr Dunn's medical ward. Geriatric Medicine, which had come into being in the late 1940s, had begun to have influence nationally, and its members welcomed Tom and other psychiatrists of similar mind, as fellow travellers in a shared mission to improve services for older people. The shared vision was based on making best medical, and psychiatric, practice available to old people – usually taking it to them in their own homes or care homes. This facilitated work with families, GPs, social services and others, to divine and enact interventions which might make things better. Intervention might include further medical assessment and investigation, medical treatment, provision of additional social care or support, benefits, advice and more. People would be followed up and followed up and followed up, to be sure things were OK – or in need of a revised plan. Admission to hospital could be offered if needed – but the numbers of admissions were fewer than in previous years. It became possible to reduce the number of beds in each ward and to progressively improve the environment, treatment and rehabilitation potential of the hospital space and the staff. As a senior trainee I was seconded to work with Tom at the unit based in Goodmayes

Hospital. We shared ten hours almost every day of those weeks – he was an inspiration and we have been bonded in belief, hope and endeavour through 50 years.

Tom told the world: medicine, social care, politicians and the DHSS about this work in lectures and publications. He was welcomed in many places in the UK and other parts of the world – especially Australia and New Zealand, Canada and Europe. His charm and intellect opened doors and secured trust, friendship and commitment in unlikely places.

He and a small number of others involved in similar work began to meet regularly, after a while forming a Special Interest Group in the Royal College of Psychiatrists. This met quarterly. It usually included a senior figure from the Department of Health and Social Security (DHSS) - and effective plans emerged from the practical experiences of workers in the field. The Group became a Section and the Section became a Faculty. From a handful of 20, we now have hundreds of members, special training schemes, and services throughout the country. Tom was not alone in creating this – but his contribution has been enormous.

In 1977 Tom became Foundation Professor of Health Care of the Elderly at Nottingham University. The unit spanned mental health and physical health, providing a unique clinical platform for teaching and research which Tom and the colleagues he drew around him exploited to great effect – again receiving visits and accolades from people all round the world. Celebrated colleagues in that unit included Rob Jones, John Wattis, Jane Byrne and Jonathan Waite. Amongst the Nottingham students influenced by Tom I will mention Professor Shah Ebrahim.

Amongst his successful strategies was an ethical and productive relationship with pharmaceutical companies and other industries. In retirement (1995) he continued to mastermind an annual conference, updating colleagues on recent developments in the dementia field. This has always been fully booked, attracting doctors from psychiatry, geriatric medicine, general practice and elsewhere. It confirmed that Tom kept up with advances and with people making them. He attended seminar teaching with colleagues in Norwich until very recently.

Tom was a dedicated family man, ever grateful to his parents and thankful and attentive to Eleanor and to their children and grandchildren through every stage of their lives. He loved his life in retirement in Kenninghall, working on the land and orchard around the house and contributing to village activities. He took joy in shopping for bargains, and acquired a library of books which he read and shared generously. He travelled widely and often, especially in Europe, maintaining old friendships at home and abroad, and forging new ones.

He would always make time for people. It did not matter who you were, an international figure, a patient or relative, a neighbour's child – Tom gave everyone a sense of worth. He leaves us to carry on the mission.



This picture of Tom Arie in Australia, 1987 was included in a special issue of Old Age Psychiatrist 21 years edition.

It had the following caption:

Founding meeting of the Old Age Psychiatry Special Interest Group in Australia, 1987. From right to left: Henry Brodaty, Sid Williams, Ute Rosenblds, Fred Stamp, Ed Chiu, sponsoring pharma representative, Manjula O'Connor, Tom Arie, Arthur Harrison, Steve Rosenman and John Snowden.



# COVID Delirium

by

Dr. James FitzGerald

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The collective belief in catastrophe has become our most powerful narrative in the wake of the ongoing COVID-19 pandemic. What this partially represents in our collective narrative, is the destructive impact of the virus on our psyche and our mental health. The most compelling aspect of this plague, is the emergence in clinical practice and the growing number of published cases of individuals who are experiencing a psychotic episode due to the accumulative trauma of perceiving the breakdown of society. These unfortunate individuals are caught in the oppositional tension of identification and alienation from this experience, which culminates in an epistemological rupture. The individual is left tormented by the plague of phantasies, often underscored by the archetypal motif of the Apocalypse. *The world is coming to an end, and so am I!* However, the most violent and destructive of these processes occurs during the COVID-19 septic infection itself, a state known as delirium.

Delirium is an acute onset neuropsychiatric emergency that is characterised by a breakdown in the sleep-wake cycle, memory, attention, and often psychotic experiences such as delusions and hallucinations. It occurs in 1/5 of acute medical admissions, can reach over 50% in the over 65s patient group, and escalate even further to around 80% in the ITU and palliative care settings. It is the biopsychosocial condition *par excellence* and a well-known manifestation of critical illness, hence its relevance to an understanding of COVID-19 and our mental health. Delirium is often presented as a key index of the quality of elder care medicine and psychiatry. And hence its treatment is not simply amelioration of symptoms, but understanding its origin and impact on life. Known since the earliest writings in medicine, a plethora of terms has been used to describe this singular entity. Hippocrates himself used about 16 terms to describe what we now consider as delirium, while the modern clinical literature recognises over 300 terms for delirium: From the unhelpful term *acute confusional state*, to the nauseating and negligent English idiom *pleasantly confused*.

This is reinforced by the *unpleasant* facts which are the following: delirium is associated with increased rates of mortality, morbidity, and even dementia. Much like COVID-19, it disproportionately affects the oldest and frailest within the population, and is associated with detrimental patient outcomes, including increased risk of admission to hospital and increased discharges to nursing

homes, or a more permanent discharge to the mortuary. It is estimated that about 2/3 of delirium cases are missed in clinical practice as it often mimics other conditions such as depression and dementia in the elderly. It is an economic issue which expands the cost of patient care, by increasing hospital length of stay which can include a traumatic journey through ITU, coupled with a much wider cost after discharge from hospital. All worthwhile expenditures on the most precious and vulnerable.

But behind these facts, lies the personal delirium narrative, one of loss and the diffuse spectacle of meaning. Although delirium is one of the most prominent neuropsychiatric condition manifesting from COVID-19 sepsis, its existential and traumatic impact has yet to be fully circumscribed by the evidence. However, it is likely to be congruent to the current literature on personal accounts of florid delirium and its aftermath. It is now increasing evidence that post-traumatic stress disorder (PTSD) is a common result of delirium, not surprising because of the trauma of illness, the journey through ITU and the nightmare of critical illness. Within the qualitative studies and even my own clinical experience delirium presents as a nightmare from the unconscious; a kaleidoscope of delusions and preoccupations about existential threats; nursing staff trying to poison our food, monsters in the ward, wild animals causing havoc in bed, a harpy breast feeding a priest, the face of a Gorgon, The goddess Shiva - Lord of the Dance (not to be confused with my fellow countryman Michael Flatley). But this is an emerging trend anecdotally, that these hyperactive, most vibrant forms of delirium are manifesting across acute clinical settings as a result of COVID-19. All originating from the same source; the unconscious.

For the unconscious itself is that aspect of the psyche that is often unknown, and unknowable. It is a product of our lived experience and shared evolutionary processes which have shaped a distinctly human brain. The cultural experiences emerge from the unconscious as they are shaped by archetypes, transcultural representations of psychological states, and evidence of our shared humanity. In this sense delirium remains the ultimate paradox of medicine. At once universal to the human experience and unique to the individual life. It appears at different times, in different forms, to different people in different contexts. Mercurial to alchemists, divine to the devout, frightening to the ill and ignored by health care professionals; delirium casts a shadow over our lives and acts as the harbinger of our death.

But delirium, much like the rest of psychopathology teaches us something vital about ourselves, the true fragility of the individual ego and the consequence of our blind spots. The hardest hit individuals of all by COVID-19 are in the most neglected aspects of our health/social care system, nursing homes. These forms of institutionalizing the problems of frailty and senescence are but a symptom of how our society cannot and often will not directly deal with death or cherish the humanity of old age. Nursing homes and community care services for the elderly are often presented in the media, and by extension our social narrative as

hopeless situations. But it should provide an opportunity to teach us the importance of caring for the most vulnerable, and in supporting and sustaining their integrity. Investment of resources, time, money, passion and innovation to restructuring the health/social care system is not only desirable, but necessary. The Royal College of Psychiatrists has often called for increased funding for mental health and social services, while the wider healthcare community consistently cry out for adequate resources invested in the healthcare and social care sector. The recommendations have not been implemented, and the situation escalates accordingly, not through chaos but by design.

For me the categories of pessimism and optimism are two sides of the same experience. Instead, I push them aside and attempt to embrace an extemporized hope. Although there has been the emergence of a coordinated effort to facilitate and implement research on several fronts, it is only in its infancy. In point of fact, we are a long way off from having an efficacious vaccine, and beyond this singular goal we are confronted with crises that are more dangerous and more terrifying than the initial COVID-19 wave. The crises segment into three areas, the climate, the economy, and the relationship between the individual and the nation-state. To add to these, a fourth category that underscores the others should be recognised, the critical dialogue between oneself and the unconscious psyche. To have the courage of facing these challenges we cannot continue to quietly wait for the catastrophe of our psyche to seem beautiful again and hopeful. Instead, the world as we know it must end.

# Capacity to apply for a Mental Health Tribunal

by

Dr S. M. Umar Nasser – CT1 psychiatry, Coventry and Warwickshire Partnership NHS Trust

Dr Martin Curtice – consultant in old age psychiatry, Coventry and Warwickshire Partnership NHS Trust

This article reviews the decision of an Upper Tribunal judgment from 2018<sup>1</sup>. This clarified for the first time a key question: what is the capacity threshold to apply for a Tribunal hearing? Whilst this case involved a younger adult it has learning for older adult psychiatrists in terms of understanding and applying this new test of capacity in practice.

## The case

Mr S was detained under the MHA. He did not have insight into his mental health difficulties (the judgment does not describe his diagnosis or what section he was detained under but suffice it to say he had a right of appeal to a MHT). He spoke only Lithuanian; communication was aided by a Lithuanian-speaking health care assistant as well as formal interpreters. The patients' consultant described how Mr S had demonstrated on multiple occasions not wanting to remain in hospital and to be discharged. The consensus of the treating team was that although Mr S did not fully understand the need for inpatient treatment and lacked capacity in this respect, he had consistently asked to be discharged and could comprehend this when informed of his s132 rights and the appeal process. Overall, the consultant and treating team concluded, on the balance of probability, that Mr S did retain capacity to appeal against his detention "in view of requirements for a 'very limited' and 'not demanding' capacity."

A solicitor was asked to represent the patient thereafter. She raised concerns regarding his capacity to apply for a Tribunal. Specifically her concerns were that:

- he told her that he wanted to be discharged to have a cigarette;
- he could not understand that he was being held in hospital;
- he could not retain information about the purpose, procedure and powers of the Tribunal.

Her concerns were centred on Mr S's inability to give a true representation of how or why his freedoms were being curtailed, and his lack of understanding of the purpose of a Tribunal. These concerns were considered by the First-Tier

Tribunal Judge, who deemed that they did not make him incapacitous to apply for a Tribunal. He noted that when the solicitor saw Mr S, he was clearly expressing his wish that he wanted to be discharged as he was unhappy with the restrictions placed upon him by being detained e.g. smoking. Furthermore, the judge observed that Mr S's inability to retain that he was being held in hospital was not 'ultimately fatal to a finding that he has capacity' because Mr S was able to understand he was being held somewhere he did not want to be, and had repeatedly demonstrated his unhappiness about this. The judge opined the processes and powers of the Tribunal were not 'relevant information' as to whether a patient wants to appeal (this being a separate decision). What was relevant was that the person wished to be discharged from the place where he was being kept against his wishes. Ultimately, the reality for Mr S to achieve this against medical advice was via a Tribunal i.e. he understood there was a process whereby the authority for his detention could be challenged and potentially overturned. The judge found Mr S to be capacitous to apply for a Tribunal which went ahead. Mr S continued to be detained under the MHA.

Following this decision of the First-Tier Tribunal the case was referred to the Upper Tribunal for analysis of the issue of patients being capacitous to apply for a Tribunal and what a test would be when applying the MCA 2005.

### **Application of the MCA 2005 & The Tribunal Procedure Rules 2008**

The judgment systematically applied the MCA with which the reader will be very familiar with and so will not be repeated here. The salient parts of The Tribunal Procedure Rules 2008<sup>2</sup>, which provides the rules of procedure for a Tribunal, were outlined. Rule 11 provides for 'Representatives' to be appointed by the Upper Tribunal for patients – under rule 11(7)(a) if they have stated that they do not wish to conduct their own case or if they wish to be represented, and, under rule 11(7)(b) where the patient is lacking capacity to appoint a representative, a legal representative can be appointed in the patient's best interests. The judgment also noted rule 11(8) where a representative cannot themselves currently be subject to the MHA either as an in-patient or in the community. They also cannot be an informal patient at the same mental health facility as the patient in question.

### **Analysis of capacity to apply for a First-tier Tribunal**

The specific issue that arose in this case was the ability for a patient to bring proceedings before a First-tier Tribunal. In doing so the judgment drew upon previous jurisprudence related to Tribunal issues (Box 1) and noted the Tribunal rules do not describe the nature of the capacity required by a patient at any stage of the process i.e. to apply for a tribunal or undertake Tribunal proceedings. It was noted that current case law found there was a 'demanding threshold' to have capacity to conduct proceedings<sup>3</sup>. However the judgment delineated that capacity required to *bring* proceedings is less demanding than the capacity required to conduct them. It was appropriate for there to be a

'minimal control' over access to a Tribunal as it would be 'surprising' if the position was otherwise.

This view was supported by two sources. Firstly, from a 2006 House of Lords judgment<sup>4</sup> where Lady Hale (later to become the President of The Supreme Court which superseded the House of Lords as the highest court in the land) felt that most patients admitted under the MHA *do* have the very limited capacity required to apply for a Tribunal or have someone else aid them to do this – the only exceptions she felt may be patients with severe LD or severe dementia (she commented it was 'now unusual' for such people to be formally admitted under the MHA). This suggests a low threshold of understanding is needed. Secondly, the judgment noted the capacity to bring proceedings in the Court of Protection 'simply requires P to understand' the court has the power to decide if the patient should or should not be subject to certain care arrangements and this was again a lower threshold than capacity to conduct proceedings<sup>5</sup>. The more detailed and demanding requirements for capacity to conduct proceedings were not in point at the stage of making an application (and hence should be assessed separately). So what is the threshold required? The judge formulated it thus: "The patient must understand that they are being detained against their wishes and that the First-tier Tribunal is a body that will be able to decide whether they should be released." He therefore provides a simple two-step test of capacity. A patient must understand:

- 1) They are being detained against their wishes, and,
- 2) That the First-tier Tribunal is a body that can decide on their release.

Satisfy the two limbs of the test and that is enough to apply for a Tribunal.

## **Conclusion**

Clinicians now have clarity with a test for the issue of capacity for a patient to apply to a First-tier Tribunal. This two-step test is both easy to remember and to apply – albeit for older people clinicians may need to further consider varying degrees and types of cognitive impairment(s) and sensory impairments when applying this. It is also pragmatic in that it sets a low bar so as to not ostracise the very people it is aimed at supporting. However, the judgment notes there may still be some people who are so severely mentally disordered (including those with dementia) who are unable to apply to a Tribunal or Court to challenge their hospital detention but envisages such a problem would 'very rarely' arise but may do so more often in the future<sup>4</sup> (we suspect however many old age psychiatrists might not agree such cases are 'rare' in the sense there are still many older adults with more severe dementias admitted under the MHA on most organic wards). For such patients who lack capacity to apply to the Tribunal under this new test there remains the possibility of requesting a referral to the Tribunal by the Secretary of State under s67 MHA<sup>9</sup> (under s67 anyone, including hospital managers, local social services authorities, nearest relatives and

patients themselves can ask the Secretary of state to consider making a referral to the First-tier Tribunal; such referrals are most commonly used for issues around s2 detentions<sup>10</sup>).

### Box 1 – cases relating to patient capacity and MH Tribunal procedures

The issue of a patient's capacity had been one of the themes in cases that have come before the Upper Tribunal over recent years.

- ***R (OK) v First-tier Tribunal and Cambrian Fairview [2017]***<sup>6</sup> dealt with the procedure to be followed in a case in which it was accepted that the patient did not have capacity to bring the proceedings.
- ***YA v Central and North West London NHS Mental Health Trust [2015]***<sup>3</sup> dealt with capacity to appoint a representative and with the relationship between capacity to appoint and the capacity to conduct proceedings.
- ***AMA v Greater Manchester West Mental Health NHS Foundation Trust [2015]***<sup>7</sup> dealt with capacity to conduct proceedings with particular reference to withdrawal of an appeal.
- ***PI v West London Mental Health NHS Trust [2017]***<sup>8</sup> dealt with capacity that fluctuated during proceedings.

**References** – all the court judgments can be accessed for free via [www.bailii.org](http://www.bailii.org)

1. *VS v St Andrew's Healthcare* [2018] UKUT 250 (AAC) Upper Tribunal Case number: HM/1261/2018 (<http://www.bailii.org/uk/cases/UKUT/TCC/2018/250.pdf>)
2. The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008, (SI no 2699) <http://www.legislation.gov.uk/ukxi/2008/2699/contents/made>
3. *YA v Central and North West London NHS Mental Health Trust* [2015] UKUT 37 (AAC)
4. *R (H) v Secretary of State for Health* [2006] 1 AC 441
5. *RD v Herefordshire Council* [2016] EWCOP 49
6. *R (OK) v First-tier Tribunal and Cambrian Fairview* [2017] UKUT 22 (AAC)
7. *AMA v Greater Manchester West Mental Health NHS Foundation Trust* [2015] UKUT 36 (AAC)
8. *PI v West London Mental Health NHS Trust* [2017] UKUT 66 (AAC)
9. <https://insights.doughtystreet.co.uk/post/102f1jo/capacity-and-the-mental-health-tribunal>
10. <https://www.gov.uk/government/publications/section-67-of-the-mental-health-act/section-67-of-the-mental-health-act-1983-references-by-the-secretary-of-state-for-health-and-social-care-to-the-first-tier-tribunal>

# The Utility of Health Education England's Older People's Mental Health Competency Framework for Old Age Psychiatrists

by

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## Introduction

As Old Age Psychiatrists we work daily with older people with mental illness. Mental illness covers a spectrum of disorders which fall under the remit of mental health services for older people though often functional illness needs are overshadowed by dementia care needs. Many older people with functional mental illness never reach secondary care due to lack of recognition of signs and symptoms.

For those that don't know me, my job as a community old age consultant psychiatrist and director of medical education (DME) is a 'strawberries and cream' combination. Being an educator to our colleagues, commissioners, trainees, patients and carers is one of my favourite parts of being an old age psychiatrist and developing a flourishing future workforce fit for purpose, a favourite as DME. Old Age Psychiatrists create an environment and culture where a holistic assessment is possible and use our expert knowledge and skills to provide a formulation to enable patient centred care both in Older Peoples Mental Health (OPMH) and Dementia.

As a doctor, I am privileged to have had old age psychiatry training allowing me to develop my expertise in OPMH and dementia care and ready access to lifelong continual professional development. Unfortunately this is not the same for most of our carers, the majority unpaid, and multidisciplinary colleagues in health and social care. This unmet educational need in OPMH and the need to build OPMH capability into the workforce has been acknowledged nationally. This led to commissioning and funding by the Department of Health and Social care for a competency framework for OPMH. Over the past 18 months I have worked, on behalf of the Faculty, with HEE to create an OPMH competency framework<sup>1</sup>

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<sup>1</sup> <https://www.hee.nhs.uk/our-work/mental-health/resources>; Older People's Mental Health Competency Framework



which has had an accelerated publication in response to COVID 19 pandemic and I will go on to describe it's utility to us as Old Age Psychiatrists.

### The Framework- who is it for?

This competency framework describes the knowledge, skills and attitudes needed to address OPMH and put an end to 'suffering in silence' and failure of recognition of OPMH<sup>2</sup>. The competencies are grouped into several domains describing key areas in OPMH including assessment, diagnosis, interventions, interface with physical health and supported decision making. The domains are then divided into three tiers suitable for a patient or member of the public through to RGNs, social care workers, providers and commissioner of older people's services and geriatricians. It dovetails seamlessly for primary care with the Mental Health in Older People: A Practice Primer<sup>3</sup>. It can also be used in conjunction with other HEE frameworks notably the Dementia<sup>4</sup> and Frailty<sup>5</sup> frameworks.

I am a huge advocate and enabler for this framework however the release of the framework is for me the start of the journey. It clearly defines the competencies needed in OPMH but does not provide a means to achieve them or for organisations to evaluate performance or effectiveness. It is the building blocks to breaking down barriers, raising awareness, identifying skills needed, developing training programmes and assurance frameworks to develop older people's mental health knowledge, skills and attitudes in the general population and non - old age psychiatrists working formally and informally with OPMH. It can be used as a vehicle to change attitudes in policy and commissioning to recognise the ways in which OPMH is unique and understand what care and services are required.

### The Framework- How does it work with our curriculum?

I was in a fortunate position to be involved in developing the framework whilst being a co-author for the Royal College of Psychiatrists (RCPsych) Old Age Psychiatry Specialist Curriculum. Demonstrating competency in domains in the final tier of the framework is where I see our specialist trainees in year 4 and 5 commencing and progressing through the RCPsych Old Age Psychiatry

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<sup>2</sup> Royal College of Psychiatrists; Nov 2018; CR221; Suffering in Silence: age inequality in older people's mental health care; Faculty of Old Age Psychiatry

<sup>3</sup> NHSE&I; Sept 2017; Mental Health in Older People: A Practice Primer; Alistair Burns et al.

<sup>4</sup> <https://www.hee.nhs.uk/our-work/dementia-awareness/core-skills>; Dementia Training Standards Framework

<sup>5</sup> <https://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework>; Frailty core capabilities framework

Curriculum competencies to achieve expert level of knowledge, skills and attitudes needed for a CCT in Old Age Psychiatry and to practice as an Old Age Consultant Psychiatrist. The framework and curriculum use a common language and understanding of the needs of older people with OPMH issues to enable highest standards and level of care for our patients and carers.

#### Utility of the OPMH Framework for Old Age Psychiatrists

What is the practical use of this framework for us as Old Age Psychiatrists?

- It is national acknowledgement that OPMH needs are unmet and often not treated.
- It confirms OPMH requires bespoke multi-professional competencies that are not always available in health and social care and general adult psychiatry services.
- It can be used to demonstrate to our policy makers, commissioners and service providers that OPMH is a complex and diverse area that requires holistic care between health and social care across health care and community settings
- It provides a common language for us to demonstrate our expert knowledge and skills in OPMH to enable, supervise and clinically lead those demonstrating the highest level of competency in this framework.

So through promoting this framework and future training tools to enable the framework, we can build OPMH capability into the workforce and awareness in the general public. This will assist in ensuring we, as the scarce resource that is Old Age Psychiatry, provide care for the right patient with OPMH need at the right time.

## Resource for Medical Students

The faculty of Old Age Psychiatry is excited to have published a set of Old Age Psychiatry learning resources for medical students and trainee doctors, which is now available on the RCPsych website.

The resources include case based learning modules, video and powerpoint tutorials and links to other relevant online learning resources.

The aim is to provide students, trainees and trainers with learning resources that cover the clinical aspects of mental illness in older people and give insight into the lived experience.

The learning resources are yet to be uploaded on the website. The link is <https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/supporting-trainees>

These resources have been quickly collated because of the need to support students and trainees with remote learning, and will be improved and developed over time.

If you have any suggestions for improvement or would like to contribute please contact Dr Joanne Rodda via [kitti.kottasz@rcpsych.ac.uk](mailto:kitti.kottasz@rcpsych.ac.uk)"

# OPMH and Integrated Community Physical Health Care – Bringing Benefits for Patients in Good Times and Bad.

by

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A brave commissioning decision was made in Cambridgeshire in 2014 to have all healthcare for older people delivered from one provider. The bid was won by a coalition of local NHS trusts. Unfortunately by December of 2015 this had collapsed in public fashion<sup>1</sup>. This meant the community physical health services needed to rapidly find a provider. This was a significant task as it included 55 different teams, nearly 2,000 staff and a caseload of c40,000 patients. The local mental health trust, Cambridgeshire and Peterborough NHS Foundation trust (CPFT), stepped in and combined these services with the mental health services for older people to create a new directorate. This included all the traditional OPMH services but also district nursing, dietetics, SALT, occupational and physiotherapy, community geriatrics and inpatient geriatric rehab, three minor injury units, specialist teams for diabetes, cardiac, respiratory, Parkinsons, neurology and tissue viability and rapid response teams for psychiatric and physical health emergencies.

The benefits for patients in normal times have been previously described (Tracy *et al.*, BJPsych advances, in press) but it will not surprise any reader here that no one professional holds all the answers for a complex elderly patient with multiple physical and psychiatric morbidity. Having all the services with one provider essentially means that it is easy for staff to bring in all the professionals required without tortuous and anonymous referral processes. The outcomes are excellent. Last year we delivered over 800,000 patient contacts with no never events, 68 complaints (versus >4,000 compliments) and 22 serious incidents. Staff sickness was at a record low pre-covid, we have always been in financial balance and have repeatedly been rated as good by the CQC. Most importantly 95% of our patients would recommend our service to their friends and family.

Covid-19 has presented us with our biggest challenge. We made our priority saving life and felt we could best do that by making sure community services facilitated discharge from or prevented admission to acute trusts. We set up a

single point of contact and triage and focused on the most in need patients to prevent hospital admission for Covid and non-Covid conditions. This policy was successful – at one stage our largest local acute trust had hundreds of empty beds and their medical director has made it clear the support of the community saved lives. We also mobilized our community staff to support patients with and without Covid in care homes.

From an OPMH perspective some of the changes will be recognizable to all readers. We have become well acquainted with PPE, infection control and remote consultation. We were very concerned about outbreaks on our older peoples wards, similar settings have seen rapid spread and mortality of 25%<sup>2</sup>. We did not set up specific red wards. We found the number of cases varied widely and having a ward with just one person on it was not an efficient use of resource in what is already a small bed base (52 beds for >165,000 over 65s). More importantly, the evidence suggests that once you have infection on a ward it is likely to be present in other patients and staff. This chimes with our experience where all our infections on OAP wards developed *de novo* in patients who had already been there some weeks, and thus it was likely that other patients and staff on that ward were also infected. With scrupulous infection control and 'zoning' of wards we have been able to control at least three separate outbreaks without widespread infection of patients and only two deaths, which though tragic, is far lower than mortality reported elsewhere. Our other action was to close our routine memory assessment services and psychotherapy to focus resource on our crisis teams which have been shown to decrease admission to psychiatric and acute hospitals and provide care for the most unwell<sup>3</sup>. In this way we were able to maintain our acute psychiatric care provision during the first phase of the epidemic. Though memory assessment services have now reopened it remains to be seen what the long term consequences of a three month 'pause' in routine memory assessment services are. Our integration has also allowed us to deliver in terms of research. Our trust has been a site for a number of coronavirus research projects, including the ChAdOx experimental coronavirus vaccine.

In terms of learning, for me the biggest impression has been left by the dedication, professionalism and at times sheer courage of my colleagues in all professions. It has also been clear that the NHS is perhaps more flexible than many thought and can respond quickly, effectively and with imagination in times of crisis. Deeper learning with regards to the pandemic response will come with further analysis of the longer term effects of our actions. From an OPMH perspective this has underlined that OPMH (at least in Cambridgeshire) is no longer a 'Cinderella service'. Instead it is one able to lead, organize and deliver holistic care for older people at scale in normal times and quickly respond effectively to crises as a critical part of the healthcare system.

References:

- 1 <https://www.nao.org.uk/report/investigation-into-the-collapse-of-the-unitingcare-partnership-contract-in-cambridgeshire-and-peterborough/>
- 2 <https://www.nejm.org/doi/full/10.1056/NEJMoa2005412>
- 3 <https://pubmed.ncbi.nlm.nih.gov/32200765/>

# View from history: rising to the challenge of transforming community mental health services for older people

by

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In 1960, there were only two consultant old age psychiatrists in the UK. Felix Post ran his older people's service in London, and Sam Robinson led one in Dumfries. Gradually, more psychiatrists took an interest: a handful by 1970, 120 in 1980 and 400 by 1993. The rapid growth of the specialty was astonishing. Our predecessors, like us, were dedicated clinicians who enjoyed working with older people and rose to the challenge of practicing in unpromising circumstances. Unlike us, when appointed as consultants, many of them inherited several hundred long stay patients and practiced from dilapidated facilities in psychiatric hospitals designated for closure.

From a passive and custodial model of mental health provision for older people, based on the assumption that they were on an inevitable slippery slope of decline, our predecessors totally re-designed what was then available. They created pro-active services which improved older people's mental health and allowed them to live as independently as possible in the community. How did they achieve such a transformation? Their route to success was by persistent and determined innovation and creation and seeking allies and solutions in all corners where they might be found. They listened to feedback from patients and carers and advocated for them within the NHS and outside it. Based on clinical knowledge and understanding of local need, and with mutual support from other old age psychiatrists, they changed services for the better.

At the first ever meeting of the RCPsych old age psychiatry special interest group (GPOA, forerunner of the Faculty) in 1973, they highlighted that they needed to be involved in cross disciplinary education, training and working, with junior doctors, geriatricians, general practitioners, nurses and social workers. They also began to discuss how they would implement the first ever government blueprint for hospital and community services for older people.<sup>1</sup> Being an old age psychiatrist was not just about providing assessment and treatment for individual older people, it was about creating effective services.

In this issue, we sadly have Professor Tom Arie's obituary. Regarding creating services, he was a hero. As he modestly put it: "I enjoy, so to speak, making grass grow in the desert—enthusing, fostering, encouraging, making things happen, fighting my corner."<sup>2</sup> "Fighting" may have been more accurate than "advocating". It required being constantly on the alert to counteract ageist sentiments and to seize every good opportunity. It is worth considering Tom's principles for developing services (but remembering that he was working from a psychiatric hospital with well over 1,000 beds and that the term "old people" was politically correct at the time):

- (1) *Availability*. A service for old people is nothing if it is not readily available to all who need it—patients, their families, doctors, social workers. There must be the minimum of fuss, and, when the situation demands it, a crisis must be quickly met.
- (2) *Such a service must be flexible*: I was prepared to try any solution, however unorthodox, which seemed sensible and with which my resources could cope.
- (3) All work must be based on *assessment*, whenever possible at home, before any plan of action was undertaken; patients were never simply to arrive in hospital.
- (4) *Communication* and collaboration must be open and effective: situations should not collapse for want of the right hand knowing what the left hand is doing.
- (5) We should take *responsibility* for every solution which we formulated, and always be ready to think again.<sup>3</sup>

Today, we are in a situation of being asked by NHS England and our Faculty, to contribute to the Community Mental Health Transformation Programme, to advocate for older people and to generate creative solutions in a holistic, integrated way, to develop new ways of providing the best quality services. It is vital for clinicians now to be involved in reshaping services just as they were in earlier decades. It might seem strange to be asked to provide this organisational creativity, but in the past it was a rewarding aspect of the specialty which helped attract people to work in it.

We all like to think that what we do is new, but sometimes we can feel out of our depths and it can seem a bit daunting. It helps when we can search the archives to draw inspiration from historical parallels. Of course, the material situation has changed, but the need to advocate for an undervalued patient group remains. Without that advocacy, old age psychiatry would not be the specialty it is today. The Equality Act in 2010 was important, but it can't abolish an undercurrent of ageist attitudes which persist in society, including among those with authority to interpret the law and with responsibility for providing services.

Tom Arie included his principles in a paper published in 1970, 50 years ago.<sup>3</sup> We need to take up his baton to advocate innovatively and optimistically to ensure that the patients we most like to work with get the timely, comprehensive and high quality services which they deserve.



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1. Department of Health and Social Security, *Services for Mental Illness Related to Old Age* HM(72)71. London: HMSO, 1972.
2. Tom Arie and Elaine Murphy, A conversation with Tom Arie, *International Journal of Geriatric Psychiatry* 1996; 11: 671-679
3. Tom Arie, The first year of the Goodmayes psychiatric service for old people. *Lancet* 1970; ii: 1179-1182.

## Cochrane Corner

by

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Life has been hard for patients with dementia and their carers in the last months, whether they were living at home and having to cope with the sudden loss of support networks and services, or in care homes, where loss of family contact, increased restrictions and staffing pressures compounded the direct risk from Covid-19.

Those providing dementia services have had to be creative and innovative to try to find new ways of working, often with little or no evidence to guide decisions. Although the immediate scramble to work differently may be over, we now face an indefinite period when services may still have to be provided in new ways. Cochrane has been and remains very active in providing rapid, 'living' syntheses of the emerging evidence on the diagnosis and treatment of Covid-19 (see <https://www.cochranelibrary.com/covid-19>). In the Dementia Group, we hope over the next few months to publish reviews which will help to shape the new ways of working needed to keep patients and carers safe while maintaining high quality dementia diagnosis and care.

Anecdotally, lack of contact from family members has contributed greatly to an increase in distressed behaviours among people with dementia in care homes. Many families have attempted to maintain contact using technology. The use of audio or audiovisual recordings of family members to soothe distress has been described in the past as 'simulated presence therapy.' Abraham and colleagues undertook a quick update of their review on this topic (1) (<https://doi.org/10.1002/14651858.CD011882.pub3>). Unfortunately, they found no new RCTs to add to the three which had been included in the review in 2017, but they brought the review methods up to date. All three studies were small (144 participants in total) and had significant methodological problems, and there were important differences between them in the way the intervention was implemented, in the choice of control interventions, and in the ways outcomes were measured. Therefore it is not surprising that the review was inconclusive regarding benefits or harms. However, this is a non-pharmacological intervention with face validity which surely warrants more attention and some high quality research, perhaps using mixed quantitative and qualitative methods.

Looking ahead, we are working on a review of remotely-delivered information, training and support interventions for caregivers and on reviews looking at the diagnostic test accuracy of short cognitive tests conducted remotely (using telephone or video calls), self-administered cognitive tests, and telehealth assessments for suspected dementia. Follow us on Twitter @CochraneDCIG to be alerted to these reviews as they appear.

We have recently published one addition to our portfolio of diagnostic test accuracy reviews: Structural magnetic resonance imaging for the early diagnosis of dementia due to Alzheimer's disease in people with mild cognitive impairment (<https://doi.org/10.1002/14651858.CD009628.pub2>) by Lombardi and colleagues (2). In most services, structural imaging is the only biomarker test applied routinely as part of memory clinic assessments and this review aimed to determine its utility for identifying which patients with MCI would go on to develop AD dementia. The review used a 'delayed verification' method, meaning that the reference standard was a clinical diagnosis of dementia due to AD at follow-up. There were 33 included studies with 3935 participants of whom 1341 (34%) progressed to Alzheimer's disease dementia during the studies; almost all the others retained an MCI diagnosis and only 1% developed other forms of dementia. The median duration of follow-up was only 2 years (range 1 to 7.6 years). The authors considered all of the included studies to be at high risk of bias in at least one domain with particular bias risks related to participant selection (non-consecutive enrolment, or poorly defined or inappropriate inclusion or exclusion criteria) and to the index test (lack of a pre-specified definition of what was considered to be a 'positive' result of the MRI, or lack of blinding of radiologists to the reference standard, or both).

There were sufficient data to derive summary estimates of sensitivity and specificity for total hippocampal volume (mean sensitivity 0.73 (95% confidence interval (CI) 0.64 to 0.80); mean specificity 0.71 (95% CI 0.65 to 0.77)), for medial temporal lobe atrophy (mean sensitivity 0.64 (95% CI 0.53 to 0.73); mean specificity 0.65 (95% CI 0.51 to 0.76)) and for lateral ventricular volume (mean sensitivity 0.57 (95% CI 0.49 to 0.65); mean specificity 0.64 (95% CI 0.59 to 0.70)). These are low sensitivities and specificities. The authors conclude – cautiously, due to the quality of the evidence – that structural MRI added to clinical assessment in people with MCI is not currently informative for identifying prodromal dementia due to Alzheimer's disease. This is consistent with international guidelines which recommend structural neuroimaging to exclude some alternative causes of cognitive decline, not to confirm a suspicion of MCI due to AD.

1. Abraha I, Rimland JM, Lozano-Montoya I, Dell'Aquila G, Vélez-Díaz-Pallarés M, Trotta FM, Cruz-Jentoft AJ, Cherubini A. Simulated presence therapy for dementia. Cochrane Database of Systematic Reviews 2020, Issue 4. Art. No.: CD011882. DOI: 10.1002/14651858.CD011882.pub3.

2. Lombardi G, Crescioli G, Cavedo E, Lucenteforte E, Casazza G, Bellatorre AG, Lista C, Costantino G, Frisoni G, Virgili G, Filippini G. Structural magnetic resonance imaging for the early diagnosis of dementia due to Alzheimer's disease in people with mild cognitive impairment. *Cochrane Database of Systematic Reviews* 2020, Issue 3. Art. No.: CD009628. DOI: 10.1002/14651858.CD009628.pub2.

## Research update

by

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Please find below a summary of recently published articles relating to Old Age Psychiatry.

### **Markers of cognitive reserve and dementia incidence in the English Longitudinal Study of Ageing (1)**

Almeida-Meza et al, *The British Journal of Psychiatry*, published online March 2020

Having identified the importance of identifying preventive measures for dementia in today's ageing population, this study implemented an index of cognitive reserve markers and investigated dementia incidence over 15 years of follow-up in a representative sample of the English population. Data was collected from 12,280 participants >50 years of age from the English Longitudinal Study of Ageing who were free from dementia at baseline assessment. The Cognitive Reserve Index was constructed as a measure of education, occupation and leisure activities, and Cox proportional hazards regression models were used to estimate hazard ratios of dementia in relation to cognitive reserve levels and its components. Results showed that 602 participants developed dementia during the follow-up period, and higher levels of cognitive reserve were associated with lower risk of dementia (hazard ratio 0.65, 95% CI 0.48-0.89, P = 0.008). Further analysis showed that higher levels of education, occupation and leisure activities were predictive of reduced dementia risk, with education and occupation particularly protective for younger participants (<85yr). In summary, this study showed a reduced risk of dementia for individuals with a higher level of cognitive reserve, represented by higher education, leisure activities and complex occupations.

### **Resting State Functional Connectivity and Outcomes of Psychotherapies for Late-Life Depression (2)**

Solomonov et al, *The American Journal of Geriatric Psychiatry*, August 2020 edition (online first)

Assuming antidepressant medication in treatment of late-life depression has modest efficacy, this study states that problem solving therapy (PST) and "Engage" – a reward-exposure based therapy - are important treatment options. Abnormal function of the reward and default mode networks has been previously observed during depressive episodes, and this study examined if resting state function connectivity (rsFC) of reward and DMN circuitries is associated with treatment outcomes. Thirty-two adults with major depression were randomized to 9 weeks of either PST or "Engage". The mean age was 72.7yr. rsFC was assessed at baseline and week 6, with three particular areas of interest: subgenual anterior cingulate cortex (sgACC), dorsal anterior cingulate cortex (dACC), and nucleus accumbens (NAcc). Outcome measures included the Hamilton Depression Rating Scale and Behavioural Activation for Depression Scale. Regarding results, in both PST and "Engage", higher rsFC between sgACC and middle temporal gyrus at baseline was associated with greater improvement in depression severity according to HAMD. Furthermore, preliminary findings suggest that in participants treated with "Engage", lower rsFC between the dACC and dorsomedial prefrontal cortex at baseline was associated with HAMD improvement. In "Engage" only, increased rsFC from baseline to week 6 between NAcc and superior parietal cortex was associated with increased BADS scores. The paper concludes as follows: *'patients who present with higher rsFC between the sgACC and a structure within the DMN may benefit from behavioral psychotherapies for late life depression. "Engage" may lead to increased rsFC within the reward system reflecting a reconditioning of the reward systems by reward exposure.'*

### **Co-occurrence of positive staff interactions and positive affect in memory-care residents: An observational study (3)**

Fauth et al, *International Journal of Geriatric Psychiatry*, July 2020 edition (published online April 2020)

The study recognizes the importance of maximising psychosocial well-being for people with dementia living in residential care and aimed to observe whether proportions of positive affect in residents differed based on co-occurring staff interaction types. Researchers observed staff / resident interactions and affect in residents with dementia in common areas of a residential memory care unit over the course of one year (6999 minutes in total). The results showed that the most observed resident affect type was neutral, followed by positive affect. The most common staff interaction type was neutral / no interaction, followed by positive staff interactions. There was little resident negative affect or staff negative interactions observed. Of note, when staff had neutral/no/ negative interactions, residents were positive 36% of the time whereas when staff had positive interactions, residents were positive 81% of the time ( $p < 0.001$ ). A qualitative review of notes field notes identified themes providing a deeper understanding and context of resident affect and staff interactions. Though quantitative

analysis suggested low rates of negative staff interaction, qualitative review highlighted that 'neutral' or 'no' staff interactions with residents at times comprised missed opportunities. The paper concluded that eliciting positive social interactions between staff and residents is vital in order to promote positive affect and wellbeing in persons living with dementia.

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# Thoughts and Reflections on my Time as Trainee Editor

by Dr Victoria Jones, outgoing Trainee Editor, RCPsych Old Age Faculty Newsletter. Core Trainee, Greater Manchester

I was appointed to the role of Trainee Editor of the RCPsych Old Age Faculty Newsletter in Spring 2019, and I recall feeling a little nervous as to what the role would entail and whether I'd be able to maintain the high standards set by previous trainees. The other editors ushered me in with warm support, and I have found the last year and a bit to be a wonderful experience, if slightly prolonged due to Covid!

I have had the opportunity to liaise with academics at the forefront of their field for the Cochrane Corner, whilst also making sure I am up to speed with current research as I write the update for each newsletter. I've really enjoyed flexing my own writing muscles, with two articles published in the newsletter on end of life care in dementia, and on psychiatric practice during Covid-19. I also ran the annual essay competition, which attracted fantastic contributions from the UK and further afield, and I relished the opportunity to work with psychiatrists with amazing breadth and depth of experience who kindly judged the contest. I will be sad to leave the role but am sure my incoming colleague will do a fantastic job as I hand over the reins.

Finally, I'd like to acknowledge the experience of working in a Corona-stricken environment whilst I've been in this role. I was and still am struck by the kindness, compassion, and pragmatism shown by my colleagues every day. That's not to say it hasn't been hard; I know there have been times where I have felt exhausted and ground down by the seemingly constant changes to work and home routines, and by the ever-present low-level uncertainty about what each day may bring. Though wells of resources may have been drained, and foundations may have been shaken, I hope that we will have built up some strength during these last few months which will better equip us for whatever the future may bring.

On that note, I leave you with a poem.



**Scaffolding,**  
**by Seamus Heaney**

Masons, when they start upon a building,  
Are careful to test out the scaffolding;

Make sure that planks won't slip at busy points,  
Secure all ladders, tighten bolted joints.

And yet all this comes down when the job's done  
Showing off walls of sure and solid stone.

So if, my dear, there sometimes seem to be  
Old bridges breaking between you and me

Never fear. We may let the scaffolds fall  
Confident that we have built our wall.

# Film Review:

## The Notebook (2014)

Director: Nick Cassavetes

Currently streaming on Netflix

Dr Anitha Howard, Consultant Psychiatrist, Bensham Hospital, Gateshead

The Notebook, a commercially successful film, is based on the book of the same name by bestselling author Nicholas Sparks. The film tells the story of two star crossed lovers across decades, initially separated by class in the early stages of their teens and by dementia in their later lives.

We first meet Noah and Allie in a residential home where he reads to her every day from the eponymous 'notebook'. The story he reads to her details the relationship from their early passionate love affair, their brief separation and then their eventual happy reunion. Allie has no recollection of her own love story and makes comments on how the young women should have acted but Noah reads to her with belief that she will remember her story and therefore him.

The film accurately reflects the sadness partners can experience when the person they have loved so deeply can no longer recognise them. The young doctor warns Noah that simply reading to Allie will not bring her memories back, yet Noah continues to read to her everyday waiting for the brief few minutes when Allie recognises him as the love of her life. As Noah reads to her about the young Allie having to choose between a wealthy fiancée and working class Noah, she remembers she chose him. Allie becomes lucid and recalls her life asking him how much time she has left and enquiring about her children and grandchildren. She asks Noah to take her away from their care home to run away together, again, a familiar experience for many carers. This period of lucidity while cinematically poignant would be highly unlikely in real life especially as within a few minutes she forgets completely that she has ever seen him before.

The film is set in the USA in a 24 hour care setting that is different from what I am used to seeing in England. At the start of the film, Allie is immaculately dressed and made up, residing in what looks like a pleasant three star hotel with caring nurses hovering around discreetly. There appears to be a doctor present and available at all times to provide medical care and therefore appears instantly when Allie becomes distressed indicating a medical intervention being used before any other de-escalation techniques are used. When Noah is taken away

to hospital for a few days, Allie is moved to what I can only assume is the dementia floor, and left to sit in a wheelchair dressed in a hospital gown surrounded by others in wheelchairs. The room appears barren and lifeless with no stimulation.

The film accurately portrays the sadness and bewilderment that carers especially partners experience as their loved ones forget them but also how people with dementia are aware of this loss. We find out at the end of the film, the notebook was in fact written by Allie to keep her memories and feelings of loving Noah alive for the time she can no longer remember.