

Old Age Psychiatrist | Issue 72 | September 2018



The Old Age Psychiatrist

Issue 72, September 2018

Old Age Psychiatry faculty
newsletter



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In this issue

1. [Update from the Editorial team](#), Helen McCormack
3. [View from the Chair](#), Amanda Thompsell
11. [Update from the National Clinical Director for Older Peoples' Mental Health](#), Alistair Burns.

Competition Time

14. [Essay competition](#)

Updates

15. [Mental Capacity \(Amendment\) Bill Update](#), Sharmi Bhattacharyya
19. [Integration Insights](#), Kapila Sachdev

Careers

23. [Career Development Programme](#), Henry Dunne
26. [What's new and exciting in the Faculty](#), Chloe Pickup and Helen Hopwood

Evidence

49. [The latest evidence on older people's mental health](#), Ruyiyya Saeed
53. [Cochrane corner](#), Jenny McCleery and Ciaran Abbey
58. [Continuing Professional Development opportunities for trainees and old age psychiatrists](#), Mohan Rajendra Gondhalekar

Book review

63. ["Can't We Talk About Something More Pleasant?"](#), Reviewed by Dr S. Gascoigne-Cohen

Featured

Features

30. [Dementia and capacity to marry](#), Martin Curtice and Mohan Gondhalekar
36. [Tackling dementia in Tanzania](#), Stella-Maria Paddick, Catherine L. Dotchin and Richard W. Walker
44. [This patient is dying](#), Anna Crozier, Matthew Leahy & Fiona McDowall

Update from the Editorial Team

by

Helen McCormack

Editor, Old Age Psychiatrist, Royal College of Psychiatrists.

We would like to thank our outgoing Trainee Editor, Phillip Slack who made a great contribution to the newsletter, particularly in creating our now regular Research Update, which I hope you find interesting and informative.

We are very happy to welcome our new trainee Editor, Rugi Saeed, who joined us in mid-May. She says 'I am Rugi, an ST5 currently working with the Cardiff and Vale Health Board in Old Age Liaison Psychiatry. Having completed my foundation training in the Oxford Deanery, I moved to Cardiff to start core training in psychiatry, and I have greatly enjoyed my time in Wales since. The current research being carried out on preventative measures in dementia is one of my main areas of interest. Outside of work, my hobbies include learning languages, reading, baking and travelling with friends and family.' She will be with us over the next year and has already made a flying start.

Rugi will be continuing the Research Updates, and running this year's Essay Competition. We are excited about this one 'What role will technology play in Old Age Psychiatry in the future?' I hope you will be tempted to join in and let your imagination run wild!

As always we have some great features in this issue from tackling dementia in Tanzania to dementia and capacity to marry, and management of dying. I hope you find something there to interest you, but also take a look at our section on training, as our new faculty trainee reps introduce themselves, and encourage you to write a blog.....

There is this edition's update on integration and very importantly, the Mental Capacity (Amendment) Bill Update, written for us by our editor Sharmi Bhattacharyya.

Finally, you may have noticed last time that we now have a new look newsletter thanks to the work of the digital team at the College. We like it because it is very colourful, and allows us to easily insert pictures. So why don't you consider adding a picture (being sure to ask permission if it is copyrighted) if you are submitting an article.

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

Adding images

It is best to resize images to size to keep the file as small as possible. The width of an A4 page is 210mm. and resize via a corner. You can always make a picture smaller, but cannot make one bigger without distorting it.

See online tool to crop and resize images <https://pixlr.com/express/>

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View from the Chair

by

Amanda Thompsell

Chair, Old Age Faculty, The Royal College of Psychiatrists.



Here we go, here we go, here we go!

As I am writing during the height of World Cup fever, this term's View has a footballing theme. So here is the match report on how your Executive continues to dribble and pass its way to glory.

After a gruelling selection process where we had to turn away some other great candidates, we have seen major changes to the squad. We have welcomed no less than eight new people to join the array of talents that is your Executive. The passion is there to deliver our updated Strategic Aims, and they are all ready to give 110%.

In the last few months since the last View once again we have had to step up and face events taking the chances as they come, using every free kick and throw-in that we can. It has been a game of two halves. April to early June involved bringing out influence to bear in various consultations:

- helping develop NHSEs safeguarding competencies guidelines;
- inputting into the drafting of Advanced Practitioners' competencies relating to older peoples' mental health issues: there continues to be ongoing work with HEE and Daisy consultancy re core competencies for those in health and social in older peoples' mental health;
- a call in May by the APPG in Mental Health to give evidence on the progress and future direction of the Five Year Forward View (**FYFV**) where I was able to argue for greater focus on older people and a recommendation that there should be medical input available to acute hospital wards and in Older People's Mental Health Units akin to Liaison Services. They thought it was all over. It is now: our response is available on the website.

As June progressed and into July we have been able to make the most of set-piece opportunities to promote the Faculty and older people's mental health:

- June saw our launch of our *Choosing Wisely for older adults* campaign at the College's International Congress.
- *Independent Age* decided to focus on ageism particularly around mental health and this has thrown up an opportunity to publish a blog to help us promote our Age Discrimination document which I hope to be completed by September.
- I was recently delighted to support the launch of the Royal Pharmaceutical Society's focus on mental health and this has led to an opportunity to publish a blog to their members and ideas about further collaborations.
- Finally, it came to my attention that the website for some of the Faculties had been updated so I asked for ours to be. Whilst this is still a work in progress, I hope that the changes make the site more useful for members.

But the big game is the one that has come at the end of the season.

The tension was palpable as, after such a long wait, and with no apparent movement in extra time extra time, it came down to penalties. And then

the miraculous result – a hoped for but in the end an entirely an unexpected win for our team.

I refer to the Faculty's success in identifying and making use of an opportunity to lobby for changes in the proposed Mental Capacity Act Amendment Bill introducing the proposed Liberty Protections Safeguards (**LPS**) that are being slated to replace the Deprivation of Liberty Safeguards (**DoLS**). We were worried that the Law Commission's document proposals for this would significantly reduce the ability to use the MCA procedures in a mental health setting. Fortunately, we got wind of a chance to meet the Department of Health, the sponsor of the Bill a week before the Bill came to the Commons to explain our concerns. Who knows if we were listened to, but there was relief when the Bill was published it will continue to allow the MCA to be used in mental health hospitals under certain conditions.

This is not the final or even the semi-final –there is still a huge amount to do to clarify points in the Bill and we will continue to scrutinise the Bill's passage and to offer our support in development of the Code of Practice for the LPS which will be vital to clarify key concepts used in the Bill. Fortunately, we have some expert Faculty members who are engaged on this and I am hopeful that our voice will be heard.

Of course, the England game is not the whole story. What about other National teams?

In Northern Ireland, the Faculty continues to work with the NI Department of Health in preparing to implement the new Northern Ireland Mental Capacity Act and is also using its expertise to shape the development of metrics that are practical and of real value to patients and carers. The NI Faculty has identified three main areas that it wishes to see developed and has had several successful conferences.

The Faculty in Scotland has been no less busy with successful conferences and it is planning how to engage and influence the Health and Social Care

Partnerships and Integrated Joint Boards. It is also supporting members by looking at retention issues and developing more formal links with research opportunities available.

The Faculty in Wales RCPsych in Wales has been working with Welsh Assembly's Health, Social Care and Sport Committee in relation to its report into the use of antipsychotic medication in care homes and was pleased to see a number of its recommendations highlighted in the report. Dr Chineze Ivenso, Chair of the Faculty in Wales has called for action to address the issues identified within the report.

Following the strategy

But not everything is reactive. The Executive team works to a plan and here is what else we have been doing to further our **strategic aims**.

Enhancing the Faculty's profile related to mental health of older people of all ethnicity.

We continue to raise the issue of older people with NHS England and the Older People's Mental Health Forum and The Adult Mental Health Steering Group. I have also been liaising with Parkinson's UK and Mental Health Foundation on how we could work more closely together.

We have been working with Alistair Burns to get more useful data about older people from NHS Digital. As any football manager can tell you statistics are important. Increasingly, and encouragingly, more statistics are now being collected about the treatment of older people but there is room for improvement.

Falls and dives are a feature of any tough game. A campaign for creating a national audit of falls in Mental Health Units is underway and we have linked into this.

We have been meeting with the College communications team, to plan our efforts to ensure that the forthcoming Green Paper for older people's

social care will address mental health issues. As a result, there have been various meetings with Government and opposition members. It is unfortunate that the time for release of the Green Paper has now slipped. Given the proposal for increasing taxes to pay more for the NHS, I fear there may be little desire to announce increases in spending for social care at the same time.

To attract and retain within Old Age Psychiatry the best Doctors

We have developed a leaflet *Foundation Year Trainees* which we were able to distribute at the Trainees' Conference and which is available to download from our website. This is so good that the other Faculties want to copy our lead here. We have now moved onto developing further leaflets for Medical Student and higher trainees.

We have ensured medical student input into our newsletter and into our web-pages. We are hopeful to get the main trainee webpage of the College to have links to our Faculty.

I provided comments on the Undergraduate Curriculum. We have obtained a list of events for medical student which we are able to attend and I will be asking for volunteers from the Executive to attend these. We have reviewed our prize awards policies and have developed a small grant projects for trainees and consultants to apply for. [Find out more about our Small Project Funding on the website.](#)

Perhaps the best goal of the season is that we have worked with the Liaison Faculty to develop a College document that states that within an acute hospital, the gold standard for Liaison Psychiatry service provision for patients of "all ages" requires consultant staff in Old Age Psychiatry. It also recommends that further expansion in Liaison Psychiatry services across the age span will require an increase in consultant staffing, especially in Old Age Psychiatry and that this should be taken into account in national workforce planning.

To focus our membership engagement on those who are difficult to engage

We are about to repeat our annual survey of members and are extending its range. Whilst the survey was previously focused on ageless services we are not including questions about matters such as recruitment and retention that link in to our strategic aims. I urge you to respond to it. We have started to put together an interesting programme for the annual conference in Nottingham which we hope will deal with issues that our members want covered. Highlights will include an address by the President of the RCGP and numerous examples of innovative services. This is one game you will not want to miss. This year it will be combined with the Trainees Conference and will offer content that simply cannot be found elsewhere. Buy your tickets now before the scalpers get them! We also have the Neurology-focused one day Conference in October. This more specialist conference also has an excellent programme. The places are going so I would encourage people to apply.

We are in the final stages with the policy department on the Transitions Document. A report on Physical Health conditions in older people with mental health issues is also close to completion and is due to go back to Policy in the near future. I hope that this will be useful to colleagues to be able to show Commissioners the complexity of the cases that we deal with.

We also will be launching the Young Onset Dementia report in October which will help members when talking about the need for services.

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

I have been promoting [MIND ED](#) since March in meetings with the Royal Pharmaceutical Society; Care England; Parkinson's UK; Silver Voices; Independent Age; the Mental Health Foundation, Housing 21 and carer's

groups, to name but a few. If you haven't already looked at Mind Ed please take a few moments to check it out, and think about who might benefit from you telling them about it.

We are continuing to work on translating our video on Depression that provides an accessible way for lay and medical staff alike to understand this topic.

We have secured a speaker spot for old age psychiatry at the joint College Primary Care Conference.

There is a real interest in inequalities in Mental Health and it is important we capitalise on this. We are finalising a major document on Age Discrimination which I hope will be finalised and on our website towards the end of September.

Next Season's Challenges

The shape of mental health services over the next ten years is being decided now. Work has already started to prepare for a new Ten Year Forward View and we have been working hard to make sure that old age psychiatry gets a better shout this time. The NHS is also working on its Sustainability and Transformation Plans which look likely to shake up the way that services are provided.

This is not a matter of life and death; it is more important than that. With the Carter report predicting that by 2025, the number of people aged 65 and over is expected to increase by 20% to 12.4 million, and the number of people living with a disability is expected to increase by 25% to 2.8 million this is a key time to get our voices heard. We cannot wait for people to ask for our opinion (as they generally won't) but rather we need to engage with them early so they can understand how essential good mental health services for older people are.

We also need to demonstrate potential benefits of new models of working and to grab the opportunities to link more to the integration and frailty agenda.

There is everything to play for and it is up to us whether when the whistle is blown our supporters are sick as a parrot or over the moon.

Update from the National Clinical Director for Older Peoples' Mental Health

by

Alistair Burns

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



It has been a comparatively and relatively quiet few months since the last newsletter but the announcements over the last weeks of the NHS Long Term Plan is important. The headlines have been articulated and now the more detailed work proceeds. Integration between health and social care for older people and mental health across the life course are key aspects for us to be aware of and to work on. As things progress over the next few months I will provide updates of the various work streams we are doing to integrate ourselves with these programmes.

The review of the NICE dementia guideline has been published and congratulations to many members of our fraternity who were involved. It is a great document and clearly emphasises the issue of post diagnostic support and its importance. For me, one of the main issues is that both the diagnosis of dementia and treatment for Alzheimer's disease can now legitimately be undertaken by GPs and nursing colleagues with specialist expertise. This really begins to loosen up some of the issues we are

discussing around dementia and is extremely helpful. Many thanks to everyone for their support in achieving this.

At this time of year, I thought I would reflect on a few of the blogs I have written over the last few years which, similar to the contributions to this newsletter, almost give an indicator of how things have progressed. I have highlighted one or two below but if anyone was interested, simply go on the NHS England website, look under blogs, and use "Burns" as the key word (you will get lots of information about "Burns Units" as well and "care of burns patients" which underscores the great work that is being done in that area).

Most recently and unashamedly to coincide with the World Cup was one which emphasised that watching football is good for your nerves. This was largely to do with the fantastic work of Sporting Memories and the fact that memories like this can bring things back to life like nothing else. There was also mention of the association between football and dementia and the link that many people will know of from clinical practice. There was a piece on the news recently to say that the Football Association are going to fund a project to look at this in more detail and many people will remember the tremendous Alan Shearer documentary on "[Football Dementia and Me](#)".

In May 2018, I wrote something with Ben Underwood and Tracy Dowling (from the Cambridge and Peterborough NHS Foundation Trust) [describing the Cambridgeshire experience](#) and emphasising that integrating care across mental and physical health is good for our patients.

Cambridgeshire have certainly developed a very innovative model driven partly by need but also the tremendous vision of the staff involved to look at bringing the two approaches together. Many people would recognise this as one of the corner stones of the original work of old age psychiatry and, in some way, from whence we grew. I think linking to frailty gives us

an opportunity to look at that again and colleagues in geriatric medicine have been very supportive in looking at mental health issues in their patient populations.

As is often the case, one tends to under estimate the time between events and there was a gap of several months between that one and the one before, the aptly named "[keeping your ear to the ground on dementia](#)". This emphasised the need for appropriate assessment of hearing difficulties in older people and specifically people with dementia. The links between the two are well articulated and one of my ambitions is to see if we can get some form of training for audiologists to be more aware of the issues. Of course, it is important to involve all professions and, as I recently sat getting my eyes tested, it was clear that the optometrists see many people with memory loss and dementia and there is great potential to raise awareness of dementia.

The picture for this newsletter is the celebration of the award of the [Essex Dementia Challenge Prize](#) where I was honoured and delighted to chair the panel. It was a great day and a timely manifestation in the importance of dementia. Congratulations to everyone involved.

Competition Time



We welcome all forms of creative writing including non-fiction, essays, short stories and poetry on the topic

What role will technology play in old age psychiatry in the future?

Will artificial intelligence replace Doctors and Nurses in the future?

Will robots solve the issue of social care?

What will this future look like?

We welcome all forms of creative writing including non-fiction, essays, short stories and poetry.

Word limit: 1000 words

Closing date: 30th November 2018

Winners will be contacted by email In February 2019

Prizes: 1st prize £100

2nd prize £ 50

The two winning entries will be published in the May and September 2019 editions of Old Age Psychiatrist.

Please submit entries to essaycompetitionoap@gmail.com with your name, address and email on the competition entry.

Mental Capacity (Amendment) Bill Update

by

Sharmi Bhattacharyya

Consultant Old Age Psychiatry, North Wales Visiting Professor, University of Chester

The Government published its Mental Capacity (Amendment) Bill with the first and second reading in Parliament on 3rd and 16th July 2018.

The headline summary of the bill by Alex Ruck Keene, Barrister is available at <http://www.mentalcapacitylawandpolicy.org.uk/mental-capacity-amendment-bill-published-headlines/>.

The Bill amends the process for authorising deprivation of liberty. It focuses upon a version of the Law Commission's Liberty Protection Safeguards and attempts to reduce the bureaucracy and confusion associated with DOLS. Although broadly welcomed there are considerable challenges and confusion in understanding terms and their interpretation.

Key points

- The six assessments required under DOLS will be replaced by three: that P lacks capacity; is of 'unsound mind' and that the arrangements are necessary and proportionate. The term 'unsound mind' may be perceived negatively however is in keeping with ECHR article 5.
- The age limit for P remains at 18 – the law commission proposal to extend it to 16-17 year olds has not been included.
- The Bill allows for a deprivation of liberty in an emergency situation (a modified section 4B of the MCA) where a person lacks capacity to consent to those arrangements. This would therefore apply in the A&E department where the holding powers in s.5 MHA could not be used because the person is not yet a patient.
- There is however no statutory definition of deprivation of liberty so the confusion remains.

- The necessary and proportionate test more or less replaces the best interests test and there is scope for use of earlier assessments
- There appears to be no clarity on assessments and who will conduct them and whether there is a necessity for 'objective medical expertise'.
- Part 7 deals with excluded arrangements: mental health. The scheme in the Bill is different to that advanced by the Law Commission. It appears that the Bill maintains the position under DOLS, namely that patients requiring in-patient treatment for mental disorder who are not detained under the MHA and who are not objecting to their admission, could be deprived of their liberty under the provisions of the MCA (i.e. the same situation as applies currently with the DOLS procedure).
- Authorisations relate to care arrangements, including the means of transfer to place of care. Authorisations can be accessed and granted in advance however an authorisation cannot be given for more than 28 days before it is due to take effect.
- The responsible body is the body providing or commissioning care. For NHS patients in hospital it will be the hospital manager. For NHS continuing care patients it will be the CCG. For others it will be the Local Authority.
- For deprivation of liberty in care homes the care home manager will be responsible for ensuring that the necessary assessments have been carried out by 'a person with appropriate experience and knowledge'.
- Best Interest Assessors (now called AMCPs) will have to assess cases only where the person is objecting.
- Deprivation will last up to 12 months initially but duration is flexible as with DoLS. LPS is renewable yearly and then for three year periods.
- The responsible body will be able to authorise arrangements if it is satisfied that the authorisation conditions are met and that a pre-authorisation review has been carried out by a person who is not

involved in the day-to-day care of P or in providing any treatment for P. If P objects to the arrangements, the review must be by an AMCP.

An interesting table is provided by Edge Training to compare with DOLS. This is available at <http://www.edgetraining.org.uk/wp-content/uploads/2018/07/DoLS-and-LPS-comparison-table-July-2018-final-v1.pdf>

The second reading is on 16th July and it is anticipated that the amended Act would probably be in place by 2020 or 2021. From the Faculty, Dr Hugh Series and Dr Amanda Thompsell have been involved in discussions with Department of Health.

The challenge remains for us as Old Age Psychiatrists to interpret terms like 'unsound mind' 'objecting patient', 'necessary and proportionate' unless this is clearly defined in the Code of Practice. The Faculty has therefore strongly voiced a wish to be involved in development of Code of Practice for the Bill as this will have implications for day to day practice of Old Age Psychiatrists.

Bill stages — Mental Capacity (Amendment) Bill [HL] 2017-19

Dates for all stages of the passage of the Bill, including links to the debates.

Stage	Date
1 1st reading (Hansard): House of Lords 3 July, 2018	03.07.2018
1 1st reading (Minutes of Proceedings): House of Lords 3 July, 2018	03.07.2018
2 2nd reading: House of Lords	16.07.2018
C Committee stage: House of Lords	05.09.2018
C Committee stage: House of Lords	Date to be announced

Further reading

1. Mental Capacity (Amendment) Bill (HL Bill 117)
https://publications.parliament.uk/pa/bills/lbill/2017-2019/0117/lbill_2017-20190117_en_1.htm
2. <http://www.mentalcapacitylawandpolicy.org.uk/mental-capacity-amendment-bill-published-headlines/>
3. <https://www.39essex.com/mental-capacity-report-july-2018/>
4. <https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/890/89002.htm>
5. <http://www.edgetraining.org.uk/wp-content/uploads/2018/07/DoLS-and-LPS-comparison-table-July-2018-final-v1.pdf>

Integration Insights

by

Kapila Sachdev

Consultant old age psychiatrist, East London Foundation Trust

Sharing the latest articles on integrated care:

The last few months have been busy on the integration agenda and Kings fund have had a number of publications and updates on what has been going on in the integration world.

The objective of this article is to highlight and give a brief summary to the reader about the changes that have been going on in the integration pathway and encouraging the reader to think of ways of making changes in order to ensure that we can make our services sustainable and also leading the way in integration.

Here is a summary of some of the interesting articles/blogs I have come across:

Kings fund published an article called Learning by doing: integrating health and social care in Scotland on 3rd of July 2018.

The main learning points in this article were:

- Scotland and England have adopted a similar approach to integration as they are both looking at ways of making the services work differently rather than go through structural reorganisation.
- Scotland have gone a bit further in their work with integration and more than half of the total NHS and adult social care budget is delegated to an integration joint board (IJB) for each area. IJBs have a statutory basis and are not owned by either the NHS or the local council. This gives them scope to work collaboratively and to develop new models of care. At present, we are not sure what way Accountable care organisations would go in England.

- A summary of the findings can be found in the Kings fund report titled in the report called as Leading across health and social care across Scotland: learning from Chief Officer's experience planning next steps published on 21st of June 2018. This report highlights the role of the chief officers of integration authorities- discussing about the direction of travel and ambitions.

Richard Humphries wrote on his blog on the role of Non-executive directors and integrated care: time to think

- Richard Humphries discusses the role Non-executive directors play in STPs. The non-executive directors play a vital role in oversight of how effectively their organisation is ensuring the safety and quality of care, meeting constitutional targets and achieving financial balance
- He discusses the changing landscape of NHS and the role of the board in ensuring that they maintain a dual focus- continuing to focus on performance of the local system and ensuring that the organisation continues to have a role in the changing NHS landscape

Professor Chris Ham wrote an article "What has the STP or ICS done for me?" This was published on 17th of May 2018.

He gives an interesting account of the various examples of the STPs and ICS that have got together to work.

- The main examples that he gives are of Frimley ICS which has already started delivering measurable result – **a functioning ICS**
- An example from Greater Manchester is the way in which Salford Royal and Manchester University NHS Foundation Trust are providing support to Pennine Acute Hospitals NHS Trust after the Care Quality Commission rated the trust as inadequate. Support is being overseen by the Greater Manchester Improvement Board with

involvement of both commissioners and regulators- **sharing of ways of improving care across the system.**

- He describes the future of STP and ICS being dependent on willingness of organisations and the leaders working together to transform health and social care for their populations. **He talks about leaders and organisations thinking ‘What can I do to ensure that the STP/ICS succeeds?’ and not ‘What has the STP/ICS ever done for me?’**

I think for me this article was really useful as in my consultant journey I have recently moved to being involved in the community where mental health is an important part of the integrated care network. It was an eye opener and made me realise the importance of relationships. Being relatively new I have had to start from forming the important relationships and getting to know the people. As a learning point I have tried to get invited to a lot of meetings and ensuring that I attend them as it is only then that I can ensure the voice of my Speciality is heard. I appreciate this can be a big challenge as we all know due to the work commitments but the changes are happening now and if we are not there we run the risk of being forgotten about.

I will talk more about my journey in the next newsletter meanwhile I hope you all can read some of these interesting articles.

Happy reading.

References:

Kings fund -Learning by doing: integrating health and social care in Scotland <https://www.kingsfund.org.uk/blog/2018/07/integrating-health-and-care-scotland>

Non-executive directors and integrated care- time to think system <https://www.kingsfund.org.uk/blog/2018/05/non-executive-directors-integrated-care>

Leading across health and social care in Scotland: learning from chief officers' experiences, planning next steps

<https://www.kingsfund.org.uk/publications/leading-across-health-and-social-care-scotland>

What has the STP or ICS ever done for me? Blog by Chris Ham

<https://www.kingsfund.org.uk/blog/2018/05/what-has-stp-ics-done>

Taster Weeks - A Dash of Old Age Psychiatry

by

Henry Dunne

Medical Student, Kings College London

In the final term of medical school, I was able to undertake a 3 week 'Career Development Programme' (CDP) in old age psychiatry. New to the Kings College London curriculum, each student is asked to organise a local elective placement to explore specialties that they have interest in or haven't had the opportunity to experience during their previous rotations. I wanted to have another look at psychiatry. Although I had found my third year psychiatry rotation interesting I was not sure whether it could be a career that would suit me so I was excited to have this opportunity. My aims were to assess whether psychiatry could be a good fit for me and try to find out what the day-to-day life of a psychiatrist would involve. Thanks to a very committed supervisor and generous Old Age Psychiatry teams I was given a very interesting timetable full of many different facets of Old Age Psychiatry – community care, inpatient care, academic work, liaison old age psychiatry and specialist care unit. I was glad to be able to personalise the schedule to suit me and my interests. Here I will describe my CDP experience and what I have been able to take away from it.

Walking into a specialist care and nursing home for elderly patients with complex mental health needs the high level of care was immediately apparent. The staff appeared highly motivated and genuinely interested in the residents' wellbeing. For example, when shadowing the speech and language therapist, en-route to see a patient with swallowing difficulty, twice a different resident crossed our path. Rather than ignoring them, we said hello, pointed them in the correct direction and helped rearrange their clothes before continuing. This level of kindness and attention to

detail was omnipresent. Reflecting on this, I think I would enjoy working with such a motivated and kind team.

Two days with the liaison Old Age Psychiatry team also provided many useful lessons. The first patient we reviewed had a neutropenic sepsis secondary to her cancer therapy; the next patient had a delirium, likely secondary to a UTI. We felt like detectives deciphering what was causing the current highly anxious state of another patient: was it her medications, lack of compliance, environment, sepsis, personality disorder, side room isolation, or lack of provision of food that she liked? Or all of the above? Which could we alter? I liked how often the simplest adjustments recommended by the liaison team could make significant differences. It didn't take rocket science to discover that a banana to eat for breakfast would improve her oral intake. It did take someone to ask the right questions and listen to the patient. I understand how on the acute wards it is almost impossible to optimise everybody's care and mental wellbeing – however working alongside the liaison old age psychiatrist it was rewarding and satisfying to be able to contribute. I came to appreciate the level of medical knowledge and holistic understanding needed to optimise patient care.

An afternoon talking to eminent researchers also outlined exciting elements of the discipline. What is not to like about unravelling the mysteries of the brain and underpinnings of mental illness, including dementia? Curbing the inevitability of cognitive decline that so many people are affected by in some way or another is something I would like to be involved in.

In the inpatient setting I attended a discharge meeting. The Consultant psychiatrist, social worker, occupational therapist, ward nurse, patient's carer, patient's daughter and the patient were all present to discuss optimising her discharge plan. Although I had only been on the wards for

a morning and didn't have much to say, it was nice to be a fly on the wall and see first hand the level of teamwork required in the speciality.

Nearly every experience on this CDP module I had was positive and enlightening. It was great to see so many aspects of a career in Old Age psychiatry. If more time were available, I would have liked to spend a few more days in just one centre in order to gain an appreciation of the day-to-day working grind. I have heard how every patient and every day in psychiatry is different and varied – I would have liked to see that play out in the same setting. Given more time, I would have also liked to spend more time with trainee psychiatrists to learn what their working day consists of.

My aim was to assess whether Old Age Psychiatry could be a good fit for me. I feel I have now got a much better picture of this and a greater appreciation of the specialty. I think psychiatry is an amazing career option, with generous training arrangements, lovely teams, interesting patients, and really interesting pathologies. It seems to be a career that one doesn't just fall into, but one that requires a conscious choice. I would recommend organising a CDP in psychiatry to any student – especially if like me, psychiatry is a career you are open to but haven't had the chance to think much about, and so don't have enough information to make that conscious choice. At this stage of my training on the cusp of graduating I am looking forward to working as an F1 in medical and surgical jobs. If I fall in love with those then that would be great. If I do not, thanks to the CDP experience, I now know that I would enjoy a fulfilling career in psychiatry.

What's New and Exciting in the RCPsych Faculty of Old Age Psychiatry

by

Chloe Pickup and Helen Hopwood

ST4s in old age psychiatry at North Central and East London and Higher Trainee Representatives

We wanted to introduce ourselves as the new trainee reps for the Old Age Faculty. Whilst we are nominally higher trainee reps, we are meant to represent all levels of training from medical students, foundation and core to higher trainees. Since taking on this role in March, we have been amazed by how much the faculty has to offer and hope this brief newsletter bulletin might whet people's appetites. We hadn't previously been aware of how much the faculty wants to engage with trainees at all levels and how much there is available for us.

Social media for the faculty

Starting with social media, the faculty has a really active Twitter page @RCPsychOldAge and were you aware that we also have an affiliated Facebook Old Age Psychiatry UK

<https://www.facebook.com/groups/127440287368298/>? We'd love you to join and take part!

Get involved

The faculty are always looking to improve the way trainees in old age across the country interact with the faculty. An exciting new prospect on the horizon is our new trainee blog. This will be a once monthly piece to showcase the diversity of Old Age Psychiatry, showing Old Age Psychiatrists as academics, neuroscientists, teachers, leaders, clinicians and advocates. Email kitti.kottasz@rcpsych.ac.uk if you are interested in submitting something.

Did you know that there are currently five trainees doing national work for the faculty? Also, a higher trainee created a leaflet for the much publicised Choose Psychiatry campaign. This was to advertise our exciting speciality and how to get involved throughout your training. The faculty are keen for any level of trainee to contact them if they are interested in all the opportunities of observing, attending and representing the faculty at the various meetings taking place in the College. These are: the Speciality Advisory Committee, Choose Psychiatry, the Executive Committee and the Psychiatric Training Committee (PTC).

If you have an exciting innovative idea, please contact the faculty (alex.bailey@nhs.net) as they are keen for help to establish the next generation of dynamic trainees and early career leaders. They are developing small grants for three projects up to £3,000 each. Funded projects must be in line with the faculty's strategic aims. They encourage projects in teaching, training, service development, videos, operational work etc. rather than direct patient research. Successful applicants will be required to present at the Faculty Annual Scientific Meeting in March and submit a detailed report. Please get in touch for more details!

Conferences

From our recent survey, we have realised not enough people are aware that as well as having our fantastic yearly faculty conference, we also have a yearly higher trainee faculty conference. The name is a misnomer because we want any and all medics and doctors who are interested in old age psychiatry to attend, learn and have their voices heard. This year, the faculty asked for your views in a survey. We listened and as such, that is why it will now the old age faculty higher trainee conference will now be held on one of the three days of the faculty conference.

Whilst we're on the subject of the faculty conference, we also want to publicise the number of bursaries and prizes available. These are both to

attend the conference and to showcase your exciting service innovations and research. In particular, a little-known prize is the Phillip Davis prize, which is an essay of maximum 6,000 words. If the conference is hard for you to get to, please do apply for a bursary. If you're interested, why not attend the up-coming Faculty of Old Age Psychiatry Winter Meeting, this year on Neurology for Old Age Psychiatry?

Website

We hope you have noticed the newly updated faculty website <https://www.rcpsych.ac.uk/workinpsychiatry/faculties/oldagepsychiatry.aspx>, which is a useful resource and highlights the many interesting and varied opportunities within our faculty at this time. We hope you have seen the faculty's excellent new videos showcasing the faculty and College in general. We'd love to hear more old age specific stories. Why not film yourselves or an enthusiastic colleague talking about the specialty and their career or service?

I hope trainees have noticed TrOn has also recently been updated. The faculty is also currently in the process of updating the curriculum, which you may be able to find out more about or get involved in. Please contact us if this is an area you would like to take part.

We'd like to hear from you

A suggestion we have heard from you has been for improved, faster communication and how this could be delivered. An idea was to host a nationwide WhatsApp group. We think this is a fantastic idea and are happy to proceed. If this idea appeals to you too, please email kitti.kottasz@rcpsych.ac.uk your name, mobile number, grade and where you work.

We hope this brief introduction and summary has been of use to you. We certainly have found the faculty update to be educational as well as informative about the changes happening in psychiatry in the current

climate. It has offered us an opportunity to learn about innovation and service changes throughout the country and sparked ideas for how to change services that we work in. As your newly appointed trainee reps, we want to involve and hear our colleagues as much as possible. So please contact us with any ideas, concerns or suggestions!

Dementia and capacity to marry

by

Martin Curtice

Consultant in old age psychiatry, Worcestershire Health and Care NHS Trust

Mohan Gondhalekar

ST5 General Adult and Old Age Psychiatry, Essex Partnership University NHS Foundation Trust

Introduction

This article reviews a 2017 Court of Protection judgment regarding an elderly man (*DMM, Re (Alzheimer's: marriage: power of attorney)* [2017]). The case in the main revolved around the issue of assessing someone's capacity to marry. In doing so it reviews previous case law and provides some learning points for clinical practice.

Background to the court case

DMM was a retired insurance broker in his mid-80s. He had three daughters from a first marriage having divorced many years previously. He had lived with his current partner SD, who was in her 70s, for over 20 years. In 2013 he executed a will giving SD two thirds of his pension, a legacy of £300,000 and the right to reside at his property for two years after his death, the remainder of his estate being divided between his three daughters. One of his daughters, EJ, was appointed as his sole attorney for property and financial affairs. All parties involved in the case agreed the diagnosis for DMM was one of 'Alzheimer's disease' (albeit the judgment did not use the term dementia at all or offer any evidence as to the possible severity of the condition).

In 2016 SD took DMM for a capacity assessment to revoke his LPA, to make a new LPA and to marry. A report was provided by a consultant psychiatrist and concluded DMM had the capacity to marry but not make an LPA. In response, the daughter EJ entered a caveat at a Registry Office to prevent any marriage taking place between DMM and SD (under s29(1)

of the Marriage Act 1949). In 2017 EJ commissioned a report from an independent mental capacity assessor assessing DMM's capacity to marry and his testamentary capacity to make a will – this concluded he lacked the requisite capacity for both these decisions. Once the case came to court the DMM was represented by the Official Solicitor as his litigation friend (appointed as DMM was assessed as lacking litigation capacity to engage in court proceedings) and an eminent consultant old age psychiatrist was jointly instructed to report on DMM's capacity to marry. The judge in this case analysed all the various expert views presented including evidence from his GP.

The crux of the case was that the effect of the marriage between DMM and SD would be to automatically revoke the will previously made in 2013 by reason of the provisions embedded within s18(1) of the Wills Act 1837. DMM had total assets of around £1.8million. Should DMM marry but then die intestate i.e. not having made a new will (the issue of capacity to make a will – testamentary capacity – was not a specific decision decided by the court in this case though) then under the rules of intestacy which dictates who can inherit when there is no valid will in place, SD would have a statutory legacy of £250,000, his chattels and half the balance of the estate, about £950-990,000 out of the assets with the rest divided between the three daughters. Hence the effect of the overall financial position should DMM die intestate was 'very significant' to SD and DMM's daughters.

The MCA and the capacity to marry

The court systematically applied the appropriate parts of the MCA 2005. The key issue to be decided was to determine if the legal test for whether a person has capacity to marry included a requirement that the person should be able to understand, retain, use and weigh information (s3(1)) as to the reasonably foreseeable financial consequences (s3(4)) of a marriage, including that the marriage would automatically revoke the person's will. S3(4) was of particular overall importance in the overall

conclusion of the judgment and states: The information relevant to the decision includes information about the reasonably foreseeable consequences of (a) Deciding one way or another, or (b) Failing to make a decision. The judgment then cited pertinent previous case law relating to capacity to marry – the importance of this case was that it was the first to directly address the point of a second marriage undoing a previous will.

In *Sheffield CC v E and another* [2004] it was held that “capacity to marry was about the ability to understand the nature of the marriage contract and the duties and responsibilities attached to marriage namely that marriage was a contractual agreement between a man and a woman to live together to love one another to the exclusion of all others in a relationship of mutual and reciprocal obligations involving the sharing of a common home and a common domestic life and the right to enjoy each other's society comfort and assistance.” This judgment also opined the contract of marriage was a simple one which did not require a high degree of intelligence to understand. This judgment was before the MCA was enacted and did not specifically refer to the aspect of understanding the foreseeable consequences of marriage.

In the post-MCA case of *London Borough of Southwark v KA* [2016] the judgment stated that a person “...must understand the duties and responsibilities that normally attached to marriage, including that there may be financial consequences and that spouses have a particular status and connection with each other.” However the judgment made clear this did not necessarily mean for example a person needed to understand financial remedy law before getting married. It also affirmed the “...test for capacity to marry is not high or complex. The degree of understanding of the relevant information is not sophisticated and has been described as rudimentary”. The judge in the DMM case considered there was ‘clearly a policy issue’ involved as the test must not be set too high as this would be an ‘unfair, unnecessary and discriminatory bar against those with capacity

issues potentially denying them that which all the rest of us enjoy if we choose, a married life'.

In the case of *A Local Authority v AK* [2012], involving the assessment of whether a severely brain injured man had the capacity to marry, the judgment further addressed the bar for the test of capacity: "...for most people marriage is to be regarded as a fairly straightforward concept (compared for example with litigating, or with many medical procedures) one would not normally need to spend too much time on assessing an individual's ability to 'understand, retain, use and weigh' the information about marriage which is referred to in "Sheffield". Nevertheless, there will occasionally be cases where the degree and/or nature of the individual's impairment does make it necessary to do so, because for him or her a decision about marriage is not actually a simple one."

Marriage and financial affairs

The judge considered whether a financial effect on the parties involved was relevant to capacity to marry. In applying the MCA the judge opined it was clear that DMM had to be able to understand the information relevant to a decision to marry and such information did include information about the reasonably foreseeable consequences of deciding one way or the other. In this case the effect of the marriage making the will invalid was not just a reasonably foreseeable consequence of marriage but was a 'certain consequence of marriage which will have financial consequences to the parties'.

The judgment noted previous jurisprudence had considered whether people should be able to understand that a reasonably foreseeable consequence of marriage is that your financial position might be affected by marriage – particularly if it failed and there were financial proceedings as a consequence of this. The judge concluded that "importing that into capacity to marry is setting too high a standard, too refined an analysis, asking to take too many hypothetical situations into consideration."

However, when addressing the core issue in this case, he felt this was very different from the fact that a previous will would be revoked if you marry – this was a “statement of fact and not a hypothetical situation”. In this case it was a simple concept to understand in that what DMM had wanted to happen with his will in 2013 could not now happen because the will would be invalid because of the marriage. Hence, if you cannot understand this factual consequence of marriage then how is a person “said to be able to understand, retain, use and weigh information as to the reasonably foreseeable consequences of the marriage?”. The Judge concluded the fact that a second marriage revokes the will is information a person should be able to understand, retain, use and weigh to have capacity to marry.

Conclusion of the court

The judge was persuaded by old age psychiatrist expert witness findings (from a two hour interview with DMM) who concluded that DMM did have the capacity to marry as he was able to understand that his will would be revoked and the financial position of his three daughters would be affected by that and his marriage. Furthermore, it was ‘clear’ that DMM knew the will would be cancelled, that he may not be able to make a new will and that intestacy rules would therefore produce a different result to the old will such that his children may receive less and his wife-to-be more. On this evidence the judge concluded that DMM had the capacity to marry.

Implications for clinical practice

- Case law has provided a legal test to marry.
- The test for capacity to marry is not high or complex.
- The Mental Capacity Act underpins the test to marry.
- A second marriage will revoke any previous will made.
- If asked to assess capacity to marry it would be advisable as part of such an assessment to be fully apprised of any key financial

aspects that a person may need to understand as a reasonably foreseeable financial consequence of marriage (s3(4)).

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A Local Authority v AK [2012] EWHC B29 (COP)

DMM, Re (Alzheimer's : power of attorney) [2017] EWCOP 32

DMM, Re (Alzheimer's : marriage : power of attorney) [2017] EWCOP 33

London Borough of Southwark v KA [2016] EWCOP 20

Sheffield CC v E and another [2004] EWHC 2808 (Fam)

*The above judgments can be found in full at: www.bailli.org

Tackling dementia in Tanzania

by

Stella-Maria Paddick

Academic Clinical Lecturer, Institute of Neuroscience, Newcastle University

William K. Gray

Senior Research Associate/Statistician, Northumbria Healthcare NHS Foundation Trust

Catherine L. Dotchin

Consultant Geriatrician and Honorary Senior Clinical Lecturer, Northumbria Healthcare NHS Foundation Trust

Richard W. Walker

Consultant Geriatrician and Honorary Professor of Ageing and International Health, Northumbria Healthcare NHS Foundation Trust

Why Tanzania?

Our UK-based team are from Northumbria Healthcare NHS Foundation Trust and Newcastle University in north-east England and became interested in the health of people in Tanzania in the 1990s through the Tanzanian Adult Morbidity and Mortality Project in which Newcastle University was a partner. The project sought to monitor the health of the population of three representative demographic surveillance sites (DSS) within the country. One site, Hai district DSS, in the north of the country on the lower slopes of Mount Kilimanjaro has become the focus of our work over the last 20 years, with studies of stroke mortality, prevalence and incidence and prevalence of Parkinson's disease, hypertension, atrial fibrillation, neurological disorders, frailty and epilepsy, amongst others. This work has been supported by dedicated teams in Tanzania and the UK and a range of funders.

Why dementia?

Much of our work in Hai has been led by geriatricians (Prof Richard Walker and Dr Catherine Dotchin) and has focussed on older people, many of whom had cognitive problems. In 2009 we decided to conduct a study to look at the prevalence and nature of dementia and mild cognitive impairment in Hai. At this time, there were fewer than 10 previous reports on the prevalence of dementia anywhere in sub-Saharan Africa (SSA), and these were restricted to a few key sites in Nigeria, Benin, Congo and Central African Republic, all in west or central Africa. Reports from Nigeria suggested dementia was less prevalent than the developed world. Despite being home to more than a third of a billion people, there were no reports on how common dementia was in East Africa, or how it affected people's lives in this largely resource poor setting. Furthermore, with rapidly improving management of infectious disease (such as HIV, Malaria and tuberculosis) and steady social and demographic transition taking place, issues related to dementia could only become more of a burden to already stretched healthcare services, meaning that having information on the nature and impact of dementia in this setting was needed to allow health services to adapt to the changing healthcare needs of the population.

Is dementia common in Tanzania?

In a study of 1198 people aged 70 years and over living in six randomly selected villages in Hai district we found a crude prevalence of dementia of 7.5% (6.4% adjusting for age). This was similar to rates found in many high-income countries and towards the high end of reports from many low-income countries (see Figure 1). Dementia prevalence increased significantly with age and was significantly more common in those who had never gone to school than in those who had attended school for one year or more. Since around a third of men and two-thirds of women in this age group had never attended school, the role of schooling (and schooling as a marker for wider socioeconomic status and life prospects) was likely to be an important driver for the higher than expected

prevalence rates seen. In addition, we noted that of those who had dementia, a remarkably high proportion (41.0%) had a probable vascular subtype. This is one of the highest proportions of vascular dementia within a dementia cohort reported anywhere in the world. This finding may be partly explained by the high prevalence of hypertension, and incidence of stroke in Hai which is in turn influenced by the ready availability and high dietary intake of salt across much of east Africa.

How does dementia impact on people's lives?

Although dementia has a significant impact on functional ability and the burden on carers from behavioural and psychological symptoms is high, attitudes towards dementia within the community are diverse and at first glance may appear contradictory. Many carers and community members view dementia as a normal part of ageing and see the care they provide for their relative as an expected part of caring for an elderly relative. However, if the disease is accompanied by obvious behavioural abnormalities then the condition is viewed by some within the framework of traditional health beliefs (e.g. due to witchcraft). In such cases, dementia is highly stigmatising, often for the entire family, and people with dementia are often hidden with little social contact.

How can we identify people with dementia in this setting?

During the prevalence study we used a lengthy (40-50 minutes to complete) cognitive screen (the community screening instrument for dementia, CSI-D), which includes a detailed informant interview, to identify people who may have dementia and who required a second visit by a doctor to reach a formal diagnosis by DSM-IV criteria. Although the CSI-D was developed for use in low education settings, some of the test items were not suitable for people with no education, who may never have held a pen (e.g. drawing interlocking shapes). We have therefore gone on to develop a much shorter, six-question screening tool (the IDEA cognitive screen) that appears to be highly predictive in our setting. The screen works well in both community and hospital inpatient and

outpatient settings. We also developed a culturally appropriate assessment of instrumental activities of daily living (IADLs) as identification of functional impairment can be difficult when using tools designed for high-income studies. This tool was developed during a workshop with rural healthcare workers and the activities described differ greatly from those included in functional assessments in the UK. We are currently developing a decision support app, based on the IDEA screen and IADLs which can be used on a tablet or smart phone.

There may be particular patient groups with additional susceptibility to dementia in Tanzania (e.g. those with HIV). Since the widespread introduction of highly active antiretroviral treatment (HAART) in SSA, for many people HIV has become a chronic disease and, although dementia conversion rates are now much lower, individuals with HIV are still at increased risk of mild cognitive impairment (MCI) and dementia.

What can be done to improve the lives of people with dementia in Tanzania?

One of the greatest challenges facing people with dementia in Tanzania is the lack of specialist healthcare workers. There are no specific old age psychiatry services in Tanzania and there are currently 15 psychiatrists working in the whole country. This situation is not unique in SSA. The Lancet global mental health series estimated that there were 200 times fewer trained mental health workers of any discipline per head of population in most of SSA when compared to high income countries.

People with dementia and their carers need access to advice and support as well as evidence-based interventions. Cholinesterase inhibitors can be purchased privately in large urban centres, but not elsewhere. They are not included in the Tanzanian formulary, and are not available in government facilities, or covered by health insurance.

We have recently helped to form a network of health professionals (doctors, nurses, psychologists) interested in dementia in Tanzania. They report that advising and assessing people with dementia and their families is challenging, and guidance and training on these issues is generally not available.

Follow-up is difficult, with most families only seeking help in a crisis when challenging behaviour becomes problematic. Health workers report feeling under pressure to prescribe medication at that visit, usually an antipsychotic. They also report that patients and families rarely return for a follow-up appointment.

One intervention which may be beneficial in this setting is Cognitive Stimulation Therapy (CST). There is evidence from controlled trials in the UK that this can have a similar effect to cholinesterase inhibitors in improvement of cognition. We recently conducted a small controlled trial of CST in Tanzania which showed that this was feasible and showed cognitive benefits. We are proceeding to a larger trial with CST delivered by occupational therapy students and by health workers in sites across Tanzania in 2018.

What is the future for managing dementia in Tanzania?

Our findings are likely to have relevance outside of Hai district, to many areas of Tanzania and much of SSA. Through ongoing work funded by Grand Challenges Canada (in Tanzania and Nigeria) and the UK National Institute for Health Research (in Tanzania, India and Malaysia), we have identified a number of key areas for research which we believe will help improve the lives of people living with dementia and their families in SSA.

1. Engage with key stakeholders in investigating how research findings can help drive policy decisions around dementia – We are working with heads of education institutions and regional and national government healthcare

officials to facilitate evidence-based decision making with regard to changes in healthcare worker training and resource allocation.

2. Raise awareness to reduce stigma in communities – We have gained support from religious leaders and other community leaders (e.g. tribal elders) to help raise awareness of dementia as a disease, distinct from normal ageing, that is not caused by witchcraft.

3. Develop simple tools that can be used by non-specialist healthcare workers to screen for dementia – These include the IDEA cognitive screen, the IDEA instrumental activities of daily living (IADL) screen and a method of screening to rule out delirium.

4. Investigate interventions to help improve the lives of those living with dementia – We have conducted the first trials of Cognitive Stimulation Therapy (CST) in Africa and shown significant improvements in cognitive function. A carer educational manual has also been developed. In the future, we hope to roll this out to a wider population and have developed training for undergraduate occupational therapy students in this area.

Conclusions

Although healthcare resources are scarce across SSA, we believe that, with careful planning, much can be done to help identify people with dementia and improve their lives with relatively small amounts of money and human resources. In the longer term, preventative strategies aimed at increasing life-long access to education, availability of CST, tighter primary and secondary prevention (e.g. blood pressure control) and dietary advice (e.g. reducing salt intake) may help to reduce the incidence and prevalence of dementia in this setting.

Figure 1. Age-standardised prevalence of DSM-IV dementia in Hai, Tanzania compared to results from the 10/66 dementia research group.³

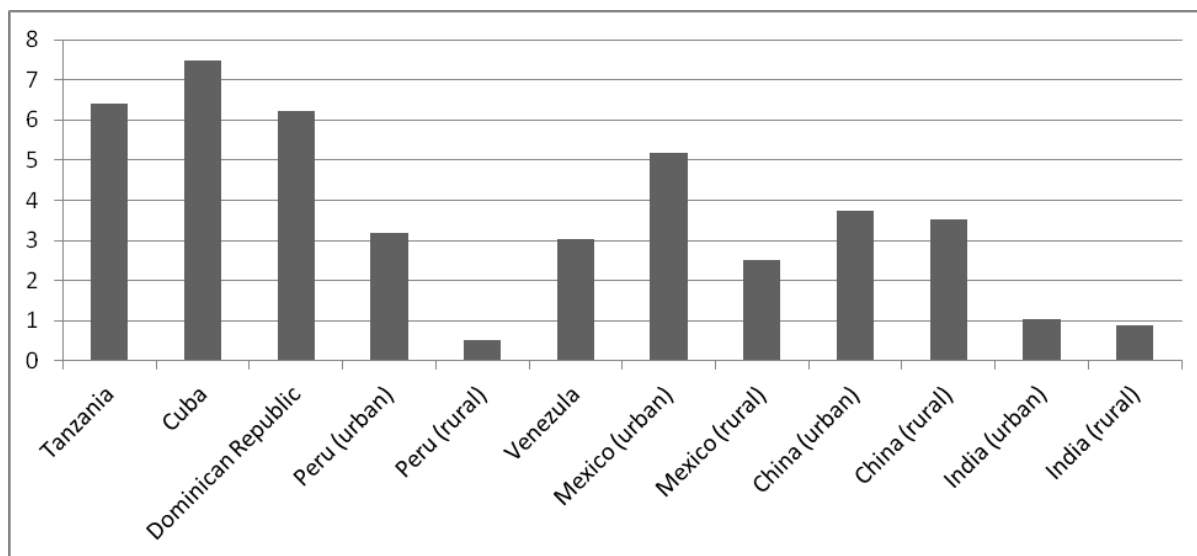


Figure 2. Instrumental Activities of Daily Living (IADLs) developed for Tanzania

1. Wanatoa Historia/They give histories of the family, their life, past events.
2. Wana suluhisha/ They settle conflicts.
3. Wanasaidia shughuli ndogo ndogo/ They assist in small works in the home.
4. Wanatoa ushauri/ They give advice.
5. Wanadumisha na kufundisha mila/unyago/They teach traditions of society.
6. Ni walinzi wa nyumbani/They watch over the house when others are out.
7. Wanatunza wajukuu/they look after the grandchildren
8. Wanatoa ushawishi/Persuasion, or changing people’s ideas for the better.
9. Wanasaidia katika maswala mazito kama sherehe/They preside over feasts and ceremonies
10. Wanapangia watu majukumu/Delegation of responsibilities to others.
11. Wanasimamia haki/They ensure fairness.

Figure 3. Hai, Kilimanjaro region Tanzania



This patient is dying: Quick, call the Psychiatrist!

by

Anna Crozie CT3, Matthew Leahy CT1, Fiona McDowall, Consultant Psychiatrist for Older Adults
Essex Partnership University NHS Foundation Trust.

Life is finite. We are all going to die. It is normal if you are feeling uncomfortable now. Most of us choose not to dwell on this painful truth unless events force us.

But we are doctors. We have contact with illness, death and dying on a regular basis. We may be good at denying this personally but are we guilty of extending this denial to our patients even as they are dying?

Referrals to our Liaison team

Locally, our Older Adult Psychiatric liaison team is receiving an increasing number of referrals for us to see dying patients. They are referred with the belief that their presentation is psychiatric and an expectation that we should admit them for emergency treatment, including ECT. This belief can be held with almost delusional intensity resulting in hostile stand-offs between Specialities. It is deeply unhelpful to our patients and their families. It has caused us to wonder what is going on in the minds of our colleagues. To reduce and later refuse food and fluids is a normal part of the dying process.

Kubler-Ross (1969) in her book *On Death and Dying* stated: 'It is important to differentiate between this kind of healthy weaning off on the part of the dying patient and a pathological depression where the patient is giving up hope prematurely and does not want to bother anymore. With a patient who is in the process of separation, it is mandatory that we allow him to wean off in order to find peace in his own inner resources'. Why is it so difficult for so many of us to differentiate between the two?

Referrals to A&E

This is not actually a Physician versus Psychiatrist issue. As a service, we are equally guilty of referring our patients with severe dementia to A&E. Introducing the concept of a ceiling of care with families is anxiety provoking. Far better to let the medics decide when no more can be done and hopefully the patient will come back to the ward with a DNACPR form. But as we have seen, our Physician colleagues fare no better. We are lucky if our patient with end-stage dementia doesn't come back with a PEG tube.

Liaison Nurses

This is also not a nurse versus doctor issue. You might think a doctor is more qualified to diagnose dying than a nurse but this has not been our experience. Our Psychiatric nurses agree they have relatively little training in physical health. And yet, it is our liaison nurse colleagues who are returning from the acute wards puzzled as they recognise another end stage organic presentation.

Playing God?

It is uncomfortable to acknowledge that interventions that (might) prolong life can also impair it. It is uncomfortable to accept when no more can be done. Who are we to give up and allow our patient to die? This smacks of paternalism and playing God. We are only Psychiatrists. It's not our job. We send our patient to A&E to exclude hypoactive delirium. They are referred back to us from the wards to exclude depression, catatonia, eating disorder. So we cannot rely on our Physician colleagues to recognise when our patient is dying for us. They clearly struggle with it too.

Incapacious patients

It is a particular issue for our incapacious patients where the default position appears to be to investigate, rule-out, diagnose and treat until the very bitter end. The last year of life can be spent with the indignity of going back and forth to hospital. A patient with capacity can and does tell us when they no longer want to go to hospital. They can make end of life plans. But they can only do this if we have been honest with them about their prognosis. Why do we find this so difficult? Could it be due to the emphasis on diagnosis and cure during our training? Lieff (1984) observed that 'when faced with a difficult elderly and dying patient the doctor may experience psychological impotence'. Does the dying patient represent professional failure? Is this explanation sufficient? We live in a society that celebrates youth and beauty over age and wisdom. It is no surprise we are in collective denial about aging, madness and death. It is thus no surprise that we are in denial professionally too.

Thanatophobia

Freud (1915) described Death anxiety (Thanatophobia): 'our own death is indeed unimaginable...at bottom no one believes in his own death...in the unconscious every one of us is convinced of his own immortality'. Do we sense our own mortality when we recognise a patient is dying? Could we be defending ourselves from our own death anxiety by failing to see it? We protect our egos by depersonalising our patients and reducing them to diseases states rather than seeing them as fellow human beings. We mentally turn away from them and their families. In doing so, we let them and ourselves down.

Suppress not repress

Some clinicians are good at managing uncertainty, diagnosing dying and accepting death. They are the ones who have the DNACPR conversation long before the crisis admission to hospital. They are the ones who talk about LPAs, Wills, Advance Directives, ceilings of care and end of life plans to the patient with dementia before she loses capacity. They are the ones who make time to have honest conversations with families. Could it be that these clinicians suppress rather than repress their own death anxiety? They are able to survive and contain the distress of their dying patients. I aspire to be one of them. I was a GP for 10 years before training in Psychiatry. In my experience, these conversations are universally welcomed. It is not fair to expect our patients or families to start them when we won't because of our Thanatophobia. 'The Dying have a right to their Decease' writes Robert McCrum (2017) in his book *Every Third Thought* quoting Shakespeare's *The Tempest* 'Every Third Thought Shall be my Grave'.

Thanatophobia

So let's start having these conversations with our patients. Each will be as unique as each patient is unique. Let's practice the Art of Medicine rather than the Science. Let's bring our personal death anxiety into consciousness and have an honest look at the defences we employ to protect ourselves from it. 'Physician Heal Thyself' (Luke 4:23, King James Bible). Let us acknowledge the Thanatophobia within, become better at death-bearing (Thanatophobia) and allow our patients to die well. To quote Shakespeare again, I hope this courtesy will be extended to me when I am approaching 'mere oblivion. Sans teeth, sans eyes, sans taste, sans everything' (Shakespeare; *The Seven Ages of Man*).

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

by

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

The important thing in science is not so much to obtain new facts as to discover new ways of thinking about them.

– Sir William Bragg

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

Nucleus basalis of Meynert degeneration precedes and predicts cognitive impairment in Parkinson's disease

Jonathan Schulz, Gennaro Pagano, Juan Alberto Fernandez Bofante, Heather Wilson, Marios Politis. Nucleus basalis of Meynert degeneration precedes and predicts cognitive impairment in Parkinson's disease. Brain. May 2018 (online first)

A study that investigated the structural and microstructural changes in the cholinergic system nuclei and associated limbic pathways in patients with Parkinson's disease, which could predict the development of cognitive impairment. The study sample comprised of 304 patients with Parkinson's disease not on Parkinson's disease medication and 167 healthy control subjects. The Montreal Cognitive Assessment was done for each of these patients at baseline and every 6 months until the data collection was concluded at 36 months. They performed a cross-sectional comparison of MRI data (T1-weighted MRI imaging and diffusion tensor imaging) of those with Parkinson's disease with and without cognitive impairment at baseline, and then a comparison at 36 months between the patients with Parkinson's disease who remained cognitively intact and

those who developed cognitive impairment. The images showed lower grey matter volume and increased mean diffusivity in the nucleus basalis of Meynert in Parkinson's patients with cognitive impairment in comparison to those without. The authors found that these changes were predictive of developing cognitive impairment in cognitively intact patients with Parkinson's disease, regardless of other clinical and non-clinical markers of the disease. Hence they concluded that the degeneration of the nucleus basalis of Meynert precedes and predicts onset of cognitive impairment in patients with Parkinson's disease.

The course of apathy in late-life depression treated with electroconvulsive therapy; a prospective cohort study

A. Carlier, E. van Exel, A. Dols et al. The course of apathy in late-life depression treated with electroconvulsive therapy; a prospective cohort study. Geriatric Psychiatry. May 2018 (online first)

The authors studied the course of apathy in patients with late-life depression treated with electroconvulsive therapy (ECT), and the predictive value of vascular burden and white matter hyperintensities (WMH) on its course. The study sample was derived from a prospective cohort study, MODECT, which recruited older persons (aged 55 to 87 years) with a unipolar major depressive disorder from 2 psychiatric hospitals in the Netherlands and Belgium. Exclusion criteria included major neurological illnesses such as dementia and Parkinson's disease, bipolar and schizoaffective disorder. Apathy was defined by a score of >13 on the Apathy Scale, and information was collected on depression severity, vascular burden and other putative confounders. WMH data was collected from MRIs available in 52 patients. A regression analyses was used to look for possible risk factors for apathy post ECT. They found 52% of depression remitters after treatment with ECT still suffered from clinically relevant apathy symptoms. This was not associated with higher age, severity of apathy and depression at baseline, or use of benzodiazepines. There was no association between vascular burden and

WMH with post-treatment apathy. They also found that post-treatment apathy was predicted by poor response in depressive symptomatology after ECT.

Antipsychotic treatment of very late-onset schizophrenia-like psychosis (ATLAS): a randomised, controlled, double-blind trial

Robert Howard, Elizabeth Cort, Rosie Bradley et al. Antipsychotic treatment of very late-onset schizophrenia-like psychosis (ATLAS): a randomised, controlled, double-blind trial. The Lancet. June 2018 (online first)

A two-stage randomized, controlled and double-blind trial that investigated whether low-dose amisulpride (100mg daily) was more effective compared to placebo in reducing psychotic symptoms over 12 weeks (stage 1), and whether the benefit was maintained if treatment was continued after 12 weeks (stage 2). It enrolled participants in 25 old age psychiatry services in the UK having a diagnosis of very late-onset schizophrenia-like psychosis and a Brief Psychiatric Rating Scale (BPRS) score of ≥ 30 , without cognitive impairment. Three arms of the study were: Group A – amisulpride in stage 1 and 2, Group B – amisulpride then placebo, or Group C – placebo then amisulpride. Out of 101 patients recruited, 91% participants took trial medication, with 64% completing stage 1 and 58% completing stage 2. During stage 1, the improvements in BPRS scores at 12 weeks was greater with amisulpride than with placebo, while in stage 2, BPRS scores deteriorated once amisulpride was switched to placebo. Fewer participants given amisulpride discontinued the trial treatment due to non-efficacy compared to the placebo. More serious adverse events were noted in those in the amisulpride group, which included infection and extra-pyramidal side effects. The main limitations were the low recruitment rate to the study and the variable duration of stage 2, which was reduced from 24 weeks to 12 weeks to improve compliance, hence optimal duration of treatment could not be recommended.

Stopping cognitive decline in patients with late-life depression: a new front in the fight against dementia

Eric J. Lenze, Aristotle N. Voineskos, Meryl A. Butters & Jordan F. Karp.

Stopping cognitive decline in patients with late-life depression: a new front in the fight against dementia. The American Journal of Geriatric Psychiatry. June 2018 (online first)

In this editorial, the authors propose a dementia prevention strategy by focusing on those individuals who present with late-life depression (LLD), which is considered a high-risk cohort given their 4-to-6 fold increased risk of developing dementia based on numerous other studies. They suggest the pathophysiology behind this to be multifactorial, with findings of increased amyloid pathology in this cohort, high rates of Alzheimer's disease (AD) in those with LLD on post-mortem studies, higher burden of white matter hyperintensities in them (more so in the treatment-resistant cases), and other shared physiological pathways between LLD and dementia such as proinflammatory burden. They propose the late-onset of affective symptoms as a prodrome of dementia and a critical time to intervene with preventive measures. To investigate the pathways of AD risk in treatment-resistant LLD, they plan to carry out longitudinal neuroimaging, neurocognitive assessment, and peripheral biomarker testing in a sample of patients recruited for the study, "Optimising Outcomes in Older Adults with Treatment-Resistant Depression" (OPTIMUM). This is an American five-site comparative effectiveness trial, which is recruiting 1,500 community-living men and women 60 years and older with treatment-resistant depression. The authors also propose testing lithium as one of the potential treatments to prevent AD in the context of LLD.

Cochrane corner

by

Jenny McCleery, Consultant old age psychiatrist, Oxford Health NHS Foundation Trust, and Joint Co-ordinating Editor, Cochrane Dementia and Cognitive Improvement Group

Ciaran Abbey, Consultant old age psychiatrist, Oxford Health NHS Foundation Trust

In this edition, we will be looking at three reviews from the Cochrane Dementia and Cognitive Impairment Group (CDCIG). These reviews address three of the most common clinical questions we are asked as old age psychiatrists.

Firstly, should antipsychotics started for the treatment of neuropsychiatric symptoms in dementia be withdrawn or continued long-term

(<http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD007726.pub3/full>)?

Secondly, should antipsychotics be used to treat delirium in hospitalised patients (<http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD005594.pub3/full>)?

And finally, how effective is donepezil for Alzheimer's disease and what is the optimum dose (<http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD001190.pub3/full>)?

NICE's most recent guideline on the **management of dementia (June 2018)** (<https://www.nice.org.uk/guidance/ng97>) recommends antipsychotics for agitation, aggression and psychosis if psychosocial and environmental interventions have not worked and there is a risk of harm or severe distress. 60 to 98% of people with dementia suffer from behavioural and psychological symptoms of dementia (BPSD) during their illness with up to 30% of the cost of caring for someone attributed to management of these symptoms. However, there are questions about the

efficacy of antipsychotic drugs in managing challenging behaviours. BPSD are often episodic so improvement may have occurred without treatment. Antipsychotics are reported to increase mortality with possibly little positive effect. Carers may be reluctant to withdraw antipsychotics, especially if challenging symptoms appear initially to have responded to medication. This study is an update of a 2013 review. The authors found 10 RCTs which had a total of 632 participants with dementia who had been taking antipsychotics for at least 3 months before entering the study. The primary outcome in the review was the successful withdrawal of antipsychotics either in the short term (4 weeks) or long term (more than 4 weeks).

In Cochrane reviews, a combination of the quality of evidence (using GRADE) and the effect size is used to generate the conclusions. In this review, evidence quality was low or very low so confidence in the conclusions is limited. Because the studies were so diverse, particularly in the ways they measured outcomes, it was not possible to combine data numerically. The review authors' overall conclusion was that, in general, it is possible to stop long-term antipsychotics without behavioural problems worsening. However, in some people who had psychosis, agitation or aggression and who had improved significantly when they first started antipsychotic treatment, the authors found stopping the drugs may increase the risk of behavioural problems getting worse again. There was also some evidence from subgroups that agitation might decrease after stopping the drugs in people whose BPSD were relatively mild at the beginning of the studies, but increase in those with more severe baseline symptoms. There was not enough evidence for the authors to comment on other important outcomes such as quality of life, mortality or morbidity.

The rationale most commonly given in the literature for using antipsychotics in delirium is the acetylcholine deficiency and/or dopamine excess theory. As old age psychiatrists, we are used to seeing older

people with delirium in the emergency department (8 to 17% of older adults), on the wards (29 to 64%) and, perhaps most challengingly, at home. Delirium is associated with poor outcomes in hospitals (increased length of stay, cost, mortality, readmission, institutionalisation). Similarly to BPSD, NICE recommend use of antipsychotics only where people are distressed and other forms of management have not been effective (<https://www.nice.org.uk/guidance/cg103/chapter/1-Guidance#treating-delirium>). However, in practice, they are widely used despite concerns around efficacy and adverse events.

Our review of **antipsychotics for the treatment of delirium** found 9 RCTs which included 727 medical, surgical and palliative care patients (<http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD005594.pub3/full>). The review did not cover delirium in critically ill patients in ICU. Some included studies compared antipsychotics to lorazepam or placebo and some compared atypical antipsychotics to typical ones. Haloperidol was the most studied drug. Again, all the evidence was of low or very low quality. The review authors' chosen primary outcome was duration of delirium, but no trial reported on this. There were also no reported data on length of hospital stay, discharge disposition or quality of life. In the comparison of antipsychotics with placebo or lorazepam, there was no evidence of an effect on delirium symptoms, either resolution or reduced severity, but this was very low quality evidence and hence very uncertain. The review also found low quality evidence that there may be no difference between typical and atypical antipsychotics on these efficacy outcomes. The authors were unable to detect any differences between treatments on mortality or adverse events (again, low quality evidence). Most research on this topic in recent years has been in critically ill patients in ICU. Clearly, there is still a need for research into the best pharmacological management of delirium in older medical and surgical patients if preventive and non-pharmacological management strategies have been unsuccessful.

Donepezil is, of course, used very widely to treat cognitive symptoms in Alzheimer's disease, but we wanted to update our review of the **evidence about donepezil for Alzheimer's Disease** using the most current Cochrane methods. The updated review (<http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD001190.pub3/full>) included 30 RCTs with more than 8000 participants. 28 RCTs reported data which could be included in meta-analyses. Most of the evidence was of moderate quality so the conclusions can be viewed as more robust than the conclusions of the antipsychotic reviews discussed above. However, there were significant limitations to the evidence. Only one small trial lasted as long as a year. Only nine of the trials included participants with moderate-to-severe or severe dementia. Also, most of the evidence still comes from industry-funded trials (17 of the 22 which disclosed a funding source). The review authors were interested in cognition, daily functioning and behavioural symptoms along with safety and tolerability. However, one well-known challenge for the reviewers was identifying what constitutes a clinically significant difference in outcome. For people treated with 10mg Donepezil for 6 months, there were small cognitive benefits regardless of baseline severity. The mean difference in ADAS-Cog score was 2.67 points (95% CI 3.31 to 2.02), in MMSE score 1.05 points (95% CI 0.73 to 1.37) and in Severe Impairment Battery (SIB) score 5.92 points (95% CI 4.53 to 7.31), all favouring donepezil over placebo. There were also small advantages for donepezil on functioning and clinical global impression, which led the authors to suggest that the benefits are probably clinically significant. There was no evidence of effects on neuropsychiatric symptoms or quality of life. 72% of participants on donepezil and 65% on placebo reported at least one adverse event, but serious adverse events were rare in both groups. Overall, a 10mg dose was slightly better than a 5mg dose on the ADAS-cog, but not on the MMSE or SIB, nor on function or clinical global impression. 5mg was favoured over 10mg for quality of life, adverse events and withdrawals from treatment. 23mg of donepezil was no more effective than 10mg but was associated with more adverse events and dropouts from treatment.

To summarise, this updated Cochrane review on confirms that, when compared to placebo, donepezil probably does have a modest beneficial effect on the cognition and functioning of people with mild, moderate or severe AD at the expense of a small increase in the rate of adverse events. There is very little evidence that 10mg is better than 5mg, but 5mg appears to be better tolerated and associated with a slightly better quality of life.

Quality Network for Old Age Mental Health Services (QNOAMHS):

Continuing Professional Development opportunities for trainees and old age psychiatrists.

by

Mohan Rajendra Gondhalekar, ST5, General and Old Age Psychiatry, Essex Partnership University NHS Foundation Trust, Clinical Fellow at the Centre for Quality of Improvement, Royal College of Psychiatrists

In my previous newsletter article¹, I discussed the benefits that membership of a Quality Network can provide to individual old age mental health wards. In this article, I would like to present the Continuing Professional Development (CPD) opportunities that Quality Network membership can afford to its clinicians. The General Medical Council (GMC), within its guidance document entitled: *Good Medical Practice*, emphasises the importance that it places on CPD for all clinicians.²

The Royal College of Psychiatrists, via the Centre for Quality Improvement, provide a variety of useful CPD opportunities that Old Age Psychiatrists and trainees can take advantage of. Clinicians from services that are members of the Quality Network for Old Age Mental Health Services (QNOAMHS) can take part in several CPD events that are offered to them free-of-charge by QNOAMHS.

QNOAMHS hold special interest events at the Royal College of Psychiatrists, London. These focus on a variety of important topics, which are highly relevant to Clinicians and help them with their everyday practice. The latest special interest day, entitled "Psychology: Best Practice in Older Age Inpatient Wards" took place on 16th July 2018.³ This special interest day was jointly hosted by the British Psychological Society.³ The day was split into several workshops. These workshops focussed on strategies that could be employed to meet the psychological

needs of patients on both organic and functional wards, as well as looking at how to establish a psychologically informed culture on the ward. In one of the workshops that I attended, we explored the patient journey in greater depth and we looked at the importance of providing psychological input to patients and their families at every stage of the inpatient journey i.e. right from the pre-admission phase to the point of discharge. We also looked at some of the psychological tasks that should be undertaken with patients and their carers on the ward, such as maintaining and establishing identity and attachments, re-establishing a sense of competence and comfort, maintaining and promoting inclusion, and most importantly of all, re-establishing hope.⁴ As a psychiatry trainee, this workshop both challenged me and empowered me to become more psychologically aware about the patients that I assess during weekly ward reviews. It also helped me to appreciate the lasting contribution that psychologists make to patients, carers and the ward staff in general. The overarching message from this special interest day, was the assertion that responding to the psychological needs of patients was every healthcare professional's responsibility and that it should form part of the multidisciplinary approach towards patient care. This special interest day was very warmly received by attendees and feedback was highly positive:

"Extremely helpful day. I genuinely hope to implement some of the ideas learnt today to shift culture and practices back in my own place of work."

"Very helpful day, bringing together different professional groups. Presentations were practical in terms of ideas to take forward."

In addition to the special interest days, QNOAMHS also hosts an annual forum at the Royal College of Psychiatrists, London. Entry to this event is provided at discounted rates to healthcare professionals from member organisations. The Annual Forum invites speakers from academic, research, and clinical backgrounds within the world of old-age psychiatry to deliver educational talks and it also provides a unique networking

opportunity for likeminded, enthusiastic clinicians to share new ideas and new clinical models of working with one another.

There are currently 75 member services within the QNOAMHS family; 61 are accreditation members, 11 are developmental members and 3 are associate members. All members should provide staff from their service to participate in the Developmental Peer Review and Accreditation Review visits that QNOAMHS is responsible for organising and conducting. Participating in the Developmental Peer Review and Accreditation Review process offers unique opportunities for clinicians and trainees to develop their leadership and management skills. Working with fellow colleagues from other old-age inpatient services around the country offers an excellent opportunity for healthcare professionals to network and enhance their communication and team-working abilities. Furthermore, lead reviewers need to be able to produce high-quality structural reports at the end of each visit for the services that they have reviewed. Additionally, they also need to possess the time management and organisational skills, essential to making sure that each developmental peer review or accreditation review visit runs smoothly and all relevant tasks are completed as timetabled.

QNOAMHS also has two important Governance Groups within which, CPD opportunities exist for trainees to attend as observers, so that they can learn more about the art of quality improvement. Furthermore, there are also opportunities for more experienced clinicians to participate in, and drive forward the vision of quality improvement at the national level through invitation, election, and induction onto these QNOAMHS Governance Groups. The groups include the accreditation committee and the advisory group. Both groups contain members of a multidisciplinary team of professionals which include; a clinical psychologist, a psychiatrist, nursing staff, and carer representatives etc. The Accreditation Committee meets on a quarterly basis in order to discuss and evaluate individual services that have undergone the accreditation review process. The

committee can then make a final decision as to whether or not to award a service coveted accreditation status. The advisory group meets biannually and provides external oversight and expert knowledge for the CCQI to effectively deliver and develop the quality network. It has an important role in ensuring that the standards and methods are appropriate, realistic and relevant to modern Old Age Mental Health Services. The advisory group of QNOAMHS also evaluates advances and innovative ways of working.

Conclusion

Through the course of this article, I have tried to present some of the highly valuable career developmental opportunities that QNOAMHS can offer to health care professionals from its member services. These opportunities are available to clinicians at all levels of training; from the core psychiatry trainee to the highly experienced Consultant. They include getting involved with developmental peer review and accreditation review projects and the high-quality educational opportunities; such as the Annual Forum and the carefully selected special interest days. Finally, there are also opportunities for experienced clinicians to utilise their transformational leadership skills, to further the Quality Improvement work within Older Adult Services at the national level.

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Book review

by

S. Gascoigne-Cohen

CT3 Psychiatry, North Central London

Word count: 857

Title: *Can't We Talk About Something More Pleasant?*

Author: Roz Chast.

Publisher: Bloomsbury. 2014.

ISBN: 978-1-63286-101-6

Discussions about death may be expected in Old Age Psychiatry. Graphic novels addressing dying, on the other hand, might not be. Roz Chast, a prolific American illustrator and author, manages to discuss death sensitively and humorously in the format of a graphic memoir, *Can't we talk about something more pleasant?*. Chast's work was the New York Times' number one bestseller and won numerous awards, including the Kirkus prize for nonfiction. A memoir, it is told from the perspective of Chast, an only child, as her parents approach the end of their lives and she becomes increasingly involved in their care. The book is also a therapeutic reflection on her parents' marriage, the relationship she had with each of them and how this shaped all of their interactions in later life.

As the memoir's title suggests, people often want to avoid discussing 'unpleasant' topics and its success may be from depicting commonplace events that can be incredibly difficult to talk about honestly and openly. The book opens with Chast tentatively trying to discuss death with her parents to understand their wishes but the conversation swiftly ends. It is against her parents' principles to talk about death and Chast sees the anxiety it causes them. Struggling with the consequences of this aversion to discuss the inevitable, the memoir addresses the 'unpleasant' things that need to be talked about as they unfold in her parents' lives and thus her own.

The 'unpleasant' topics are not simply death and dying but the multitude of challenges that can accompany ageing, such as falls, incontinence and moving into a care home. These are described in short chapters, usually focusing on one incident and its consequences. The broad and mostly chronological approach is evident in the chapter titles, which include 'The Fall', 'Sundowning' and 'The Move'.

This book is relevant to old age psychiatrists because it paints a picture of ageing from the perspective of both an older couple and their carer and reminds us how challenging it can be for everyone, from the psychiatric disorders to the legal aspects. Chast's parents, like many, are expected to address the topic of death if they wish to exert some control and establish legal safeguards such as lasting power of attorney. We learn about a fear of losing control and having to trust lawyers and their adult children with issues they may never have approached before. Chast also reminds us of the alarming amount of paperwork and the tedious administrative issues society expects family members to undertake to facilitate care. Chast makes no apologies for her pragmatic approach to learn about 'incredibly boring stuff' to help her parents. Although it takes place in the USA, it resonates with the situation in the UK.

A particular strength is how Chast highlights the impact of dementia and frailty on the individual and their carer with both sensitivity and humour. She uses an interesting mixture of prose and dialogue, caricatures and lifelike drawings plus the occasional photograph to create vivid characters. She brings to life her father's dementia and her mother's delirium and her own ad-hoc coping strategies. Her honesty about how challenging she finds her father's paranoia is confronting and refreshing. Chast communicates well the confusing immature feelings that can occur when a daughter must swap roles with her parents to take care of them whilst wishing deep-down they could stay in their roles as the carers. Overall, Chast shows us the complex human mixture of fulfilment, even

pride, from helping her parents and the frustration at the reversed and challenging carer role.

Chast's black humour is prevalent throughout and while popular, it may not suit everyone, particularly when addressing the sobering topics of ageing, dementia and dying. The comic interludes, if they align with your sense of humour, lighten the tone of the chapters. It is also presumably deployed as the author's coping mechanism. Complex issues, such as DNAR orders, are handled sensitively in the prose but are often juxtaposed with a witty and dark illustration. Colloquial terms are liberally used to describe people and behaviours and could cause offence, as could the odd expletive.

While the book is ostensibly about death and dying, the underlying issue in most chapters is the complicated relationship Chast has with her parents, particularly with her mother. The tension between Chast and her mother is a frequent feature; her mother is drawn as larger than the other characters, conveying her domineering personality, and is often shown shouting at Chast and at her husband. The early and final chapters depict Chast's attempt to understand and reconcile with her mother. As it is a posthumous memoir, the personalities and behaviours of her parents are only seen through Chast's eyes. We will never know what her parents' thought about their psychological graphic portraits, that are often quite unflattering. Despite this, their affection for one another runs throughout the book and the endings of both their lives, and of the book, are poignant and sensitive.

If you only read one graphic novel about death this year and you don't mind dark humour, this is an excellent choice, and I would welcome further discussion about it.