

Old Age Psychiatrist (66)2016

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

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Bangash**

Old Age Psychiatrist (66) 2016

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Update from the Editorial Team, Helen McCormack

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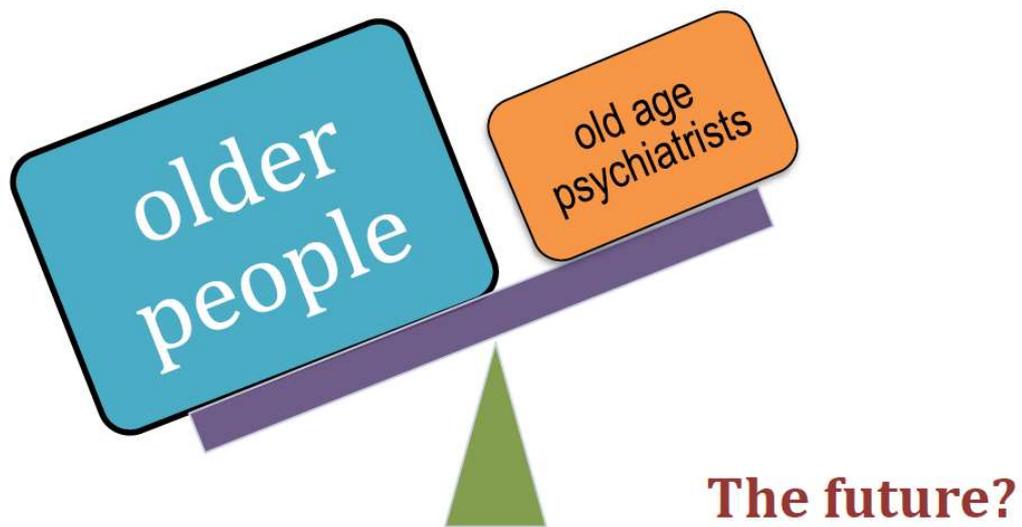
We have a packed newsletter for you this time, and hope that you enjoy the variety of articles we have included.

Firstly , we have a very thought provoking piece from the new Chair of the Faculty, Amanda Thompsell, in which she talks of the challenges ahead for us in the next few years. You will also see this time a new section on Integration, where we hope that we can learn from the experience of our peers across the UK. We know that not everyone has the time or resources to carry out original research, but that we can benefit in our own area through hearing what others have done, with all the successes and pitfalls. We would really welcome similar articles if you feel moved to write. We would also still like to hear from retired or retiring colleagues who would like to share their thoughts on their careers and inspire the next generation.

The content of our newsletters is led by you and our style of editing has been to see what people send to us and to fashion a newsletter around those submissions. We have no shortage of material, and the quality of peoples' work is very high. We like the articles we are publishing and we hope that you do too. We have great support from the digital team at the College and are now able to see how many people look at the Newsletter, which articles they look at and how long they spend looking at them. We were pleased to note that the percentage of people looking at the newsletter rose by nearly 20% between January and May. We want to make sure that the content of the newsletter is relevant to you and that articles are of a length and degree of detail that is valuable. With that in mind , we will be working with the digital team to compile a short survey which we will be sending out to you in the autumn. I would urge to you take a few minutes to complete it, or to contact me directly with feedback. We will look to make any changes to the newsletter in the light of that feedback, so your input is vital to us.

In this newsletter, we again announce our essay competition, for qualified doctors. The topic is 'Old Age Psychiatry: how I see it 20 years from now'. The deadline for submissions is September 30th so there is still time for your entries. I would also draw your attention to the article 'Update on Psychotherapy Training.' Alex Bailey and Victor Aziz are interested in hearing from you about your experiences, and have provided their details at the end of their article. I hope you enjoy reading the newsletter and don't forget that we need your feedback!

Competition for all doctors!
£150 for the winner and £50 for the runner up!



Old Age Psychiatrist wants to hear your views on the following theme:

Old age psychiatry: how I see it 20 years from now.

What are the future challenges for old age psychiatry?
Is this specialty flourishing or in danger of becoming extinct?
How do we respond to the changing needs of the older population?
What will the role of the old age psychiatrist be?

Creative or original writing welcome (including essays, short stories, personal accounts and poems)
with word limit up to 1000 words.

For doctors ranging from foundation trainees to consultants.

Winners to be announced at the Old Age Psychiatry Faculty Conference in March 2017 and 5 short-listed entries (including those of the winners) to be published in the May 2017 edition of *Old Age Psychiatrist*.

Please email your submissions to Ayesha Bangash, trainee editor at 520ayesha@gmail.com by 30th September 2016 along with your names, grades, work addresses and contact phone numbers.

Update from Alistair Burns

NHS England's National Clinical Director for Dementia and Older People's Mental Health

I am not sure if the excitement of dementia and older people's mental health can match the pace of change occurring in the world at large, but I will try.

It was a privilege to attend and be asked to co-chair (with Professor Huali Wang from China) the World Health Organization's Global Dementia Action meeting in Geneva on the 5th and 6th of July 2016. This is huge news. The proposal is that there will be a draft action plan on dementia, initiated and supported by the WHO and backed up by their ruling council. Similar things have happened with regard to mental health and it really does give things a big lift. Not only have the UK signed up to this but have been instrumental in making it happen because of the UK G8 dementia summit in 2013 which, arguably, started the whole thing running. It is hard to say what this will actually mean in practice but previous initiatives have led to real changes and, at the very least, it is a triumph to raise the profile of dementia to this level. There was a palpable feeling at the end of the meeting – a real wow factor that we had actually achieved something significant. Watch this space to become aware of things happening in the future.

In England, there have been a number of developments. The new Clinical Commissioning Group Improvement and Assessment Framework will be launched in the next few weeks and dementia is one of six key clinical areas (the others are cancer, mental health, diabetes, learning disability and maternity). They will allow for further assessment of CCGs across a range of issues and will facilitate focusing support to allow people to improve the emphasis on diagnostic and post diagnostic support is a key area here.

In parallel, we are working with the National Collaborating Centre on Mental Health and are examining, with advice from an expert external reference group looking at access standards for services. Again, this will concentrating on diagnosis and post diagnostic support we will be looking to develop at potential standards for dementia care in these two areas.

The dementia diagnosis rate is being maintained nicely – there was a decrease for a couple of months but has increased again and now we have been fairly consistently at the two thirds ambition for many months now. There are initiatives which have been retired such as the Enhanced Services in primary care and the dementia CQUIN in general hospitals. There are local CQUINs for dementia that are available to hospitals, for example, one for John's campaign (to allow relatives of people with dementia to stay with them when they are in the general hospital in the same way that parents stay with children). There is also an older person's depression CQUIN which mirrors the one on dementia.

Mental health is now being recognised as a national priority and parity of esteem is on everyone's lips. Depression in old age is an important part of that and the parallels between depression and dementia are appealing – often under recognised, sometimes under treated, associated with stigma and sometimes associated with the same therapeutic nihilism attracted to dementia (many of us will have heard often, general nurses in hospital saying 'well if I was like that I would be depressed too'). All the mental health initiatives are across the age span and we must continue to push for the support of older people. The provision of specialist services for older people is key.

There is a strong case to keep close to colleagues in general psychiatry to emphasise how much of the adults of working age agenda concerns older people. For example we know that in liaison and crisis care the majority of people seen in the general hospital are older and in IAPT (Improving Access to Psychological Therapies) we know that older people have often a better rate of recovery but are relatively underrepresented.

So, as always there is much work to be done in an interesting and exciting time.

There are two photographs this time

A) Which meeting chaired by Gill Livingstone am I at, whose needlepoint am I completing and who is the distinguished colleague in the background?



Update from Amanda Thompsell, Chair of the Old Age Faculty.

'Four years hard labour ahead'.

Dear Colleagues

I am honoured, and slightly daunted, to take up the position as Faculty Chair. I say daunted because these are challenging times for the Faculty. Care models are changing, with integrated care being a buzzword. There remains support in some quarters for the discredited model of "ageless" care and meanwhile old age psychiatry continues to struggle to get the recognition, and funding, that it needs. Against this background it has never been more important to support colleagues on the ground, raise the profile of old age services and improve recruitment.

Fortunately, there is much that we can do.

Supporting Colleagues

First, there is already an enormous resource that James Warner has garnered of letters and articles written in support of old age psychiatric services. We are going to make these available on the website so you can download them. More generally, we are in the process of revamping the website and I hope by the time you read this you will have seen a change. The website should benefit members by providing resources (including draft protocols ,films and other links) to share best practice and avoid us all having to reinvent the wheel. There will also be a "Contact Us" area so you can tell the Faculty Executive about issues we should be considering.

Secondly, the Faculty has produced a review of the evidence for the effectiveness and cost-effectiveness of models of integrated care for older people. The evidence supports what we have always known that it does not always save costs but that patients and carers appear to benefit from it . On the back of this information we are going to produce recommendations highlighting the need for old age psychiatrists in models of integrated care and a fact sheet for colleagues to help them in defending the importance of their role. These recommendations should be finalised in September and we will be widely circulating the findings and presenting them in a form that can easily be digested by service commissioners.

Thirdly the Law Commission is currently reviewing how the DoLs regime is working and we have been contributing into this consultation both in writing and at a meeting with the Law Commission and the College. We have been trying to ensure that there is an understanding about the practical issues on the ground of operating the DoLs regime.

Raising the profile of our specialty

We have agreed at the Faculty Executive that we would focus on raising the awareness of depression in older people - an issue that highlights some of the less appreciated aspects of what we as old age psychiatrists do. I have been talking to MPs, the College's communication department the British Geriatric Society, the British Psychological Society, the Royal Pharmaceutical Society, CQC ,Age UK and Care England to name but a few. I see it as key to form alliances with health and allied health

professionals to promote increased awareness of importance of older adults mental health and I am hoping to meet soon with the Royal College of GPs. There is a possibility that we may be able to get this issue debated in a Westminster Hall Committee meeting within Parliament.

More generally I am pressing for an opportunity to obtain a discussion on older people's mental health within the All Party Parliamentary Group on Mental Health.

Recruitment and retention

I have put together a team and a lead role to focus on new ideas to boost recruitment and retention. Another group within the Executive is looking at the curriculum for the next generation of trainees to ensure that the curriculum remains relevant, interesting and covers the new changes that are happening in medical education.

A major development during James's tenure as Chair and Wendy Burns' as Dean was to obtain accreditation for the sub-specialty of old age psychiatric liaison. Members however expressed concern to me about their own accreditation as trainers in this new sub speciality. The answer I have received is that clinical and education supervisors for liaison old age psychiatry placements do not themselves have to have an endorsement in liaison. The local Head of School will however need to decide whether they have the appropriate skills. A supervisor without an endorsement should have been in a liaison post at least a year before supervising higher trainees in a liaison placement. The policy is explained at this link: http://www.rcpsych.ac.uk/pdf/Specialty_training_FAQs_24-06-16.pdf Question 22 and this will be going on the website.

At the same time we are developing our contributions to continuing professional education with a special one day event at the College on 7th November 2016 which will cover depression, delirium and the challenges of integration. In this conference we will be linking with the British Geriatric Society. We have also started developing an exciting programme for our March conference in Bristol based on your feedback. If you have any thoughts of key areas you want addressed in this year's conference or any ideas or questions on any of these topics please let me know - my email address is Amanda.thompson@slam.nhs.uk

Back to the future

In November the Executive is going to clarify the vision for our Faculty and determine our strategic aims for the next four years. The intention is to be clear about what we as a Faculty want to achieve and to have a strategy to achieve it.

I don't think that this could be a more exciting or a more important time to be an old age psychiatrist. We need to seize the opportunity to really increase the profile of our speciality. Your individual talents and passion for our speciality is what will drive us forward as we aim to secure the future of old age psychiatry.

Amanda

Attempts to erode a glorious specialism – Defending Older adult Services

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Old age Psychiatrists specialize in the mental health problems of older adults and spend at least 3 years of their higher specialist training in understanding, assessing and managing mental health problems of older adults. This specialism is acquired after rigorous 5 years training as medical doctors, then another 3-4 years of training in various specialties of psychiatry and subsequently consciously deciding to opt for older adult psychiatry as a career option.

National Institute for Health and Care Excellence (NICE) has suggested in its recent guidelines (NICE, 2015) for older people with social care needs and multiple long term conditions that referrals for a specialist clinical assessment by a geriatrician or old-age psychiatrist must be made. This will ensure and provide guidance in social care planning for older people with social care needs and multiple long-term conditions in circumstances where these needs of the individuals are likely to increase to the point where they are assessed as having a significant impact on their wellbeing. NICE (2015) suggested that when older adults need to be placed in care, specialist assessment is required. Older people with mental disorders should have their care and treatment managed by professionals who have specific expertise in that area. This principle is supported by NICE, the Department of Health, the Royal College of Psychiatrists and the British Psychological Society. The National Mental Health Strategy also recommends services to be age appropriate and non-discriminatory (Joint Commissioning Panel for Mental Health, 2013).

Old age services should not be seen as assessing and managing only dementias. A recent survey of old age psychiatrists (with responses from over 90% of Trusts across the UK) found that up to 40% of patients in older adults services have functional (i.e other than dementia) illnesses and a dual diagnosis of co-existent functional illness and dementia is common. The same survey found that around 10% of respondents had already undergone significant merger into ageless adult services and a similar number reported this was imminent. This was reported by through a joint statement issued in the newsletter by the Royal College of Psychiatrists in 2013 (Royal College of Psychiatrists, 2013). The Telegraph (2014) reported with a headline "*ageless dementia services are an insult to the elderly*". The article argued that it would *amount to insulting to older adults if it is believed that everyone can be treated the same way*. The article also reported that it is not discriminatory to acknowledge that this group of people has very specific needs when it comes to mental health care and requires dedicated and specialist teams. (The Telegraph, 14th April 2014).

A survey of Faculty of Old age Psychiatrists found only 16% (37/230) psychiatrists felt that it was 'very good or good' idea to develop ageless services. Out of 230 psychiatrists, 121 (52%) felt that it was 'very bad or bad idea'. Old-age services are traditionally community based, with teams

understanding the social, physical, and psychological consequences that ageing brings into the management of mental illness, which is essential for appropriate management (Warner, 2013).

As an alternative to “age” as a criterion for old age services, the Faculty of Old Age of the Royal College of Psychiatrists has developed criteria based on need as outlined below. There was an extensive consultation undertaken during development of these criteria. In this process it was quite evident that older people have access to dedicated specialist old age services for functional illnesses and dementia.

Criteria

1. People of any age with a *primary* dementia (primary dementia excludes acquired brain injury and Korsakoff’s syndrome).
2. People with mental disorder and physical illness or frailty which contribute(s) to, or complicate(s) the management of their mental illness. This may include people under 65.
3. People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people. This would normally include people over the age of 70 (Royal College of Psychiatrists Council, 2014).

Most patients in older age mental health services have complex social needs. The Joint Commissioning Panel for Mental Health (2013) argues that Commissioners should ensure that service providers across agencies work together if they are to meet older people’s needs and aspirations effectively. It has been clearly stated by this Panel that all *Services must be commissioned on the basis of need and not age alone*. Older people’s mental health services should not be subsumed into a broader ‘adult mental health’ or ‘ageless service’ but unfortunately across the country many trusts have tried this model since 2012 and 2013. The needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people (Joint Commissioning Panel for Mental Health, 2013). This is where the ‘*needs based model of care*’ must be implemented so that service users are seen on the basis of their need and not age. Older people’s mental health services must address the needs of people with functional illnesses such as depression and psychosis as well as dementia. The majority of the mental illness experienced by older people is not dementia and there is significant crossover between dementia and functional illnesses such as depression and psychosis (Joint Commissioning Panel for Mental Health, 2013).

In conclusion there is no evidence to suggest that ‘*ageless*’ services would be able to address the issue of stigma against ageism. Old age psychiatry and geriatric services have long been considered as ‘Cinderella specialties’ because they have been under-resourced and not considered on par with other specialties. Reducing the specialty to dementia care only will erode the future of this growing specialism. Under recruitment within psychiatry has been highlighted at many levels and although recruitment within old age psychiatry is the same as many other specialties; the nation cannot afford to further reduce the numbers by scaring the young doctors away from choosing this glorious specialty. The world population is growing and the conditions like dementia, depression, delirium, anxiety disorders, personality disorders in this group of population will need services to be geared up to face the ever growing challenge of assessing and managing them. Old age Psychiatry is a fascinating specialty with wide range of disorders, mix of physical and mental health issues,

challenging mental capacity and deprivation of liberty safeguards issues, advancement in assessment procedures with neuropsychiatric and neuroradiology advancements, and neuroscience and neurocognitive research in dementia. This specialty will continue to inspire health professionals who would like to care for a vulnerable group of the society and will thrive to achieve this goal in high spirits.

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Alzheimer's disease genetics: should we change?

Dr VM Aziz, consultant psychiatrist, Dr Danika Rafferty, CT3 in psychiatry

Introduction:

According to the Alzheimer's society "Dementia 2014 report" by 2015, 850,000 people with dementia in the UK are suffering with dementia costing the UK government over £26 billion per annum. This number will increase to 1 million in the next ten years. Alzheimer's disease (AD) is the most common diagnosis, accounting for almost two thirds of patients diagnosed with dementia. Research suggests that delaying the onset of dementia by 5 years would reduce death's attributable to dementia by 30, 000 per year. This has resulted in the focus to discover treatment and prevention strategies for AD. Alzheimer's research UK (<http://www.alzheimersresearchuk.org>) has to

date funded over 434 research projects across the UK, with a value of over £43 million. Despite significant progress we must consider whether this investment is focused in the best possible direction to help individuals suffering with AD.

The Genetics of AD and current research:

The aetiology of AD is complex because of the interactions between environmental and genetic factors. As a result there is no simple mode of inheritance that accounts for its heritability. It is reported that there is no close relationship between the strength of genetic influence and the aetiological importance of volitional processes (Bienvenu et al 2011). Moreover, other mechanisms occur at an early stage of the disease process and diminish the ability of the brain to adapt by altering its normal functioning. These mechanisms include; the cholinergic deficit; mitochondrial dysfunction; abnormalities in glucose metabolism; changes in calcium homeostasis; cytokines and immune response; and problems in the inflammatory signalling pathway.

Advances in candidate gene, linkage and whole-genome association studies have resulted in the discovery of a vast number of putative risk genes for the disease (Hollingworth *et al.*, 2011). We know that family history is an important risk factor for AD, and that familial risk factors are more prominent when onset of disease is earlier (McGuffin et al 1994). There is also good evidence from twin studies that support a complex mode of inheritance for late onset Alzheimer's dementia (Russell, 2010). The susceptibility to AD has been analysed in over 100 candidate genes and the gene groups associated with AD are essentially interactive.

The genes that have been established to predispose to AD are; amyloid precursor protein (APP) gene; presenelin 1 (PS-1), presenelin 2 (PS-2) and apolipoprotein-E. The APP gene was cloned and localized to the long arm of chromosome 21 and there have been numerous mutations identified in the APP gene that are associated with AD. All of these mutations affect A β production, A β 42/A β 40 ratio and the release of A β . APP promoter polymorphisms have also been identified as possible susceptibility factors for AD.

The finding that mutations in APP cause AD and both Presenelin -1 and Presenelin -2 mutations affect APP metabolism has provided strong support for a primary role of Amyloid-beta deposition in AD, specifically its pre-fibrillar forms and resulted in the amyloid-cascade hypothesis (Hardy and Higgins 1992). The overly produced, aggregated A β is neurotoxic and may further aggravate neuronal function by inciting a chronic inflammatory reaction in the neuropil surrounding senile plaques. In time neurofibrillary tangles form in the neurons damaged by A β , the neurons will eventually die leaving behind 'tombstone tangles'. APP is likely to have effects on multiple pathways including the activation of microglial cells leading to the production of pro inflammatory cytokines; effects on insulin signalling; inhibition of Wnt, a family of conserved signalling molecules involved in a plethora of fundamental developmental and cell biological processes; disruption of mitochondrial function; formation of ion channels; perturbation of G-protein coupled receptors function; proteoglycans dysfunction; impairment of synaptic plasticity and neurogenesis.

Apolipoprotein E (APOE) has been significantly associated with coronary artery disease and cerebrovascular disorders. APOE is involved in lipid metabolism and transportation, neuronal maintenance and repair. It also plays a role in immunoregulation, oxidative stress, and stabilization of neuronal microtubules. The APOE ϵ 4 allele is recognized as a strong genetic risk factor for AD. It

appears to predispose patients to vulnerability in the medial temporal areas with its associated memory problems. However, APOE4 is neither necessary nor sufficient to cause AD, at least one third of patients with AD lack a $\epsilon 4$ allele (Bertram and Tanzi 2004).

Systematic meta-analyses of the available AD genetic literature identified more than 20 non APOE-related loci which exhibit nominally significant association with disease risk (Bertram et al 2007).

Studies conducted of affected sibling pairs with AD found significant linkage to chromosome 10 and suggested linkage to regions on chromosomes 1, 5, 9 and 19.

Genetic markers for AD on chromosome 10 were mapped very close to a gene for insulin-degrading enzyme in neurons and microglia which degrades A β . Genome wide association analyses pointed to over 40 new relevant genetically associated risk loci.

BIN1, CLU, CR1, EXOC3L2 and PICALM have been consistently replicated and considered true susceptibility genes. These Loci support the amyloid, lipid, chaperone, and chronic inflammatory mechanisms in AD (Zetzsche et al 2010).

It has also been reported that GAB2 and SORL1 genes may be true risk genes. Multiple SORL1 variants are associated with AD endophenotypes including white matter hyperintensities and hippocampal atrophy (Reitz et al 2011).

The Cathepsin B and BACE1 genes could participate jointly as β -secretases and the growth factor receptor bound protein 2-associated binder polymorphism is associated with increased risk of AD by affecting signal transduction pathway.

The Future:

Although a large number of genes are associated with this gene group the exact nature of their relationship to AD is still unclear. Going from aetiology (cause) to pathogenesis (mechanism) is a challenge for genetics and for diagnostic prediction, the incremental improvements are slight but may be interesting and the future is to study gene-gene interaction and gene-environment interaction. Also, the problem of gene/ locus assignment is to name a gene and it does not always identify the actual gene locus because of genetic variability and expression.

There is hope that the increased understanding of the complexities of AD pathogenesis may direct future research into new predictive directions aiming at identifying new and effective treatment for preserving cognition and helping AD sufferers. Further research in the field of AD genetics will prove or disprove the role of these identified genes in the pathogenesis of AD, or new loci with risk effects will be identified. The aim must also be to identify which of these loci enable us to improve our AD risk prediction and clinical significance, or have we reached the limit of genetic research in AD?

Despite vast investment into AD research and improved genetic understanding, it is debateable whether clinical management of patients with AD has improved. There has been very little advancement in treatment options for AD, and the evidence for the medication licensed is strongest in moderate to severe AD.

The Dominantly Inherited Alzheimer's Network (DIAN) is a multicentre study that may provide evidence for a prevention strategy in AD. The DIAN study has identified measurable biochemical and imaging markers, including cerebrospinal fluid, brain amyloid deposition and brain metabolism that can be detected up to 25 years before symptoms appear individuals carrying the AD autosomal dominant mutation. If these biomarkers translated to all AD sufferers the expensive and invasive testing required to gain relevant information is likely to prohibit any global clinical implications. The DIAN trial has identified three potential treatment agents from these findings that will act upon all forms of aggregated beta amyloid including soluble beta amyloid, and directly reduce its production. Results will provide a clearer understanding of the impact of the pathological processes observed in AD on cognition and clinical presentation.

Finally, older people should be able to live the lives they want to and have access to high quality care and support to help them meet their needs, whether they are in their own home, or a care home. Therefore, we must consider transferring some of the money used in AD research into practical care to improve the quality of life and reduce the burden of care for sufferers. This will have an immediate impact for dementia sufferers. The money can be spent on integrated care that provides practical support and community care.

There is a definite need for non-pharmacological interventions, speech and language therapists, occupational therapies and social care support to keep people as independent as possible.

The Older People Commissioner for Wales (2014) reported that for those who need the care and support which is offered by a care home, they want care homes to be places where they have choice and control, they are respected and treated with dignity and where the care and support is good quality, creative and flexible, and extends beyond the meeting of physical needs and maintaining a safe environment.

Conclusion:

The severity and extent of the deficits in cognitive functioning, that are apparent in Alzheimer's disease and its impact on patients' ability to carry out normal duties at work, and complete tasks of daily living, is naturally having a negative impact on patients' mood and increasing anxiety as they become fearful of losing independence.

We hope the future will mix practical clinical care with research to improve the management of dementia care worldwide.

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Mental Health Services for Older People in Johor Bahru

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Malaysia

Malaysia is a multi-cultural and multi-ethnic developing country in South East Asia. Geographically, Malaysia consists of Peninsular Malaysia and two states, Sabah and Sarawak on the island of Borneo. The population enjoys a high standard of affordable health care both from the government and private sectors. Unlike the UK, Malaysians are not required to register to a General Practitioner. Therefore, access to medical services is dependent on the service users' preference. Sometimes, service users 'hop' between government and private medical providers.

Like all developing countries, Malaysia is expected to achieve "ageing population" status as defined by World Health Organisation in 2030 as 15% of its population will be over the age of 60. (60 is the mandatory retirement age for Malaysia). This is due to multiple reasons namely declining fertility rate and falling mortality due to improved healthcare. A new-born female in 2015 is expected to have a life-expectancy of 77.4 years while a new-born male is expected to have a life-expectancy of 72.5 years (Dept. of Statistics, Malaysia, 2015).

The challenge facing Malaysia now is to provide a healthcare system to meet the needs of an ageing population, both in physical health and mental health. In the National Health Policy for Older Persons 2008, the Government made a commitment to ensure optimal health for older persons through integrated and comprehensive health and health related services. The Government identified seven strategies namely, health promotion, provision of a continuum of comprehensive health care services, human resources planning and development, information system, research and development, interagency and intersectoral collaboration and legislation. The Policy is weighted towards physical well-being. It was only at a later date that screening for dementia and management of dementia were incorporated under health promotion.

In terms of mental health, Malaysia has a mental health framework, developed in 2001. This was based on the Victoria Mental Health Framework 1998. The Malaysian Mental Health Framework envisaged multidisciplinary approach to the assessment, treatment and management of older people with mental health problems. It emphasises the community outreach team as a core component of the service. However, the implementation of the framework is dependent on the resources available in the local authority.

In this newsletter, we describe the Mental Health Services for Older People in Johor Bahru.

Mental Health Service for Older People in Johor Bahru

Johor Bahru is the southernmost city in Peninsular Malaysia. It is the capital of Johor, the southernmost state in Peninsular Malaysia. It stretches an area over 185km. It has an urban population of 1.3 million. 5.6% of this population is aged 60 and above.

The Mental Health Services for Older People (the Service) is based at Hospital Sultan Ismail, Johor Bahru. The hospital has a fully computerised system (Total Hospital Information System) and all records are in electronic format.

Due to service needs, the Older People Mental Health Services at Hospital Sultan Ismail do assess and manage working age population, very often via the Liaison and Emergency Department route. The service also conducts working age outpatient clinics.

The Service is consultant-led supported by junior medical staff and nursing staff. It is predominantly an outpatient and community service. Inpatient beds for psychiatric admissions in medical wards are available but these are limited to two beds in the medical wards. There are four Outpatients Clinics per week; two clinics (one new case clinic and one follow-up clinic) are dedicated to working age adult, three clinics are dedicated to older people: two clinics for functional illnesses (one new case clinic and one follow-up clinic) and one dedicated Memory Assessment Clinic.

There is a handover meeting each morning; the medical officers discuss on-call or urgent cases and the community team discuss the previous day's home visits. The Service has a monthly multi-disciplinary meeting with other health care professionals where complex cases are discussed and appropriate referrals to the multidisciplinary team are made.

There are three nursing staff assigned to the community. Each nurse is a case manager and has a workload of thirty patients at any one time. They cover a mixed urban and semi-urban area of approximately 40 km radius from Hospital Sultan Ismail. Patients are referred from the outpatients' clinic. Following home visits, cases are discussed in the daily handover meeting and the consultant makes the decision on whether it is appropriate to discharge patients back to the outpatients' clinic or from the service completely.

Staff Training

Junior doctors in Malaysia complete a two year pre-registration house officer training similar to foundation training in the UK. This is followed by mandatory two years of service within the government sector as medical officers. This is similar to the 'senior house officers' status in the UK prior to Modernising Medical Career. Medical Officers usually request to be placed to their specialty of interest towards the end of their house officers' training. However, the requests may be denied or deferred as the Ministry of Health may allocate placement into specialties and geographical localities of greatest need. For example, a medical officer may spend a few years in either Medicine or Emergency Department before obtaining approval to begin training in Psychiatry.

Following placement in the Psychiatric Department, medical officers are encouraged to apply for Masters in Medicine (Psychiatry) through competitive interview. The course is run by the local universities. During the four-year course, 'Masters Students' are rotated through various specialties for example, general psychiatry, forensic psychiatry and old age psychiatry. This is equivalent to the Basic Specialist Training Scheme in psychiatry in the UK. Following completion of Masters in Psychiatry, trainees spent a minimum of six months 'gazettement' in supervised clinical environment to ensure competency to function as independent clinicians. The curriculum is similar to the Royal College of Psychiatrists Higher Specialist Training curriculum. Once gazettement is completed, trainees are eligible to apply for inclusion in the National Specialist Register. Once approved, the trainees are granted the status of Specialist.

Specialists are encouraged to further their training into Subspecialties Fellowship programme. This is equivalent to the Higher Specialist Training Scheme in the UK. Specialists intending to subspecialise in Old Age Psychiatry are required to undergo a three year Fellowship Programme including one year abroad. Hospital Sultan Ismail and Hospital Kuala Lumpur are the two designated centres approved by the Malaysian Ministry of Health for Old Age Psychiatry Fellowship Programme.

Similarly, nursing staff are trained in government and private nursing colleges. They received basic nursing training for a period of 3 years before being placed in areas of greatest need. Nurses have the option to undergo post-basic specialist training after a period of 2 to 3 years of clinical experience. However, depending on clinical needs, a nurse with post-basic Psychiatric training may not be placed in a Psychiatric Department.

It is also worth noting that in times of crisis such as natural disasters, medical and nursing staff are required by the Ministry of Health to participate in emergency/disaster relief. Disruption to service delivery is inevitable yet it allows for individual clinicians to maintain their general medical skills.

Referrals

The Service received referrals from government and private general clinics in the community, from other medical specialties including emergency department and from liaison referrals.

The Memory Assessment Clinic at Hospital Sultan Ismail is the only one in the state of Johor and is one of 15 clinics in Malaysia dedicated to the assessment of memory. As such, it is not unusual for patients and their families to travel a distance to attend the clinic.

Medical cost

The government clinics charge a nominal fee of RM1 including prescriptions for general consultations. A specialist clinic consultation such as mental health costs RM5 – the cost covers prescription and investigations, including neuroimaging. However, the fees are waived for individuals over the age of 60 and individuals with disability card.

Burden of care

Filial responsibility is deeply ingrained in the Malaysian culture. Families and caregivers looked after their loved ones at home, sometimes to the detriment of their own health. Stigma against mental illness is prevalent in Malaysia. It is not unusual for patients to seek alternative or spiritual treatment before approaching conventional mental health treatment. As a result, the Service manages many individuals in crisis or when their illnesses have progressed to a severe degree.

Alternative care in nursing homes is an option although it is costly for the average family. The nursing homes traditionally focus on the physical aspect of care. Staff have little training in managing the behavioural and psychological symptoms associated with dementia. Nursing homes in Malaysia are privately owned.

Under the Private Healthcare Facilities and Services Act 1998, owners of nursing homes are required to adhere to the strict guidelines and monitoring enforced by the Ministry of Health. This legislation can be circumvented if the nursing homes are registered under the Care Centre Act 1993. This is under the jurisdiction of the Ministry of Women, Family and Community Development through the Department of Social Welfare. The Care Centre Act 1993 does not have specific guidelines for nursing homes which may result in lower standard of care for residents.

Future for Old Age Psychiatry in Malaysia

Old Age Psychiatry is still in its infancy in Malaysia. There are approximately twelve Old Age Psychiatrists currently in practice (including ourselves – one of us is supernumerary) and one in training in Malaysia. Given that the population in Malaysia is ageing, the demand for Old Age Psychiatrists will increase in the near future.

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Developing Criteria for appropriate referrals for younger patients (under 65) presenting with memory complaints to old age psychiatry services in UK.

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Diagnosis rates for dementia have historically been low in UK. In 2010/11, less than half (42%) of those estimated to have dementia were being diagnosed. Alzheimer's society launched a campaign to improve diagnosis and the rates still only increased to 48% by 2012. Successive national campaigns, primary care QOF targets and financial incentives for GPs for case finding and several Prime Minister's dementia challenge targets increased the diagnosis rates to 59% by June 2015. The diagnosis rates currently stand at 67.4% (March 2016) and the conversation has moved to post diagnostic challenge and beyond at the behest of the National Clinical Director for dementia.

Increased public awareness of dementia, creation of a million Dementia Friends and several dementia friendly communities bear testimony to the success of the dementia strategy in UK. This had however led to few unforeseen consequences.

First, national and international debate started on importance on "early" diagnosis, general population screening for dementia etc. This led to launching of European Union Joint Action on Alzheimer's initiative who published ALCOVE guidelines on "timely" diagnosis (Brooker et al, 2014) and the debate has been settled for the time being.

Second, memory services in UK started receiving increasing number of referrals from primary care for younger patients (under 65) presenting with non-organic memory problems like FMD (Functional memory Disorder) and SCI (Subjective Cognitive Impairment).

Nonorganic, functional memory disorder (FMD) is frequent in memory clinic patients, and is an important differential diagnosis to prodromal dementia. Schmidtke K et al (2008) identified causes of distress in FMD were overwork, interpersonal conflicts, somatic illness, adjustment disorder, dysthymia, and Alzheimer phobia. The study reported that at follow-up, FMD had resolved in a few and concluded that FMD is a long-term rather than transient problem. Possible reasons include the persistence of burden factors and the failure to evade the “stress spiral” of mutual reinforcement of distress and cognitive dysfunction.

A similar but slightly different condition was identified as Subjective Cognitive Impairment (SCI) where patients report subjective cognitive impairment without any objective evidence of cognitive impairment (in comparison to patients diagnosed with MCI) and their cognitive problems do not cause any functional impairment (Riesberg and Gauthier, 2008). In 2010, the same authors found that a certain subsection of patients with SCI have 4.5 times higher risk of developing MCI within 7 years. It has been proposed that at least some of the cognitive problems stem from depressive and anxiety symptoms rather than from cognitive decline (Weisenbach et al, 2012).

Finally, memory services have started receiving increasing number of referrals from their general adult colleagues of patients with severe and enduring mental illness who report new onset memory problems as they get older.

Most memory services in spite of being ageless are geared to assess and manage people over 65 with dementias. Referrals for patients are however on the rise and this includes those under the age of 65yrs. Though rare, it is estimated that there are now 42,325 people with early/young onset dementia (under 65) in the UK. The most common causes of young-onset dementia are the same progressive diseases that cause most cases of dementia in older people. However diagnosis in some cases can be delayed due to atypical presentation.

Reasons for recent increase in referrals for assessments for patients under the age of 65yrs vary but can be broadly categorized into the following groups:

- Those who present with SCI or FMD
- MCI (Mild Cognitive Impairment- amnesic and non-amnesic types)
- Memory problems in those who have past history of depression/anxiety and are either still on long-term antidepressants or have a history of antidepressant use
- Patients with Severe and Enduring mental illness (e.g Schizophrenias, Bipolar disorder on longstanding psychotropic medication) who are in secondary care with adult services and report new onset memory problems. There is also a group who may have longstanding cognitive problems

It is to be noted that the above mentioned categories have also led to an increase in referrals for

patients over the age of 65 years.

A recent study (Kelly et al, 2015) in Cornwall showed 81% of the people referred did not have a dementia, including 7 people who disengaged, yet the assessment process would have impacted on clinical and administrative time. A Service Evaluation (North Wales- published as a poster in RCPsych meeting, 2016) shows that 72% of referrals to young onset dementia service in last 10 years did not have dementia. Another recent audit in West London (personal communication, May 2016) indicates 88% of referrals did not have a diagnosis of dementia.

Hence whilst there is a need to raise awareness for appropriate and timely referrals for younger people with memory problems and there is a drive to improve diagnostic rates in younger people with possible dementia, there is also a need to develop suitable guidance for referring appropriate patients to secondary care. This may include developing screening measures at point of referral prior to request for assessment in secondary care old age services (Rasmussen, 2015). The three audits conducted in three different UK regions provide ample evidence of this need.

The authors would like to find out experience of other old age services in the UK and would welcome if the faculty assist in carrying out a national survey to understand the nature and extent of the problem. It would be useful if a detailed literature review can be conducted on studies which looked at long term outcome of patients diagnosed with subjective cognitive/memory impairment/disorder, functional memory disorder etc. The authors wonder whether the above would help in identifying 'at risk' groups for primary prevention of dementia as well as facilitate developing a model of referral screening in primary care. The authors believe that in the face of mounting pressures of austerity, publication of how NHS England expects to achieve a £22billion saving by 2021 in line with 5YrFV (HSJ, 9th May 2016) drive towards integrated care and implementation of mental health PbR (Monitor, 2016), it is important that this piece of work is carried out so that mental health trusts and specifically old age psychiatry services carry out appropriate clinical work which will be paid for via PbR. This should also enable us to take a lead role in integrating diagnostic and management of service delivery for patients presenting with memory problems (especially those who are under 65yrs old) in primary care.

We believe such a criterion development would assist not only psychiatrists but also neurologists, geriatricians, GPs, GPSIs in psychiatry and general adult psychiatrists.

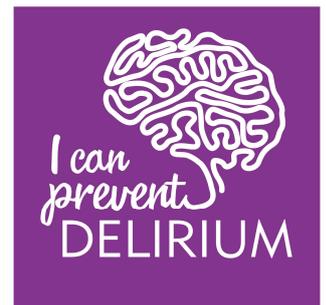
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**#icanpreventDelirium Conference &
Leadership and Management Development**

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The message from the medical profession is that all doctors should attain leadership and management competences in addition to clinical knowledge to be an effective practitioner. As a trainee at times there is little opportunity to establish a footing in this role and develop the relevant competencies outside set leadership courses.

Every year in Tees, Esk and Wear Valley NHS Trust there is an opportunity to present a business proposal to a panel of medical education leads, akin to the NHS version of the BBC's *Dragons Den*. This is to bid for funding and support within the Trust to develop an innovative project.

The focus on our work began within liaison mental health where there was a noted a surge of referrals relating to delirium diagnosis and management. Staff on the acute wards appeared to lack confidence in identifying cases and managing behaviours relating to it. The prevalence of delirium in patients based on hospital medical wards is 20% to 30% requiring a growing requirement of input within mental health liaison services. In addition the number of undetected cases is thought to be as

high as 30% to 67%. Overall the growing problem of delirium is leading to increased patient morbidity. This is where our vision was conceived, to implement an intervention to improve confidence of staff in managing delirium and improve the service patients were receiving from mental health and the acute trusts.

The first meeting with the Dragons was in 2013 when a bid to produce and roll out a teaching project within the acute hospital trust on the topic of Delirium. A small budget was given for print costs and time away from clinical duties granted to carry out the intervention. The teaching project was a success with 200 staff trained in delirium recognition and management. Surveys carried out following the teaching sessions demonstrated an increase in confidence of staff in all domains of predicting, identifying and managing delirium.

Two years later, a bigger impact was needed, a decision was made to go back to the dragons and ask for funding to hold a conference for front line staff who may come into contact with patients experiencing Delirium. Following a literature search there was evidence relating to the benefit of teaching interventions within delirium, emphasising multi-dimensional and multi professional approaches as best methodology for such interventions.

A business proposal was created to bid for resources from the budget of the Trust medical education department. Stating this was a daunting experience is an understatement, the pitch had to be succinct and to demonstrate the need for this intervention. The creation of a large scale business plan was underway drawing up costs for venue hire, speakers, staff time away from clinical duties and weighted against the potential benefits for the large scale educational intervention. Our vision was received well and the feedback was positive, ultimately we won enough money to fund a 200 strong delegate conference, print costs, travel costs for speakers; now we had to pull it together.

The team optimistically approached renowned speakers in the field of delirium and invited them to come to a small town in the Northeast, the positive responses received was overwhelming. With the Trust backing, it allowed doors to be opened to contact educators and leads within the local acute hospitals, the community workforce in care homes and social services to promote the conference. Every avenue was explored to network and spread word of the project to great effect. The conference had reached target numbers within two week of registration opening. Other colleagues were recruited to join the project to manage the large delegate and speaker numbers. The preparation for the day was relentless in the weeks running up to the event. The team was adding and adjusting ideas to ensure that the level and input was right for our delegates, we made certain the day would be run to time and that our speakers were kept involved in proceedings.

We created our own brand for the event #icanpreventDelirium. This allowed us to use social media to spread our message not just locally but to highlight Delirium across the UK and beyond. It showcased excellent work and interventions done in our area, such as our delirium prompt card, and promotion for our Trust. Tweets were encouraged in the run up and during the conference to get delirium awareness trending.

The day of the conference came and went like a blur. The organising committee, in their very own designed delirium t-shirts, were easily accessible to speakers and delegates throughout the day. Presentations went smoothly and timings kept. Overall the feedback received spoke for itself. 83% of delegate very satisfied with the conference, 16% satisfied. With 88% people very satisfied with event

staff and 83% with the registration process, 0% of delegates dissatisfied with the organisational aspect. In addition to the quantitative results, qualitative feedback gave us positive lessons, such as highlighting some aspects of community care was lacking coverage, and the missing sugar laden snacks at break times.

Overall, the project made a mark on raising the profile of delirium in the North East of England and in turn enhancing my own leadership and management skills. We would encourage all doctors in training to take part in running an educational intervention like this, not just for our patient benefits, but our own self-improvement. Delegation, networking, timekeeping have all been tested. We have learnt the skills to pitch for funding, to understand the corporate language and so much more. The journey has also highlighted the need for delirium to be part of the NHS agenda and the drive people have to put it there. As a result the second delirium conference is in the process of being planned. We are happy to hand (some of) the reigns over to our junior colleagues to allow them to experience the joy, and the stress, of this amazing journey.



Photo (left to right) : Dr M Krishnan, Dr K Barkas, Dr E Fixter, Dr S Bennett, Dr M Parker

For details on TEWVs first delirium conference please follow his link: <http://ow.ly/mt2W3027LMg>

Other resources Used in the conference:

Delirium awarenss video

Scan QR code for the video or click on the link



<https://vimeo.com/166857802>

<https://youtu.be/BPfZgBmcQB8>

Delirium Prompt card



Old Age Psychiatry Teaching and Training: online survey of higher trainees attitudes and experiences.

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There is a need to achieve healthy recruitment to Old Age Psychiatry and the experience of current trainees is a key factor determining this. There has been little specific evaluation of the quality of teaching and training in Old Age Psychiatry perceived by trainees, although the demands of service provision have potentially led to the loss of teaching opportunities, particularly formal teaching sessions. Keeping this in mind we did a survey looking at views of Old Age Psychiatry trainees on the quality of teaching and training in order to identify potential deficiencies and see what changes might help to maximise good practice.

This survey was first discussed in Trainees annual business meeting and piloted before final survey was carried out over a one month period during December 2015. An online survey monkey site was used for administration of the questionnaire and collation of responses. Trainees were contacted

about the survey and encouraged to participate, both through emails from the Faculty and through local trainee contacts. Demographic data were collected on gender, age, level of training, region of training.

The following structured information was collected on teaching/training experience:

- a) Frequency of teaching received relevant to Old Age Psychiatry.
- b) Level of satisfaction with Old Age specific teaching.
- c) Level of teaching and provider of teaching.
- d) Support including funding and study leave to attend relevant conferences/ courses.
- e) Perceived effectiveness of teaching as a preparation to be an Old Age Psychiatry consultant .

In addition open-ended questions were administered allowing narrative text responses focusing on the following:

- a) Good aspects of teaching received .
- b) Deficiencies noticed (if at all) including ease of organising the teaching, if involved, and any difficulties experienced in attending teaching sessions.
- c) Suggestions on how teaching in Old Age higher training could be improved .
- d) Suggestions on anything that the College/Faculty might do to improve Old Age Psychiatry higher training teaching.

Results

There were 95 responses in total. Most of the respondents were at ST5 level of training and majority doing dual training with maximum response rate being from trainees in London.

Concerning the frequency of teaching received relevant to Old Age Psychiatry, most trainees reported receiving this monthly or less frequently and with a third of respondents reporting dissatisfaction with teaching provision. Only two thirds reported receiving 1:1 Old Age specific teaching from consultant supervision and only a third reported receipt of formal teaching with protected time/sessions. Only a third agreed that teaching received was effective preparation for a future consultant job, and 27% actively disagreed with this statement. The majority of respondents reported receiving funding and study leave support for conference/course attendance.

45 responses were received on good aspects of teaching received, including the following statements:

- *“Clinical supervision has been excellent but this is very case specific. General teaching for old age psychiatry trainees would be very beneficial for training. The MOE trainees have training sessions (which we have been invited to)-I see no reason why old age trainees should have less teaching-perhaps there is a shortage of facilitators?”*
- *“Topics are relevant. There are some very enthusiastic and knowledgeable teaching consultants who are keen to promote their specialty and the particular interests and challenges it involves. It is quite an interesting area anyway in my opinion but the enthusiastic expert talking about it increases this effect significantly.”*

- *“Regular 1:1 time weekly but higher trainee and consultant organised regional teaching discusses complex cases and invites speakers so a varied programme emerges. The fact that regional teaching includes consultants’ staff grades and trainees makes it a diverse and interesting forum for discussion.”*
- *“Practical and relevant teaching from consultant”, “ Although there is very little formal teaching specific for Old Age Psychiatry, the weekly educational designated teaching sessions with other specialties feature Old Age Psychiatry from time to time. Also the Consultants and Educational supervisors are very supportive.”*

Forty-seven trainees described the lack of structure and organisation along with strict schedule with no protected time for teaching. This was exemplified by the following statements:

- *“Lack of organised teaching sessions for trainees. I think these sessions could also be useful to compare cases and learn from our experiences-we can't get everything from lectures and textbooks!”*
- *“I don't get any formal old age specific teaching at all, and supervision I don't really think substitutes as teaching as it has a very different focus/theme. I think this would be useful on about a monthly basis.”*
- *“Availability of protected time. Little OA specific teaching in the SPR teaching day as general adults seems to dominate and the non-protected time is harder to access as a dual trainee who is currently in general adults.”*

Forty three respondents made suggestions about how teaching at higher training level could be improved by introducing mandatory Old Age training days, with involvement of senior consultants in organising teaching and the possibility of having regional teaching so as to increase number of trainees and improve networking:

- *“More frequent old age specific teaching, maybe on the national or regional level to improve numbers. Better integration with our geriatric medicine, radiology, palliative care, general practice and neurology colleagues with joint teaching days.”*
- *“More involvement of Old Age Psychiatry Consultants in organising teaching sessions for higher trainees especially about their experiences of management of difficult cases”*
- *“Streamline higher trainee teaching days, bring in compulsory training days by individual trusts/hospitals. Create a forum where trainees can meet regularly preferably every other month.”*

In general similar themes emerged in responses on ways in which the College or Faculty might help to improve teaching. All who responded felt that the College had a major role to play in promoting speciality-specific teaching:

- *“For the Faculty to encourage all the Deaneries to have training targeted at the various sub-specialties. At the moment CAMHS and LD higher trainees have specific teaching programmes.”*
- *“As mentioned, working towards re-establishing old age psychiatry as a distinct specialty that requires a particular Specialism that cannot be replaced with generalists. Although it is recognised that this is at best an extremely Challenging goal.”*
- *“Encourage deaneries to organise teaching for higher trainees. Online modules, a resource hub for courses and journal articles about areas relevant to old age psychiatry. Co-ordinate more regional training/ networking opportunities”*

Bridging the Gap- Introduction of focussed and effective Old age psychiatry specific teaching

To our knowledge, a survey has never been completed before looking at teaching experience of Old Age Psychiatry higher trainees or at least if this has ever been previously attempted we could find no record available. The ability to administer the questionnaire online, in combination with the Faculty’s email list and active participation from regional trainees’ representative rendered sampling and data collection much more achievable than would have been the case in the days of postal surveys. Precise information on the source population (total trainee numbers) is not known but filled posts for 2012-2015 have approximated 230; if so, the 95 participants would represent a response rate of 41%. It should be borne in mind that all respondents were those who were registered with the Faculty at the time of the survey, and no attempt was made to take information from trainees who might not be on the Faculty register. Self-selection is clearly a concern in any survey and there was no feasible way to test the representativeness of the responding sample or biases which might influence participation. Finally, no attempt was made to recruit senior trainees from other specialties, so it is not possible to infer whether issues raised were specific to Old Age Psychiatry.

In terms of broad conclusions, the structured questions elicited what we feel are a concerning number of dissatisfied responses. There are clearly a number of positive aspects of Old Age Psychiatry specific teaching recorded in open text responses including the active participation of supervisors in making trainees feel confident, and practical and relevant teaching provided by consultants. Regular and committed supervision was viewed as a positive feature of the teaching; however, concerns were raised around the deficiency in structured teaching and frequency of training days for senior trainees and formal teaching / academic sessions. The most salient negative feature was a commonly reported lack of structure in old age specific teaching, possibly due to fewer trainees than in other specialties. The sense of Old Age Psychiatry being a less privileged speciality are understandably viewed as particularly important by trainees who have committed themselves to this career. A high proportion of trainees reported a shortage of facilitation and lack of formal organised teaching sessions as important concerns. Others highlighted work pressure being a barrier at times to attending regular sessions and hence the need to have protected time and mandatory

training days. The issues raised highlighted very evident concerns about functionalization and practicality of organising and providing old age specific teaching.

It is important to respond to the concerns raised by the trainees in order to continue to have cohorts of applicants for Old Age Psychiatry in future. Trainee attendance at training sessions needs to be supported by seniors, so that trainees are able to progress at appropriate training level along with introduction of mandatory training days and focussed, proficient, Old Age specific strategic teaching with active involvement of consultant, local trusts and college in promoting teaching at higher level. We believe that our findings indicate an urgent need to review more formally the quality of teaching and training in Old Age Psychiatry, in order to improve the confidence of our specialty's future consultants, and to promote our speciality as a justifiably attractive career choice.

ACKNOWLEDGEMENTS

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Update on psychotherapy training.

Alex Bailey, Victor Aziz

There have been some concerns from trainees about the increased requirement to achieve psychotherapy competences at ST4-6 level for successful outcomes at ARCP. This briefing sets out the position from the faculty executive for old age.

Psychotherapy competences have been included in the higher training curricula (including old age) since 2010. However, implementation has been patchy and has always been driven locally, which still remains the case. Psychotherapy competences can be found at various points within the intended learning outcomes, but particularly ILO 5, which states...

“Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions”

It appears that different regions are implementing this outcome in disparate ways. We are aware that it will have a significant impact on trainees' posts, as well as that supervisors may not be aware of the requirements and may be resistive to releasing trainees to achieve these competences.

The faculty feels that psychotherapy training at higher level does remain an important competence for all psychiatrists in training. However, with patchy implementation it makes it difficult for trainees to know how to proceed. The following guidelines should be considered...

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1. Trainees should discuss with their local psychotherapy tutors and TPDs what the expectations are in regards to local ARCPs in terms of psychotherapy requirements (including required relevant WPBAs such as SAPE). Concerns about not being able to fulfill these competences because of unclear local requirements should be relayed to relevant TPDs and the faculty would also like to be made aware (via the FECC co-chairs)

2. It should not be expected by supervisors that time should be taken out of special interest or research sessions to undertake further psychotherapy training (although of course trainees may choose to use their session for this if suitable experiences are available). This requirement should be discussed with your clinical and educational supervisors at the start of posts

3. Local psychotherapy tutors and TPDs must be able to furnish higher trainees with suitable experiences to achieve these competences

4. There is no requirement for psychotherapy training at higher level to be old-age specific. Whilst it would be preferable for older adult specific psychotherapy experience to be undertaken, the faculty recognises that services for OA psychology/psychotherapy are by no means uniform. Trainees should therefore avail themselves of any available psychotherapy experience, which may include experience of chairing Balint groups, facilitating CST where available, family therapy

and reflecting teams etc as well as more traditional experiences such as long and short cases with appropriate supervision

The faculty would be keen to hear about both difficulties and areas of innovation and good practice. Please feel free to email either Alex Bailey (alex.bailey@nhs.net) or Victor Aziz (victoraziz@doctors.org.uk) (FECC co-chairs) with comments.

Why should policy makers be interested in the demography of ageing?

(Part 3), Noel Collins



In a series of 3 essays, I have been examining why policy makers should be interested in the demography of ageing and the challenges that these will create for the delivery of future health and long term care in the UK. In my first essay (Collins, 2015), I looked at mortality trends, rising life expectancy and the rise of the 'oldest old' and whether health care rationing is an appropriate response to this trend. In essay 2, I examined several morbidity projections in older adults and how each scenario presents differing challenges for health and social care policy makers. In this final of three essays, I will discuss how social care policy may need to change to meet the needs of an ageing population. I will also look at the economic rhetoric of the 'population ageing time bomb' and how opportunities associated with an ageing population are generally overlooked by policy makers.

Previously we have looked at how understanding demographic trends of ageing is important for health policy and planning. It is arguably more important, and more difficult, for social policy makers to use demographic trends to plan for the future. One good example is long term care (LTC). LTC is difficult to define but 'encompasses a broad range of help with daily activities that chronically disabled individuals need for a prolonged period of time'(Stone and Fund, 2000) (p.1). LTC can be delivered in different settings *informally* by the family or *formally* by the state, the private sector or voluntary agencies at different frequencies and intensities. As seen previously with differing projections for morbidity and chronic disease, there are disagreements about projections in disability. For example, although the level of severe disability has decreased in the UK, mild and moderate disability rates may be increasing in the shorter term (Jacobzone et al., 1998). This combined with the aging population, suggests a potential increased need for LTC in the near future, but probably in community rather than residential settings. Currently the UK spends around 1% of GDP on publically funded LTC (Jacobzone et al., 1998), which makes it a poor relative to many European nations. What is the correct level of expenditure? And who should pay for any projected increase in the cost of LTC?

The issue of funding for social care goes to the heart of conflicting ideologies regarding the viability and future of the welfare state. This has been fiercely debated over the last decade (Coventry et al., 2005). Several reviews, most recently by Wanless, have examined the challenges facing the delivery of social care over the next two decades and recommended that the sharing of costs between individuals and the state is the most fairest method (Coventry et al., 2005). However, the UK government failed to not only agree on a funding model but also on more recent recommendations regarding financial thresholds for state support and the capped amount that anyone would have to pay toward LTC during their lifetime (Torjesen, 2012). It appears that the UK policy makers and governments remain proverbial ostriches with their heads in the sand in planning for future social care compared to other countries like Germany who have a comprehensive social insurance model already in place. It also seems unlikely that the UK will move towards a universal coverage system seen in Japan (Muramatsu and Akiyama, 2011) so policy makers should encourage older and younger adults to make their own plans for funding long-term-care. However, very few people make these provisions (Friedemann et al., 2004). This is important as the international experience is that as state LTC provision falls, informal provision must increase to bridge the gap (Johansson et al., 2003).

Irrespective of what future funding model for social care is agreed upon, policy makers must recognize that most LTC continues to be provided *informally* by family carers in most developed countries (Brodsky et al., 2000). It might be assumed that given the fertility rate in the UK remains below replacement level, that an army of potential informal carers is dwindling (Dunnell, 2008). Some social theorists have argued that western families are becoming less caring (Burgess, 1926) and if informal caring by families did decline, then the state would need to provide more LTC. However, although fertility has dropped, numbers of surviving children have increased (Murphy and Grundy, 2003) and the idea of a supportive 'latent kin network' of support is now more dominant (Bengtson, 2001). UK government data has demonstrated that elderly people are likely to receive more informal care than previously projected' (Pickard et al., 2000) (p.745). The demography of care giving (Agree and Glaser, 2009) is therefore vital in projecting future LTC care needs. The UK has begun to recognize the importance of informal carers through strategy and legislation, such as the Carers' acts of 1995 and 2004 which provide carers with rights to a needs assessment and improved access to training, work and leisure opportunities. Other policy strategies to support informal carers include formal guidance for carer support (Health, 2007), psycho-education (Thompson et al., 2007), understanding how best to combine formal-informal care (Sundström et al., 2002). However, most carers feel unsupported (Livingston et al., 1996) and financial assistance is lacking compared to other European countries. National carer strategies launched in 1999 and in 2010, with fanfare, have also had limited impact due to limited funding (Lloyd, 2000, Seddon et al., 2010).

Although demographic projections and future demand LTC scenarios reinforce the idea that there is only cost involved with an ageing population, this rhetoric can be challenged on a number of grounds. Spijker (2013) et al question the traditional measure of the burden of an ageing population – the old age dependency ratio – which is the proportion of the population above the statutory pension age. This has been rising gradually but 'defines all people above the statutory pension age as dependent, regardless of their economic, social, or medical circumstances (Spijker and MacInnes, 2013)'. The baby boomer generation which is currently entering retirement do so with more assets and pension funds than any retiring group before it, and perhaps after (Freedman, 2002). Retirees,

even if they are not economically active in the traditional sense, contribute vast amounts of money to the economy through caring for their grandchildren allowing their parents, particularly mothers, to be economically active (Wheelock and Jones, 2002). It is also important to remember that the vast majority of informal carers for older people are older spouses, with the highest levels of caregiving observed in people aged 80–89 (Dahlberg et al., 2007). Additionally, the increasing trend of intergenerational transfer of funds tends to occur from the top, downwards, rather than children supporting their ageing parents financially (Albertini et al., 2007).

In summary, whilst an ageing population does present challenges to health and social care policy makers, there are many benefits of an ageing population. Many of these are economic and should be publicized to help balance negative economic rhetoric surrounding current demographic trends. Perhaps we should look to countries like Japan, which has been ahead of the curve for many years in both celebrating its older population whilst making planned and incremental changes to its health and social care systems.

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A "Revised Approach" to the Mental Capacity Act 2005

Neil Allen, Barrister (39 Essex Chambers) and Senior Lecturer (University of Manchester)

On 25 May 2016, the Law Commission published a ten-page 'Interim Statement', three pages of which provide a brief summary of the likely general direction of travel for reform of the Mental Capacity Act 2005 ('MCA') and its deprivation of liberty safeguards. It follows a public consultation process consisting of 83 nationwide events and 583 written responses from interested persons and organisations. Despite its brevity, the statement reveals a substantial revised approach, not just to deprivation of liberty but to the MCA itself. This short paper focuses upon how this may impact upon those practicing in old age psychiatry.

Core Amendments

One of the most significant proposals is to amend certain core tenets of the MCA. Better Article 8 ECHR (European Convention on Human Rights) protections will primarily aim to ensure that there is proper consideration given, and the necessary assessments undertaken, as to the need to remove someone lacking capacity into institutional care before a best interests decision is made. Care plans are likely to include a record of the person's capacity to make the relevant decision and best interests assessments, setting out restrictions and confirming the legal arrangements under which the accommodation is to be provided. In short, they aim to secure better implementation of the MCA and better access to advocacy services.

The second important core amendment proposes to give "greater priority to the person's wishes and feelings when a best interests decision is being made". One way of doing so would be to introduce a rebuttable presumption within the MCA s.4 best interests checklist. Perhaps the decision maker would be required to have special regard to the person's past and present wishes and feelings, beliefs, and values, so far as they are reasonably ascertainable. And the more others intend to depart from those, the more is needed by way of justification.

Another interesting, and potentially weighty, proposal is "qualifying the immunity from legal action" under MCA s.5 "to provide additional procedural safeguards in respect of certain key decisions by public authorities". No indication is given to what these key decisions might be. If the Mental Capacity Act (Northern Ireland) 2016 is anything to go by, they could safeguard serious interventions and certain treatments. Psychiatrists, for example, would not have a defense to liability for acts done or decisions made on behalf of those lacking capacity unless and until those additional safeguards are fulfilled, such as a second opinion for certain treatments.

Article 5 ECHR

The deprivation of liberty safeguards, and the Court of Protection equivalent, will be replaced by a new authorisation scheme. This will be available anywhere including hospitals, care homes, supported living and shared lives schemes, domestic and private settings. It will continue to be triggered by a "deprivation" of liberty ('DoL'). So case law, in particular *Cheshire West*, will continue to be key.

The supervisory body role will be abolished. Instead, the authorisation to deprive liberty will derive from the body commissioning the care arrangements. So local authorities and presumably NHS bodies will essentially authorise themselves to detain. Only a (currently undefined) "defined group" will get additional independent oversight by an Approved Mental Capacity Professional.

On the face of it, authorising oneself to detain a vulnerable person could be a significant cause for concern. But whether that concern is justified will depend upon the detail to follow. Who within the commissioning body will authorise? What checks and balances will there be? We will have to wait for the draft Bill at the end of the year to see exactly what the Commission has in mind.

The evidence necessary for a DoL authorisation from the commissioning body will include (a) a capacity assessment; (b) objective medical evidence of the need for a deprivation of liberty on account of the person's mental health; (c) arranging provision of advocacy (or assistance from "an appropriate person"); (d) consultation with family members and others; (e) an existing care plan.

This is not an exhaustive list. The DoL evidence thus focuses more specifically upon whether the person's mental health warrants detention.

The Interim Statement provides only examples of the Article 5 safeguards; so there may be more. For now, the person (and others, such as family members and advocates) will have the right to seek reviews of the DoL, bring legal proceedings to challenge it, and there should be comprehensive rights to advocacy. The Commission wants to ensure that the current processes under the Care Act and the Social Services and Well-Being (Wales) Act can be used to review the DoL. And, where appropriate, commissioning bodies should be able to rely on existing assessments to avoid unnecessary duplication. The availability of well-funded advocacy services and the scope of non-means tested legal aid will clearly be critical here.

Mental Health Act 1983

The Commission's original proposal was to introduce a lower-level power for compliant incapacitated patients, with the MHA reserved for those objecting. After consultation, this has been abandoned. Instead, the new scheme will not apply to those detained in hospital for the purpose of mental health assessment/treatment. So if compliant incapacitated patients "are to be admitted to hospital (general or psychiatric) for purposes of assessment and treatment for mental disorder [eg dementia], their admission should be on the basis of the existing powers of the Mental Health Act".

This will avoid the difficult interface we presently have between DoLS and the MHA. If the purpose of admission is physical healthcare, the NHS body will authorise the DoL under the Commission's new scheme. Whereas if the purpose is mental healthcare, the MHA will be used. In legal terms, this has the benefit of simplicity and more effectively closes the *Bournewood* gap. For psychiatrists, however, it means having to categorise the person's treatment and determine the key purpose. Indeed, the legal distinction between "physical" and "mental" healthcare is likely to remain so long as we have an Act specifically catering for mental ill health. Only a fused system would avoid it and that does not appear to be on the table.

The increased use of the MHA will inevitably lead to more people being entitled to section 117 aftercare. It would not be at all surprising therefore if this provision receives close attention during the parliamentary process. No mention is made in the Interim Statement of the interface between the MHA and the Commission's scheme when it comes to deprivations of liberty in the community. So it remains to be seen whether there will be tensions between the scheme and section 17 leave, guardianship, community treatment orders, and conditional discharges. If the commissioning body is self-authorising the DoL under the MCA, there is perhaps less room for confusion and disagreement.

Many people may worry about the resulting increased use of the MHA. Apparent stigma was a concern raised in the consultation. Although it would be at the outer reaches of, and perhaps beyond, the remit of the Commission's brief, there is a timely opportunity to amend perhaps the most stigmatising aspect of the MHA, namely the compulsory treatment powers in MHA Part 4. Unless the government decides to grasp that nettle during the parliamentary process, the opportunity seems likely to be lost this time round.

Coroners

The Commission proposes to remove the scheme from the definition of “State detention” in the Coroners and Justice Act 2009. Deaths will be reported to the new Medical Examiner system proposed by the Department of Health. This should mean that deaths from natural causes can be identified more readily and registered more quickly. Instead of every death in DoLS being referred to the coroner, in future it seems that referrals will take place if the death is attributable to, amongst other matters, a failure of care. This is likely to be welcomed by many.

Interim Conclusions

At this stage, the reforms are likely to lead to more formality in the documenting of capacity assessments and best interests decision-making. More safeguards will be available before those lacking capacity are admitted into residential care. Where the care arrangements amount to a deprivation of the person’s liberty, a more streamlined and less bureaucratic authorisation scheme seems probable, and with less independent scrutiny. Serious treatments might require second opinions. There will be greater use of the Mental Health Act 1983 in psychiatric wards, with less uncertainty as to which statute applies. And a better embedded system for reviews and challenging professional decision-making.

The jury of law reform is still out on two matters. First, whether a tribunal system will replace the Court of Protection. And, second, what the name of the new authorisation scheme for deprivation of liberty will be. All in all, the “revised approach” represents a significant watering down of “plan A”. More vulnerable people look set to receive less protection than currently provided for in the deprivation of liberty safeguards.

Integrating Physical and Mental Healthcare for Older Multi-morbid People – Gateshead’s Story So Far, Dr Karen Franks.

Introduction

We have a vision in Gateshead to create joined up healthcare for older people. This process is starting off with people in 24 hour care. Our hope is that if we can get it right for them we can get it right for anyone. We have therefore built a system around the care homes in the borough and aim to learn from and develop this outwards to those with multiple needs living in their own homes. When I say we, I am talking about a group of clinicians from primary and secondary care, physical and mental health, who are working together supported by the CCG (Clinical Commissioning Group) to try to achieve this aim. Our ability to do this has been strengthened by in 2015 being awarded Vanguard status as one of the six national Care Home Vanguard sites.

Mental health problems rarely occur alone in older people and nowhere more so than in a care home population. Those of us who work in the community know that the care home population is becoming sicker and frailer year on year. This can still come as a surprise to our hospital based colleagues. Geriatrician colleagues of mine have been amazed at the levels of ill health, frailty and multi-morbidity in 24 hour care settings exclaiming it to be more than on their inpatient wards.

Background

Our story in Gateshead dates back to 2008. GP colleagues were finding the workload from care homes unmanageable and homes were getting fragmented care, for example one home interacting with 14 GP practices. In response, local GPs set up a pilot in 2009/10 into the 5 homes with the highest number of hospital admissions. This centred on specified GPs visiting regularly, supported by an older persons specialist nurse (OPSN). The recommendation from the pilot was to change the way GPs interface with homes. This led to the Gateshead Care Homes Initiative (GCHI) being formed. This comprised an alignment of one GP practice per home, named GPs for each home and a system of weekly GP ward rounds into all homes across the borough. In 2013, OPSNs were employed to work alongside the GPs, initially into the homes with Nursing beds. Each nurse covers 2 to 3 homes. The aim is to work proactively to try to anticipate potential deteriorations in resident's health and plan accordingly, alongside reactive work. All residents have an emergency healthcare plan developed. These plans involve the views and wishes of residents and their families as well as care home staff and healthcare professionals.

Alongside the rearrangement of GP services, those of us in secondary care were involved looking at how we could support and interface with this. In my usual clinical role, I had been working alongside the system during the pilot and kept in close contact with the GP leads in order to make sure that we could keep mental health needs at the heart of future service development. Geriatrician colleagues had been working with the GPs to look at evolving the Community Geriatrician role which at that time was small and linked predominantly to the CROP (community resource for older people) team.

Eventually this primary and secondary care interface crystallised in the formation in 2013 of the Care Home MDT (now called the Virtual Ward). This is a weekly meeting attended by all the OPSNs working into the care homes, the community geriatricians and myself as consultant old age psychiatrist. We also have intermittent input from pharmacists, physiotherapy, dietetics, psychology and social workers. The aims of the Virtual Ward are to provide swift access to secondary care advice and input to the care home residents and GPs. We discuss cases brought by the GPs and OPSNs, provide advice and feedback, find out additional information eg from inpatient notes to inform current issues and arrange to visit as necessary. There is an education slot every week. As well as unnecessary admissions to hospital we also aim to avoid unnecessary outpatient visits for this group of patients as much can be dealt with through discussion and domiciliary visits. We and the GPs find it invaluable to have a group of clinicians who specialise in older people's complex care who are able to work together using shared decision making to form and support balanced management plans. The understanding that it is impossible to follow NICE guidance for all of a resident's eight comorbidities coupled with a close knowledge of care home system as well as the healthcare system adds to the value.

Mental health component

As a psychiatrist, I find it productive to be able to manage people's mental health in close conjunction with their physical health alongside an awareness of each home as a social system. It helps raise the profile and recognition of dementia and mental illness, and its interplay with physical health conditions. Our input pushes the importance of non-pharmacological strategies and the role of interpersonal relationships in care settings alongside the pharmacological strategies. We work closely with the challenging behaviour team of which I am also part of.

Initially my attendance at the care home MDT was not in my job plan but I attended about fortnightly when possible as I felt it was useful. This was soon recognised by the CCG and we were formally commissioned to provide consultant sessions into the GCHI. My input clinically is different to that of the geriatricians. I cover all the homes with EMI Nursing and proactively visit these about every 4 to 6 weeks alongside the GP and nurse specialist. I can then use the MDT to keep up to date on progress and as well as answer queries. The other homes are covered by my colleagues whose job plans mean that they are unable to work in the way I do. I can give advice and pass on information but the model is fragmented. Our hope is that going forward we may be able to get additional consultant sessions and dedicated RMN time to support the team.

Vanguard

On the back of this work, Gateshead has been awarded one of the 6 Care Home Vanguard sites nationally. This will enable us to progress the model further and disseminate our learning more widely. The vision for our Vanguard is not to limit this work to care homes. It is to further develop this and use these models to try to improve care for the wider elderly population, potentially replicating the Virtual Ward on a locality basis across the borough to serve those in their own homes in a similar format. This is work in progress.

Learning

Main learning points so far include that communication is the key, especially at interfaces of care. Communication is frequently very poor between hospital and primary care. Care homes themselves are often completely 'out of the loop'. Many mistakes are made on discharge from hospital, especially when people are newly moving into care and often changing GP in the process. Unsurprising to us, but perhaps more so to others, there is high levels of mental health morbidity in the population and this is not just confined to challenging behaviour in dementia which often is the main focus of resources. Co-working enables us to marry these multiple difficulties and balance their managements. The OPSNs are all RGNs and have had a steep learning curve in many areas but particularly in mental health.

Future

Future developments include OPSNs in all homes in the next few months. I need dedicated RMN input to support my role. My CCG, geriatrician colleagues and I agree that this is good use of consultant time particularly given the diagnostic, management and medical complexities of this patient group but that the current level of resource does not allow an equitable service to all residents. The Vanguard is a fantastic opportunity to influence not only health care but the wider care environment of our patients. We are currently working on workforce development improving supporting skills and knowledge and on how best to integrate people's family carers better into the communication with care teams. We are prioritising the environments and opportunities for meaningful activities in the homes which we know can make huge difference to people's mental health and well-being and thus need for medication and input from specialist services. We are engaging to find out how we can develop and maintain strong leadership within the homes. However good the care is 'on the ground' this needs robust support and leadership from the manager and employing organisation above to allow good practice to be maintained and flourish.

Conclusions

There are likely to be developments happening in your area with care for older people, especially centred around primary care, community management of physical health conditions and hospital avoidance. If mental health is not included at the present it will be excluded or there will eventually be recognition that it is needed. It may then be added in as an afterthought, potentially amounting to a token amount of mental health nursing input. In my view, as old age psychiatrists we have an opportunity to steer care and services. In mental health we already have skills working across multiple community and hospital settings which is not the case for most other specialities.

I feel that that senior experienced medical staff in our speciality need to be involved in service development and clinical care in this area. These are people with complex needs who need experienced specialist input to ensure quality care. The models of care being developed for this group are likely to guide and inform wider services in the NHS of the future.

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Addressing the mental health needs of older adults in primary care: - my experience of setting up a service

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Introduction

A proportion of organizations in the UK who provide mental health services for older adults do so as a generic service for functional disorders or through memory clinic for organic disorders (Hill, 2008 & Warner et 2013). The author believes that Wrexham in North Wales was among the first to offer an age appropriate primary care mental health service for adults with suspected mental health disorders of both a functional or organic nature. In 2010 Wrexham saw the introduction of Primary Care Mental Health Nurses (PCMHN) specifically for older adults. This paper looks retrospectively at the work involved.

In 2009 in order to meet the growing demand on mental health services (National Service Framework 2001) funding was sought to employ four primary care mental health nurses but due to difficulties in recruitment, it was agreed to second two Community Psychiatric Nurses to set the service up. Having worked for 8 years in a community mental health team for older adults, the author was ready for a new challenge. It was an exciting time as it required intensive planning and discussions to develop the aims and objectives for the proposed service. The work included arranging several fact finding sessions, meeting with stakeholders from other agencies and secondary care services and raising awareness for the new service. A newsletter was produced to keep primary care agencies updated. Information sessions were arranged throughout Wrexham for various professionals in order to introduce the service and answer any questions.

Each of the aims and objectives had an accompanying timeline, which was reviewed as the service progressed. The referral criteria included adults over the age of 65 with mental health problems of both an organic or functional nature. Those under the age of 65 with suspected memory problems were also seen if a functional disorder needed to be excluded.

Once views of various professionals and stakeholders were sought and expectations acknowledged it was agreed that it was important to develop outcome criteria for the benefit of referees and those referred. To reduce duplication of assessments and paperwork, primary and secondary care core documents were agreed and implemented. Several other key pieces of documentation were created for use in Primary Care, which were agreed at a directorate level before being implemented.

The Service

At the time Wrexham had 23 GP surgeries to cover so it was agreed to implement the development of the primary care mental health service in three phases. An operational policy was developed based on some of the key recommendations within the National Service Framework for Older Adults (2001), stakeholder and service user feedback. This provided referral criteria, outcomes and a clear guidance on expectations from primary care mental health nurses.

The role of the primary care mental health nurses included:

- ☐ Pre-screening assessments/triage assessments
- ☐ Evidence based interventions
- ☐ Health promotion
- ☐ Medicine management/advice
- ☐ Education and training for staff, patients and carers
- ☐ Networking with other agencies
- ☐ Carer support
- ☐ Step up or step down care
- ☐ Development of a resource directory and signposting carers and patients accordingly

The main aim of the service was to increase early detection, diagnosis and management of mental health problems in older adults within a primary care setting. Collaboration with primary care colleagues ensured that the physical, social and mental health needs of those being referred were met.

Referrals to older adult community mental health services over the previous 12-month period were reviewed. With only 2 nurses in post it was agreed to launch the service in 2 phases, the first phase in 6 GP surgeries. The choice of the 6 surgeries was made on the following basis - 2 surgeries who regularly referred, 2 who never referred and 2 who sometimes referred to secondary mental health services. This mix was felt to be appropriate to identify if any changes in practice were to be achieved.

Meetings held with the key surgeries highlighted initial skepticism with comments such as “we have been here before and it stopped”, “what’s the point”, “we are not included in secondary care

decisions anyway about mental health” and “no we will stay as we are”.

This proved the need to develop a service which was prompt, efficient, evidence based and collaborative. The surgeries chosen were given a full or half day session. All surgeries in the Wrexham area were kept informed of the availability and progress off the service by a monthly newsletter.

Each surgery received an information pack which included the operational policy, the referral form, and information on community resources, a flow chart was produced which made it easier in the beginning to differentiate between services but eventually all those suspected of having a mental health problem were seen initially by the primary care mental health worker.

In the first three months the primary care nurses met with GP’s, community nurses, social services and housing associations, established logistics of patient access within or outside surgeries and set up an agreed system for data collection. Regular weekly meetings allowed the sharing of information and staff engagement. Regular audits were done at 3 months, 6 months and 12 months in order to initially address any teething problems but later to identify the strengths and weaknesses of the service. The service was implemented in two phases, at 3 month intervals and 6 surgeries were involved in each phase. There was to be a third phase but this was placed on hold as the two other primary care posts were not filled and discussions began around implementation of the Mental Health Measure (National Assembly for Wales, 2010).

The 3 and 6 months referral figures and short feedback suggested the service was meeting the initial aims. At 12 months it became evident the service was a success and this was partly down to practitioner’s enthusiasm, hard work and determination. An anonymous postal questionnaire was produced for service users, carers and GP’s as part of the audit. Written and face to face feedback was sought from all stakeholders.

Service Evaluation

Referral figures to the primary care service were reviewed in 2011 and it suggested the following interesting outcomes. Referrals to primary care mental health services increased in every surgery in the first 12 months of the service launching, this increase in referral rates to the primary care practitioner was up by as little as 21% in one surgery and as much as 66% in another. As expected, the surgeries who never referred began to refer consistently. Having two practitioners based in primary care reduced referrals to the community mental health team by 80% in the first 12-month period, these were referrals which were directly from GPs and not from other sources. The referrals showed in the first 12 months that 54% referred had a memory/cognitive disorder and were referred to memory clinic, the remaining 46% were diagnosed with a functional disorder.

The increase in referrals and working alliance with GP’s were reflected in the audit feedback which included comments such as

‘increased referrals reflect the quality of the service to patients...

‘We would previously manage these in house rather than refer as so many were rejected’.

‘If I refer I want to know the outcome and not wait in some instances for 6 weeks’.

“having someone I can discuss my concerns with is much easier”.

In 2012 Wales introduced the Mental Health Measure (National Assembly for Wales, 2010) which changed the way mental health services were delivered. The Mental Health Measure for Wales details the support that should be available for people of any age experiencing mental health problems. Prior to the introduction of the measure there had been discussions that primary care should become a generic service but the success of the service supported the author to continue in her role.

Conclusion

The suggestion that a generic mental health worker can effectively meet the needs of an older adult the author believes was a parsimonious decision and one which is highlighted by Warner & Jenkinson, (2013). Older adults are often faced with multiple, comorbid chronic physical health problems (Graham et al, 2011) and mental health issues. This affects many aspects of their lives; from their physical and mental health to their level of social interaction and being able to perform daily living tasks. Older adults have chronic diseases which places them at an increased risk of depression or anxiety, they also have an increased mortality rate because of these.

Primary care nurses are at the forefront of dealing with the physical and mental health issues of older adults and service delivery has to be robust enough to meet these demands. Depression and Anxiety are mainly dealt with in Primary care (Burroughs *et al*, 2006). However can be under diagnosed for a variety of reasons including it being seen as a normal part of aging (Burroughs *et al*, 2006).

With an aging population in the UK (Clarke et al, 2004) there is a clear need to not just expand the service currently offered in primary care but also to provide a service for older adults which is equipped to recognize their specific physical, mental health, social and psychosocial needs (Hilton, 2012). Warner & Jenkinson (2013) suggests that psychiatric practitioners need to be able to understand the social, psychological and physical consequences that come with the aging process. A survey by the Royal College of Psychiatrists found that an ageless service was regarded as very good or good by 16% (37/230) of respondents, and bad or very bad by 52% (121/230) of respondents, they add to this the suggestion that the trend for ageless services will disadvantage further a growing and already disadvantaged part of society (Warner & Jenkinson, 2013).

The author feels strongly that this specialist mental health primary care service has definite benefits to meet the challenges of the aging population, hence the need for expanding this service to ensure that the aging population are provided with a specialist service which is able to meet their complex needs and requirements (Warner, 2014).

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Glimpses of the history of Old Age Psychiatry in the 1960s: Barbara Robb and *The Organisation of Psychogeriatrics*

Claire Hilton

The lure of second hand bookshops is partly the thrill of finding unexpected books, the ones you can't buy on the internet because you didn't know they existed. In a warehouse-size bookshop in Hay on Wye, I came across a pamphlet *The Organisation of Psychogeriatrics* (1971) by David Enoch and John Howells, published by the Society of Clinical Psychiatrists (SCP).ⁱ The SCP was established in 1958 to achieve more clinical freedom for consultant psychiatrists in the days when medical superintendents ran, or ruled, the mental hospitals and the Royal Medio-Psychological Association (the forerunner of the RCPsych).ⁱⁱ

In the 1950s and '60s, far too many older people, if mentally unwell in any way, were assumed to have untreatable dementia. Creating diagnosis-based proactive, treatment and rehabilitation focussed, psychogeriatric services was novel. A few existed, or were starting, notably in Newcastle upon Tyne and at Crichton Royal (Dumfries),ⁱⁱⁱ Severalls (Colchester),^{iv} Claybury (Essex), St Francis (Brighton), Barncoose (Cornwall), Exe Vale (Devon)^v and Goodmayes (Essex). Epidemiological studies

demonstrated the need for dedicated services,^{vi} and evidence that they could be clinically and socially effective emerged from the hospitals piloting them.^{vii}

How did *The Organisation of Psychogeriatrics* come about?

Barbara Robb (1912-1976), a former ballet dancer and psychotherapist, visited a 73 year old acquaintance, Amy Gibbs, admitted to Friern Hospital in 1963, and still there in 1965. Robb was appalled by the inhumane and disrespectful care, such as slapping patients; undignified bathing arrangements; appalling food; last meal of the day served at 3.30 pm; bed time at 7pm; lack of dentures, spectacles, and hearing aids undermining independence and lack of activities, personal clothes and privacy undermining dignity and self-respect.^{viii} Wards were overcrowded (often twice as many beds as planned) and understaffed (e.g. one trained and three untrained staff for 84 'ambulant geriatric' patients).^{ix} Robb decided that she had to improve the situation. She began a campaign.

In 1966, Robb attended a three day conference 'Tackling senility', at Severalls Hospital, where she met, among others, psychiatrists, Tony Whitehead, Russell Barton, and David Enoch.^x Barton and Whitehead ran the exemplary, comprehensive psychogeriatric service at Severalls. Enoch, a recently appointed consultant psychiatrist at Shelton Hospital, Shrewsbury, was particularly keen to improve his long-stay wards. He spoke about them in an oral history interview in 2015:

'Bathing was in public...to all intents and purposes...the doctors would go in...we would see them bathing...yes... there was no privacy. That was one of the big things ... I was a fresh young man, I wanted dignity, without thinking of the word ... as a great word... the correct word... it just came....

We had a long ward in Shelton, and that became mine. I went in through the door, there is an old picture, bent, with a rusty wire hanging, then I'd go into this long passage, dribbling men, some half naked, some badly dressed.

In each of the wards, starting with one female and one male, I got carpets. The men who went out to the farm got a second suit. Then they got a narrow cupboard ... And then they began to meet, with one of the staff chairing it, and to talk about the ward and what they wanted ... and powerfully advocated privacy.'^{xi}

Robb published *Sans Everything: a case to answer* in 1967, containing eye-witness accounts by staff and visitors of degrading care of patients on long-stay wards in seven hospitals. The book also contained proposals for improvements. Whitehead, Barton and Enoch all contributed chapters. *Sans Everything* inspired the SCP to create the study group on psychogeriatrics.¹¹ Enoch wrote to Robb in October 1968:

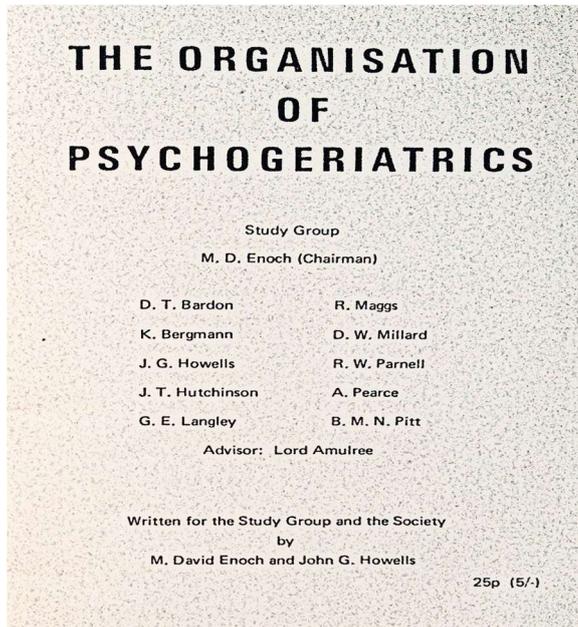
'I know you'd be interested to learn that the Society of Clinical Psychiatrists appointed a Study Group 6 months ago to deal with 'Psychogeriatrics' and kindly (or unkindly!) asked me to be the chairman, Lord Amulree being the Advisor.

We're in the process of gathering data.

The eventual aim is to produce a 5,000 word summary of the situation and recommendations, hoping to get [the] backing of this go-ahead Society'^{xii}

Fig 1.

Title page, *The Organisation of Psychogeriatrics, 1971*



The study group comprised geriatricians and interested psychiatrists. Their names appear on the title page (Fig 1). They met regularly for 2 years to produce the 20 page booklet. Its main recommendations were to:

- Carry out a thorough survey of older people in psychiatric hospitals, with a view to treatment, rehabilitation and discharge.
- Establish more geriatric and psychogeriatric assessment units, and strong liaison between them.
- Establish psychogeriatric services to cover the full range of psychiatric disorders in older people, not just dementia.
- Provide community-focussed services, for 'clinical, economic, social and humanitarian' reasons.
- Provide teaching to staff at all levels.
- Undertake research.

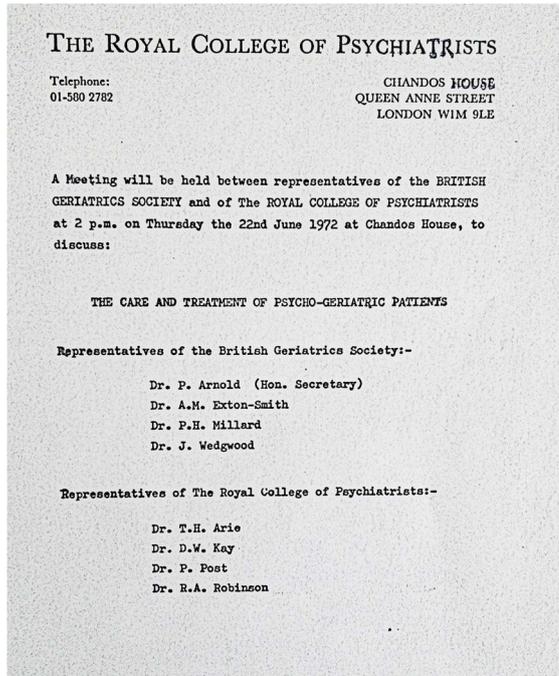
It strongly urged the Regional Hospital Boards, which had responsibility for the hospitals, to establish services as 'The tendency to leave the aged in mental hospitals largely without any organised service is to be deplored.'

What happened?

The Organisation of Psychogeriatrics was instrumental in the British Geriatrics Society approaching the RCPsych to establish a joint working party in 1972. This BGS/RCPsych group aimed to promote clinical collaboration and provision of old age services for physical and mental disorders. The group comprised four geriatricians and four psychiatrists (Fig 2). The four psychiatrists were also founder members of the Special Interest Group for the Psychiatry of Old Age at the RCPsych, now the Faculty. An initial series of meetings produced recommendations endorsed by both organisations,

including better collaboration, better training for doctors and nurses to help manage patients with complex needs, and prioritising ‘the patients’ changing needs rather than [...] administrative considerations.’^{xiii}

Fig 2. BGS/RCPsych meeting, 1972



Source: Professor Tom Arie’s archives

Comment

In a virtually desolate field of custodial care for older dependent people, clinicians’ enthusiasm and determination began to change widespread un-helpful custodial practices deeply embedded in psychiatric services and in the NHS more broadly. The work of Enoch’s committee was one of many strands which came together to help establish the new specialty of psychogeriatrics in the early 1970s. It was also one outcome of Barbara Robb’s many influences on the development of older people’s services and the NHS more broadly.

Acknowledgements:

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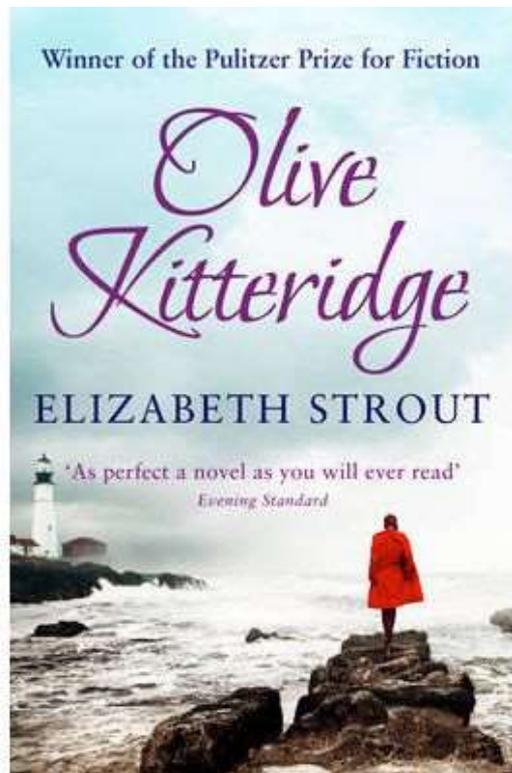
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Olive Kitteridge by Elizabeth Strout review – painfully honest

Hannah Rollmann, Psychiatry CT1 in North London

Published by Simon & Schuster UK, 288 pages (Kindle edition £5.99, paperback £7.99)



Winning the Pulitzer Prize for Fiction in 2009, Elizabeth Strout's book takes the form of 13 short stories that delve into the very complex and interrelated lives of various citizens in the town of Crosby, Maine. Olive Kitteridge, the town's retired Math teacher, is a forceful and ever-present character in these narratives. The book starts with a story by her husband Henry, the town pharmacist, and through him we first meet Olive. Henry does not paint her in a good light. When arguing with Henry she is vicious and describes him as "Mr Deacon Claptrap Nice Guy" because she refuses to accompany him to church. She is described by one townswoman as someone who "had a way about her that was absolutely without apology". From that beginning it is clear she is a force to contend with and someone you want to hear more about.

The stories in the book describe the lives and often tragic events of the town's inhabitants. Although Olive is not at the centre of all of these stories, you see her develop as a character in how she sees herself and is perceived by others. The stories travel in time and the reminiscences of the characters show Olive in her middle age before jumping forward to her present old age and at times back to her earlier life. Strout manages the challenge of maintaining the narrative plot and sense of character in a novel split up in this way. The novel creates a vivid and nuanced picture of a person who is a kind and insightful to some and hopelessly blinkered and cruel to others. In other words, she is human and flawed.

How relevant is the novel to Psychiatry? When you look at this novel and try to find relevant themes you won't have any difficulty. The narratives run through the gamut of the human condition with lives blighted by the likes of depression, suicide, abusive relationships and alcoholism to name a few. Such a list of human experience and failings could make you wonder why you would read through this litany of suffering but the novel does not feel as grim as it appears. Apart from being very skillfully written, the book is funny. A book that touches on so many themes could end up seeming facile and voyeuristic, picking its way through a set of tragic vignettes to keep the reader interested, but Strout is mostly successful in negotiating this difficult terrain with each story contributing to the whole.

Olive has much to teach to an aspiring Old Age Psychiatrist in how she manages the indignities of life that can assail us with increasing age. The book feels at its most profound when you see her trying to navigate these problems and the stories are narrated from her own perspective. The poignant scene where she witnesses her husband's stroke stays with you and feels more real because of the mundane details that surround this life altering event. The fact that Henry starts the novel makes you feel the loss of this person who understood a part of her more keenly. There are other losses too, very importantly that of her relationship with her son. Olive has regrets but there is something about the way these stories are told that continues to give you hope about Olive's resilience and how she has been able to hold on to her essential humanity throughout.

I think this may be the most important lesson that Olive teaches the reader, to see everyone as a person and not the sum of their problems is an essentially hopeful task and one worthy of aspiring to.

**Tips on writing for *Old Age Psychiatrist*, : Editorial Team, *Old Age Psychiatrist*.
Helen McCormack, Anitha Howard, Sharmi Bhattacharyya, Ayesha Bangash**

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'

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://dementiavoices.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.