

The Old Age Psychiatrist



Issue 71, May 2018

Editorial team: Helen McCormack, Sharmi Bhattacharyya,
Anitha Howard, Philip Slack



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Faculty of Old Age psychiatry

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Update from the editorial team

by

Helen McCormack

This edition of the newsletter is packed with articles that are both important and interesting, and I would urge you to take a look at all of them.

We are delighted to publish the winner and runner up of the newsletter essay competition. The theme this year was "A world without dementia: where would old age psychiatry be?". The winning essay is 'Dementia: A dystopian future' by Gareth Smith', and the runner-up, 'Interview with a retiring old age consultant - conducted 21 October 2057' by Christopher Lucas'. We will be publishing the three next best essays in September 2018.

We also publish the winner of the [Philip Davis Prize](#), awarded for an original and inspiring essay directly relating to the care of the elderly mentally ill. The winning essay, 'Personality disorder: an unknown risk factor for dementia?', by Ayesha

Bangash explores the connection between personality disorder and dementia and is a fascinating and thoughtful essay.

Claire Hilton has written a historical overview 'Choosing a new Faculty name', and this provides a great backdrop for the debate that was held at this year's Faculty Conference about the name of our faculty. The debate was very lively with the overwhelming conclusion to proudly remain with the name we have, Old Age Psychiatry.

I would also like to draw your attention to Kapila Sachdev's article about Integration and Developing an understanding of the new NHS landscape in England. She gives a great summary of the terms now in use and more importantly why engaging with those people who are leading the current changes is critical. We would like to invite articles from anyone who wishes to share information and

experience of integration in their area. Find out more about [how to submit an article](#).

Martin Curtice has done a great summary of The Competition and Markets Authority report of its market study into residential and nursing care homes for older people in the UK.

This is a really important topic and very well summarized for us.

Alongside our research update and Cochrane Corner is an article by Mohan Gondhalekar, exploring the [Quality Network for Older Adult Mental Health Services](#) and its benefits for our services which is definitely worth a look.

I have not had space to mention everything, so please take a look at everything and let us know what you think – helenjmcormack@hotmail.co.uk

Update from the National Clinical Director for Dementia and OPMH

by

Alistair Burns

It has been another busy and active time in NHS England – the profile of dementia remains very high. There is a need to articulate the next stage of a dementia narrative and emphasise the importance of post diagnostic support, now that the national dementia diagnosis ambition of two thirds has been achieved for the best part of a couple of years. Sir Bruce Keogh has stepped down as Medical Director of the NHS and has been succeeded by Steve Powis, who is very interested in work around dementia.

There are a few initiatives which are particularly worthy of note - the [implementation guide has been published](#) and emphasises the importance of good post diagnostic care as well as the timeliness of diagnosis in memory clinics. It can be used locally to facilitate

discussions with your local commissioners.

In terms of antipsychotic prescribing, everyone will remember the great interest following Sube Banerjee's landmark report Time for Action in 2009 and the activity that followed that regarding reduction of antipsychotics – using it as a proxy for person centred care. A national audit in 2012 showed that the reduction had been achieved very successfully. We have recently started to get the information on a monthly basis, quite like the dementia diagnosis rate, through NHS Digital. The current prescribing rate for antipsychotics for people with dementia is running just under 10%, a figure which is not easily directly comparable to the previous audit because of the slightly different method of collection. The important thing is that we have established a new baseline and will continue

to monitor this very closely looking particularly at trends and geographical footprints.

One of the challenges we have had for some time is how we measure dementia care planning – if this can be done in an automated way, it makes collection and collation very easily. The opportunity has arisen to follow on from [our guidance, Dementia: Good Care Planning](#), to actually build and measure using automated codes, this work proceeded very well and it really does raise the exciting possibility of having simple things that we can assess that will produce a good measure of post diagnostic support.

In addition, some extant issues are worthy of note:

- The NICE Dementia Guideline consultation has come and gone but congratulations to everybody from our faculty involved in that huge piece of work. It will be a landmark when it is published, hopefully later this year.
 - Join Dementia Research is an important initiative which has attracted a specific target with 10% of people with dementia in a clinical study and 25% of people with dementia signed up to Join Dementia Research. Supporting it through memory clinics is a good measure to show how active dementia research is.
 - Related to that, the Dementia Research Institute has just announced a position for an Associate Director for Care Research and Technology to be appointed towards the end of the year and this will be a great boost for this aspect of care and will be complementary to the biological research being undertaken in the Dementia Research Institute.
 - Linking with frailty is very important and if there is a local frailty collaborative or particular interest in frailty, it would be helpful if you could fly the flag for mental health which of course includes depression, delirium and dementia.
 - Dementia has been incorporated into the NHS Health Check for everyone over the age of 40 – this is specifically to raise the profile of dementia and to let everyone know that reducing one's individual risk of dementia is feasible and possible (studies suggest that 80% of people are not aware that you can reduce your individual risk of dementia).
- In terms of older people's mental health, it is good to make sure that mental health in older people gets advantage from the great general interest in mental health across the life course. I think it is fair to reflect that in terms of younger people and adults the interest has not quite permeated into older people. Of the key aspects in the Mental Health Five Year Forward View, some are

particularly relevant for older people - intensive home treatment, reduction of suicide, access to physical health checks, all-age mental health services and improving access to IAPT. The challenge is to link these to issues specifically around older people.

One of the things that have been published recently from our College's Centre for Quality Improvement is [a study for depression in older people in acute trusts](#).

This showed, not dissimilar to dementia, that recognition and treatment of depression in the acute Trust can be improved. We are hoping this sets the scene for more work on this area and putative NICE depression guideline includes a mention of older people with some associated research suggestions.

As part of work with Health Education England, we are examining core competencies for Mental Health Practitioner and this can set the scene very nicely for future work in this area. If you are interested in getting

involved please write to me.

So, a very exciting time for us in old age psychiatry and a real opportunity to articulate what we should be doing as a profession. In place of this issue's quiz, I would like to add a serious note around the attached photograph, which shows Tom Arie's last appearance at our

Dementias 2020 conference in February 2018. Tom and I have headed the conference for twenty odd years, which is ably organised by Mark Allen Publishers, and this was Tom's last year. It has been an absolute pleasure to be involved with one of the pioneers of our specialty, and Tom leaves with everyone's good wishes. The disappointment of

Tom leaving is partly soothed by the fact that John O'Brien will be joining me.

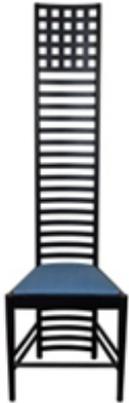
As always, happy to hear any comments or questions - Alistair.Burns@nhs.net



View from the Chair

by

Dr Amanda Thompsell



I am still buzzing with excitement following a great Faculty conference in Newcastle. I want to congratulate Dr Krishnan and the organising committee who put together such an interesting conference with a large number of excellent summaries on the key points of the recently published and forthcoming guidelines on dementia, depression, Lewy body dementia, substance misuse in older people, driving in Dementia and depression in Care Homes - to name but a few. There really were too many highlights to name them all. What I particularly noticed over the three days was what wonderful colleagues Old

Age Psychiatrists are and how enthusiastic and motivated the trainees are. I came away refreshed inspired and positive about the future.

Once again there were unexpected events in the last few months which we have got involved with. The volume of these seems to grow each quarter, which I think is a good sign as this is because we now have improved our alliances with various organisations and partly because of our greater profile.

These have included:

- The proposed review of the Mental Health Act in England. This has involved a lot of work to make sure that the Faculty's concerns are heard. I have to thank Drs Series, Bhattacharyya and Rands for all their hard work in helping with the responses. As you will see from

the article elsewhere in this newsletter, the government has responded to the proposal for a new Liberty Protection Safeguards (LPS). I urge you to read the article about MHA MCA in this newsletter which will update you on where we have got to so far. It is still clearly work in progress. We do however still need comments about the difficulties of the DoLs and the MHA interface from the point of view of patients and their relatives and carers. Please let us know if you know any patient or carers who would be willing to share with the MHA review panel their views.

- I have been collaborating with the Liaison Faculty on their position statement on what is meant by "all age liaison services" which has a clear

statement that old age psychiatrists area key component of liaison services.

- We have started our involvement with HEE to develop competencies for health and social care staff working with older people's mental health (Faculty members have been informed about this) We have also put in a Faculty response to NICE on the guidelines on dementia along with other NICE consultations thanks to Dr Akande.

At the same time, we have continued to make progress with our chosen strategic aims.

Raising the awareness and profile of older people's mental health

There has continued to be interest in older people's substance misuse and Dr Rao has been frequently quoted on this subject.

In the college promotional video in the 12 days up to Christmas the College used our animated depression video as one of the days.

We have had interest in The Mental Health Primer on Older people being translated into Russian (perhaps they may change their mind now) and more generally we are still getting very good feedback about this document. NHSE are currently planning to try and evaluate the impact.

We still do not have enough case studies about older people's mental health to use in our various engagements with the media which does mean that our ability to influence public debate is less than it could be. Whilst I appreciate it is difficult, if you do know a patient who would share their experience with the media please get in contact with me.

To be to the 'go to' organisation for mental health issues in older people

We continue to work in England with NHSE and across the devolved nations to communicate the importance of older people's mental health issues.

In Wales Dr Ivenso and colleagues have

submitted responses to several enquiries, advised on the dementia action plan for Wales.

In Northern Ireland under Dr Shields leadership, Faculty members have been doing a huge amount of work advising on the code of practice for the NI Mental Capacity Act, as well as hosting various conferences.

Dr McNulty and his team have been equally busy in Scotland advising on the Scottish Government's proposal for the reform of the Scottish Incapacity legislation.

As a result of our engagement with the European Association of Geriatric Psychiatry we had visitors from Sweden attended our conference. We hope to build further on these relationships.

To improve on how the faculty engages with its members

I had a wonderful experience visiting members in Northern Ireland in December and I was struck by their passion and enthusiasm.

As a result of information from members that transitions between services have in some cases raised issues we have been updating the transitions document (when moving to older peoples services or not). We hope that this document (which is due to be published in the next few weeks thanks to Dr Sivakumar) will help our members locally as it sets out best practice principles and the forward has kindly been signed by many of the other Faculty chairs.

We have also been voicing members concerns around Section 49s (these referrals also go to other Faculties as well) and the College is looking into this. What the outcome will be from this is unclear but our members concerns have been heard and the issue is being looked into (further information is in the MCA/MHA article in the newsletter)

We have also circulated the survey results we got back from members about changes in their current job plans compared with their original College agreed

job plan (the results were published in January 2018 newsletter) to the College leads and national policy makers so that they can take its messages into account when they are thinking about retention issues. Some of the concerning results were that 46% of respondents reported having less than 2.5 SPAs and 49% of respondents reported working beyond their job plan to cover for vacancies. We also found that 5 out of 11 respondents who had been in post for a year or less had experienced changes to their job plans

To improve recruitment

Dr Bailey continues to consider various options to increase recruitment and we are developing a leaflet about old age psychiatry for the International Congress. The small pilot looking at delivering training in old age medicine by psychiatric trainees swapping with geriatric trainee continues has already lead to some interesting learning. We have begun to work even more closely with our trainees on how we

can enhance the identity of old age trainees and support them by providing opportunities for them with projects from the executive and reviewing our prizes. We have updated the Trainee section of the website at least a start in the short term and we are in the process of improving it further. Any recommendations of books to read (not text book) or films to watch would be appreciated.

Looking forward we have a lot to be proud of:

[MindED for Older People](#) is being launched on 28 March 2018. It is a new online educational resource aimed to equip older adults, families worried about their older relatives, and with the necessary information to manage their mental health needs. Whilst mostly produced by Faculty experts, the co-production with lay older authors has meant it is in an easily accessible format and focuses on what older people want to know. The topics covered in the 20 sessions including among many others insomnia, medications to be aware of, depression, anxiety,

bipolar disorder. If you would like any leaflets about Mind Ed to distribute locally, please contact keith.chambers@rcpsych.ac.uk and he would be happy to send you some.

We can also look forward later in the year to an updated Young Onset Dementia report, a report addressing depression in care homes, physical health issues in inpatient units and an updated report on age discrimination in mental health.

The updated best practice guidance on dementia and driving (with helpful draft letters) is also due to be published soon.

We plan to translate the depression video into four languages to see if it is useful to local communities. I am also looking forward to the [one day conference on Neurology on 8 October in London](#).

At this time of change we need to seize the opportunities to capitalize on the increased interest in mental health issues in older people so that older people get a better deal.

In England we urgently need to engage with STPs and ICSs (If you are not sure what they are please read the helpful summary article in this newsletter.)

We also need to support our colleagues to feel reinvigorated so they can inspire the next generation. To this end the Faculty Executive are discussing a vision for the future of our specialty.

I am keen to hear your views, so please let me know if you have any thoughts c/o oldage@rcpsych.ac.uk.

Competition winners

Writing competition – Judges biographies

by

Philip Slack, Trainee editor, ST5 OAP, Cardiff

This year the topic for the Old Age Psychiatrist writing competition was "A world without dementia: where would old age psychiatry be?".

To judge this competition, we have had the help of Dr Ceri Evans, Hazel Ratcliffe and Dr Victor Aziz. We have included brief biographies for each of these judges below:

Dr Ceri Evans:

Dr Ceri Evans is a consultant old age psychiatrist working at Cwm Taf University Health Board and Cardiff University School of Medicine with a special interest in education and training, in particular the relevance of emotional resilience in professional development. He also has an interest in psychological therapies and mindfulness in health and education. He is the joint RCPsych lead for recruitment for the RCPsych in Wales. When not at work he enjoys transporting his three children to their increasingly complex

social commitments. He relaxes by going to gigs and getting out in nature (trail running if he can muster the energy).

Hazel Ratcliffe:

Hazel Ratcliffe is a Qualified Nurse, Psychotherapist & Social Worker. She has been involved in working with most client groups, but more intensively with people living with Mental health & Dementia. Hazel has been an 'associate specialist in learning & development for the Association for Dementia Studies at Worcester University since 2010. With a reputation for delivering exceptional training and coaching services to improve the quality of support that people receive. She has created a number of innovative training packages which are person centred in their thinking, are designed to encourage exploration, creative participation and intends to bring the best out of even the most reluctant delegate! She is committed to providing training, consultancy or

support that is relevant to the individual. She is also currently the Strategic Touring Project Manager for [Vamos, a Theatre Company based in Worcester](#) who are touring the UK with a production called 'Finding Joy'- a story of Joy who lives with dementia and her son Danny who cares for her. It's an Arts council funded project engaging Arts in Health & Education.

Dr Victor Aziz:

Dr Aziz is a consultant psychiatrist specialising in older adults' mental health. He qualified as a doctor from Alexandria University Medical School, Egypt in 1990. He undertook training in psychiatry in Alexandria Egypt before training in the UK in 1994. Dr Aziz has been appointed as a consultant psychiatrist in Cwm Taf University health board since 2006. He was appointed as honorary senior lecturer with Cardiff University Medical School and was responsible for Cwm Taf Undergraduate Department.

He has a doctorate degree in psychiatry and a degree in medical education.

Dr Aziz was elected as chair of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists-Welsh Division in 2013 and as the Wales Deanery School of Psychiatry Quality Lead in 2016. He also sits on the Welsh Government Speciality Advisory Committee-Old Age and on the Education Training Committee of the Royal College of Psychiatrists. His work both in the College, Medical Education field and with the Wales Government has helped push the quality of patients' care forward.

Competition winners

Winning essay: "Dementia: A dystopian future"

by

Dr Gareth Smith

Dr Alan Hughes was an unassuming man. Sat hunched over his oak desk, glasses perched precariously at the end of his nose with receding brown hair greying at the temples; he could easily have been mistaken for the conventional image of an accountant. His badge boldly proclaimed his role as 'CONSULTANT (Old Age Psychiatry)'. Alan gazed with disinterest at the thick pile of official documents sat in front of him.

The office he sat in was sparsely furnished other than the wooden desk, chair and a small desk lamp. The other features of the room consisted of pale green wallpaper, garish eco-lighting. Dust collected in the corners of the hard wood flooring and damp stains were slowly encroaching along the wall from above the doorway to the window. The view from the small window overlooked the dilapidated mildewed remnants of the Older Adult Psychiatry Services' building opposite. The

office generally exhibited an atmosphere of neglect.

"More detention notices?" Alan softly asked the tall thin clean-shaven man standing stooped next to him at the desk as he sifted through the pile of papers.

"Yes, Dr Hughes" the man answered. This man appeared exactly as one might assume with his profession - a low-level civil servant functionary dressed in a crumpled ill-fitting grey suit. "These are the forty persons who were appropriated from the care home placement in Surrey that had resisted the implementation of the new government protocol".

"When will these people learn?" sighed Dr Hughes with mild exasperation.

"They have dementia, sir. They can't learn" replied the government functionary with the same passive indifference that he

approached most of the mundane petty tasks that he was allocated.

Alan frowned and peered through the detailed notes that had been made of the first name on the pile.

Name: Dr Annabelle Victoria Peterson
Occupation: Doctor
DOB: 12 December 1946
Diagnosis: Dementia, Early Onset, Alzheimer's Type

Alan reminisced dispassionately on the rapid medical advances that had been made in the early years of the 21st century. The diagnosis, detection and prevention of dementia had occurred almost overnight. A new future awaited the millions of individuals who had been saved from a fate of gradual cognitive deterioration, social isolation and physical ill-health. Hope had filled the medical community about the realms of possibility for future advancement.

However, what had not been achieved was the reversal of cognitive impairment from those people who had already been diagnosed with a dementia condition.

Almost overnight, the mood of the nation had changed. Following the insidious implementation of Ageless Services (in combination with the financial and social fallout from the infamous Brexit debacle), public feeling escalated. Fury about the socio-economic cost of dementia patient care frequently made it to the front pages of the newspapers. Public demands were made, marches were organised and rallies were held. The so-called 'cure from dementia' had overtly morphed into the 'cure of society from dementia'. Mass demonstrations with chants of 'No Brain, No Drain' resonated through the streets of London all the way to Parliament. Swept in a wave of populist nationalist sentiment, what followed was a hastily assembled referendum and a series of rapidly ill-conceived government initiatives. Very soon the argument had teetered over from the withdrawal of care from affected persons to

the withdrawal (removal) of affected persons.

The consequences of this multi-factorial combination had led to the public perception of the redundancy of the specialty. The irony was not lost on Alan – the death of dementia had in turn led to the death of old age psychiatry. Alan had subsequently been made redundant from his previous post and this is what had led the unassuming Dr Hughes to his current employment – the unenviable task of signing the documentation enforcing the removal of persons with the residual diagnoses to await their government-mandated fate.

Alan looked back to the paper as it crumpled between his fingers. The tall thin man at his shoulder coughed softly, expectantly awaiting Alan to sign the document. Alan reluctantly lifted his pen and held it hesitantly over the paper, the shadow of his government-approved pen looking more like a dagger than a writing implement.

A cure for dementia had certainly been achieved and the future looked rosy for the nation - free

from the shackles of the medical, social and financial burden. Alan reflected solemnly that soon the very existence of those people who had been defined by a diagnosis would be forgotten, just as their own memories had gradually eroded.

Competition winners

Runner up: "Interview with a retiring old age consultant – 21 October 2017"

by

Christopher Lucas

When I think back to the start of my career I am stunned at the progress we have made and how this has changed the role of the old age psychiatrist. It really does feel as though we have almost cured dementia.

First off how did it happen – Well, back in the 2010s and early 2020s when I was training, there was certainly an awareness of the potential developments neuroscience would have on schizophrenia, bipolar and Alzheimer's dementia. There was a real feeling that we were on the cusp of a new wave of understanding and treatment for these patients. I don't think any of us expected the changes to occur so rapidly.

In hindsight I feel the "cure for dementia" happened due to the development of open access research and faster IT software in the

2010s and 20s. This allowed teams to quickly sift through the enormous amount of bioinformatics data that had been collected from hospital records, scans, memory clinics and large scale clinical trials. With our knowledge of molecular biology and epigenetics we were able to analyse millions of anonymous patient populations within a few days.

By the start of my higher training in the early 2020s molecular biomarkers were already approved by NICE for the diagnosis of mild cognitive impairment (MCI). We were able to test patients who had shown very mild symptoms of cognitive impairment. We could assess them quickly with associated tests (imaging, neuropsychological, blood tests) and provide an accurate 1, 5, 10 and 15 year prognosis relative to the development of common

dementias (Alzheimers, vascular, Lewy Body). Although this felt like a huge advance there were still no definitive treatments for MCI patients. We therefore closely followed the development of "new wave" treatments. Thankfully the first most successful of these arrived and completely changed our clinical practice. This was the anti -dementia drug Pro-Cognitium (Pro-C).

Pro-C manipulated the methylation and acetylation status of immune cells. It was the first epigenetic neuro-psychiatry drug. It could completely halt the development of Alzheimer's, Vascular, Lewy Body and Fronto-temporal dementias. It was initially licenced for all patients diagnosed with MCI. In association with newer more accurate biomarkers, Pro-C had dramatic effects on the structure of in and out patient old age services.

Over the next five years to about 2030 the memory service became a quick diagnostic service with 70% of patients commencing Pro-C. Patients could then be triaged to a follow up provision. This became much more akin to a modern oncology outpatient service. As with oncology, most patients were diagnosed, treated and stabilised prior to the development of any serious malignancy. These patients would be discharged on lifelong treatment (Pro-C) and followed up in a yearly outpatient clinic.

It is important not to forget that this was also the start of our now burgeoning neuro-molecular counselling service. All patients started on Pro-C were referred on to counselling. This would provide a more in-depth discussion on genetic and molecular prognosis and management. This was needed, with the understanding of now multiple receptor subtypes of dementia (e.g. Alzheimers 1, 2 and 3). A molecular counsellor could help the patient navigate the growing landscape of dementia. If desired, this would

include family counselling regarding inheritance and susceptibility of family members being at risk of MCI/dementia. We would then plan early management for any at risk family members to help reduce MCI developing.

In regards to inpatient services, trials began to assess if Pro-C could reverse established dementia. Results were encouraging. Our own inpatient ward was part of a UK wide trial and saw an improvement leading to premature discharge of over 52% of patients. We saw improvement in cognition and a return of pre-morbid personality in some patients. It really was akin to the start of the antibiotic era.

Old age Inpatient services at this point transformed to the now familiar neuro-psychiatric departments we see in most hospitals. These wards were typically for patients presenting from memory clinic with some of the rarer subtypes of dementia with only a limited response to Pro-C or newer adjunct treatments. We could quickly investigate if there had been any progression or change in

the disease. They tended to require admission for a more rigorous battery of molecular testing to provide a more specific treatment. The average inpatient stay at this point was 3-7 days. The majority of patients were discharged with a reversal in cognitive decline and returned home with only a 6 month follow up needed.

We have seen a large growth in the number of the "healthy elderly" taking Pro-C. These are patients that previously would have developed worsening dementia and sadly died prematurely. As a result, (despite improved treatments) our inpatient/outpatient services for other mental health conditions (e.g depression, anxiety) have sky-rocketed. It is estimated that 75% of all A&E admissions are now older adults. 55% of these are with mental health issues. The older adult inpatient wards and community services are now some of the busiest places in the NHS.

So, I find myself nearing the end of my career at the age of 78, taking my lunchtime Pro-C capsule. I first look to the future and think to myself about a recent lancet issue

headlined "Dementia vaccine – a new era". I wonder what life my current young trainees will have in old age psychiatry. It has been a fascinating journey fuelled by the results seen from transparent, collaborative research. This has provided a much needed map and compass on what could previously feel like a voyage into the unknown.

Prize winner

Personality disorder: an unknown risk factor for dementia?

by

Ayesha Bangash, ST6, OAP, Birmingham and Solihull Mental Health NHS Foundation Trust

Introduction

Little attention has been given to personality disorders in middle adulthood and later life in the literature.

Explanations include research on personality disorders being focused mainly on younger adults, a belief that personality disorders "age out" in old age and measurement instruments on personality disorders not fully applying to the later life context. There are few reports of patients with diagnoses of personality disorders in middle or later life. The case is the same for people with personality disorders who develop dementia in old age; one such case includes that of a European monarch. This article describes a case of a lady who received a diagnosis of borderline personality disorder at the age of 64 years, having the clinical features of this condition since early adulthood.

The diagnosis was changed to that of a frontotemporal dementia (FTD) a year later. The article also discusses views expressed by researchers on a possible link between personality disorder and dementia; can a personality disorder lead to a dementia in later life or does it represent the first clinical features of a dementia with an insidious onset? ^{1 2 3}

Case report

Miss X is a 67 year old lady residing in housing with care. There is a strong family history of depression in her mother and siblings. Five of her siblings died during

adulthood; some had taken their own life. There is no history of illicit drug use or smoking. There is no significant history of alcohol use nor is there any history of physical health problems. She worked in a number of cleaning and factory roles until retiring at the age of 55.

Miss X suffered from low mood since childhood due to a difficult upbringing. She was the fifth eldest of thirteen siblings. Their parents often argued with each other and their mother suffered from depression. The children were often neglected. She had to miss out on school throughout most of her childhood due to having to help out at home.

Miss X was married when she was 19 years old. She has one daughter from this marriage. Miss X's husband died of a heart problem when their daughter was 2 years old

¹ Mattar S, Khan F. Personality disorders in older adults: diagnosis and management. *Prog Neurol Psychiatry* 2017; 21(2): 22-27.

² Oltmanns T, Balsis S. personality disorders in late life: questions about the measurement, course and impact of disorders. *Ann Rev Clin Psychol* 2011; 27(7): 321-349.

³ Forstl H, Immler G, Soitz M, et al. Ludwig II, King of Bavaria: a royal medical history. *Dtsch Med Wochenschr.* 2007; 132(40):2096-9.

following which she had a number of relationships with men due to a constant need to have someone with her. The relationships were short-lived and characterized by her inability to handle criticisms over her unpredictable mood swings and behaviours including spending money unwisely which would lead to arguments with the partner. At times, usually around the time a relationship ended, Miss X would display outbursts of anger and would either cut her arms superficially with a razor blade or take an overdose of approximately 10 tablets of paracetamol. Her daughter recalled her mother frequently stating that she did not have a strong sense of who she was and that she felt empty and cut off from herself. Despite encouraging her mother to seek medical attention for her problems, her daughter recalled her only seeing the GP for episodes of low mood occurring a few times a year. SSRI's (*selective serotonin reuptake inhibitors*) would get prescribed by the GP on an infrequent basis.

Miss X became known to mental health services at the age of 64 years. Around that time, a relationship with a partner had ended. She was cutting her arms superficially with a razor blade. There were mood swings and fleeting suicidal thoughts. Her daughter felt that she was acting oddly in that she was muttering words of an impolite nature to no one in particular; Miss X stated that she was doing this due to stress. She had frequent arguments with her family members; a few quarrels led to her throwing crockery against a wall. She was not deemed to be suffering from a mood disorder or psychosis. There were no concerns over her memory and her Mini-Mental State Examination (MMSE) score was 30/30.

Miss X was given a diagnosis of a borderline personality disorder. In accordance with both the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD 10) and Diagnostic and Statistical Manual of Mental Disorders 5th edition

(DSM-5) criteria, her clinical features included feelings of emptiness, unstable mood, identity disturbance, recurrent self-mutilating/suicidal behavior, liability to anger outbursts, dissociative symptoms, efforts to avoid abandonment and a tendency to have conflicts with others especially when her impulsive actions were criticized. Such clinical features appeared to be traced back to her early adulthood.^{4 5} Miss X moved into housing with care as she felt lonely living on her own. Over the next year, her daughter became increasingly concerned over changes in Miss X's presentation. Her mother began to forget hospital appointments and her daughter had to remind

⁴ World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders [internet]. Geneva: World Health Organization; 1990 [cited 2017 Oct 20]. Available from: <http://www.who.int/classifications/icd/en/bluebook.pdf>.

⁵ American Psychiatric Association. DSM-IV and DSM-5 Criteria for the Personality Disorders [internet]. Missouri: American Psychiatric Association; 2012 [cited 2017 Oct 21]. Available from: http://www.psi.uba.ar/academica/carrerasdegrado/psicologia/sitios_catedras/practicas_profesionales/820_clinica_tr_personalidad_psicosis/material/dsm.pdf.

her of them. Staff at the accommodation had to remind her to attend to her personal care. Despite having a full wardrobe of clothes Miss X would wear the same clothes for several days. She could not remember to wash her hands after going to the toilet nor could she remember to take a bath.

There were also changes in personality. The frequency of uttering impolite words began to increase such that she would utter them constantly. She would previously say that this was due to stress but she was now unable to give a reason for this aspect of her behaviour. It was, however, less noticeable when distracted such as when occupied in conversation however she had become less conversational with others over time. She had previously helped her daughter at home on a regular basis however it became noticeable that she did not seem concerned when her daughter would be tired and needed help with household chores. At times, she would stare at people inappropriately in public. Miss X had never

been particularly fond of eating sweet foods however she started eating them in large amounts on a daily basis.

An organic cause of her presentation was suspected. A CT (*Computed tomography*) brain scan did not reveal any abnormalities. A FDG (Fluorodeoxyglucose) PET (Positron Emission Tomography) brain scan showed reduced metabolism in the anterior temporal lobes.

A neuropsychological assessment was performed. On the Schonell Graded Word Test she obtained an estimated premorbid intellectual functioning score that fell within the average intelligence range. This was felt to be keeping with her educational and occupational experience. Regarding the Repeatable Battery for the assessment of Neuropsychological Status (RBANS-version A) she obtained a total score of 63 which fell within the extremely low range and was 2 standard deviations below the premorbid estimate; scores for immediate memory (2.1

standard deviations below the premorbid estimate) and attention (1.9 standard deviations below the premorbid estimate) were extremely low; the scores for delayed memory (1.2 standard deviations below the premorbid estimate) and visuospatial skills (1.4 standard deviations below the premorbid estimate) were borderline; and the score for language (0.7 standard deviations below the premorbid estimate) was below average. She struggled with the tests of executive functioning; her scores for the Hayling, Brixton and Key Search tests fell in the impaired range. An overall score on the neuropsychological test which is 2 standard deviations below the premorbid estimate tends to indicate a dementing process. Her delayed memory score was better than her immediate memory score which hints at a dementia other than Alzheimer's disease (in which one would be expected to score poorly on both immediate and delayed memory tests).

In contrast to the memory scores, her score for tests of visuospatial function and language were relatively better. It was thus wondered whether she was suffering from a frontotemporal dementia. People with this condition also tend to score poorly on tests of attention (as seen in her case).^{6 7}

FTD typically comprises of 2 clinical presentations; the behavioural variant and primary progressive aphasia. Primary progressive aphasia, in turn, comprises of 3 variants; the non-fluent variant leads to agrammatism and speech apraxia; the semantic variant involves fluent speech and loss of semantic information; and the logopenic variant is associated with word-finding pauses and impaired sentence repetition. Miss X did not

appear to have features of primary progressive aphasia. In order to diagnose one with probable behavioural FTD, there should be at least 3 out of the following clinical features: disinhibition, apathy/inertia, dysexecutive neuropsychological profile, compulsive/perseverative behaviours, loss of empathy/sympathy and hyperorality. There should also be evidence of a functional decline and imaging results consistent with FTD. Miss X had scored poorly on the tests of executive function. She seemed unable to control the uttering of impolite words (compulsive/perseverative behavior). She did not seem concerned when her daughter would be tired and needed help with household chores (loss of sympathy/empathy) and had starting eating large quantities of sweet foods (hyperorality). Miss X's functional decline and evidence of anterior temporal hypometabolism in her FDG-PET scan were also in favour of FTD. A definite diagnosis of

behavioural variant FTD could not be given; genetic blood tests were not done due to a fear of needles and it was not possible to get histopathological evidence of FTD.^{8 9}

There are no specific treatments for FTD¹⁰ therefore Miss X's treatment was supportive in nature. She was not suffering from low mood however an SSRI (sertraline) and an antipsychotic (quetiapine) were tried in the hope of managing the repetitive behaviours (uttering impolite words) and agitation (leading to arguments with family members). It was deemed appropriate to try sertraline due to GPs having only prescribed SSRIs for brief periods and on an infrequent basis. Both medications showed some effect.

⁶ Braaten AJ, Parson TD, McCue R, et al. Neurocognitive differential diagnoses of dementing disease: Alzheimer's dementia, vascular dementia, frontotemporal dementia and major depressive disorder. *Intern J Neuroscience* 2006; 116:1271–1293.

⁷ Piguet O, Hornberger M, Mioshi E, et al. Behavioural-variant frontotemporal dementia: diagnosis, clinical staging and management. *Lancet Neurol* 2011; 10:167-72.

⁸ Woollacott IOC, Rohrer JD. The clinical spectrum of sporadic and familial forms of frontotemporal dementia. *J Neurochem* 2016; 138 (Suppl.1):6-31.

⁹ Ghosh S, Lippa CF. Clinical subtypes of frontotemporal dementia. *Am J Alzheimers Dis Other Dement* 2015; 30(7): 653-661.

¹⁰ Tsai RM, Boxer AL. Therapy and clinical trials in frontotemporal dementia: past, present and future. *J Neurochem* 2016; 138 (Suppl 1): 211-221.

Social services arranged for her to attend a day centre daily. The team psychologist and occupational therapist (care coordinator) visited the staff at Miss X's accommodation on a regular basis in order to support them with the management of her condition.

Discussion

Frontotemporal dementia

Frontotemporal dementia is a neurodegenerative disorder caused by atrophy of the frontal and/or temporal lobes. It occurs less frequently than Alzheimer's disease however it is a common cause of dementia in individuals below the age of 65 years. However, it can also affect people younger or older than this, and it is probably under-recognized in older people. Approximately one third of FTD cases are familial i.e secondary to autosomal dominant mutations with the majority of cases occurring sporadically.⁸

Frontotemporal dementia is a more rapidly progressive disorder compared to other forms of dementia. The mean survival from time of

diagnosis is estimated to range between 3 and 4 years indicating that there is significant delay from symptom onset to diagnosis. Early diagnosis can raise the survival by 3 years.⁹

Misdiagnosis of frontotemporal dementias as personality disorders

About 50% cases of FTD show clinical features that are not included in the current diagnostic criteria and thus mistakenly receive a primary psychiatric diagnosis such as depression, obsessive-compulsive disorder, bipolar disorder or schizophrenia; a number of cases have been described in the literature.^{11 12 13 14}

¹¹ Birkhoff JM, Garberi C, Re L. The behavioural variant of frontotemporal dementia: an analysis of the literature and a case report. *Int J Law Psychiatry* 2016; 47:157-163.

¹² Ibanez N. Atypical presentation of frontotemporal dementia masquerading as bipolar disorder and substance abuse: a case report. *W V Med* 2012; 108(4):16-7.

¹³ Gourzis P, Skokou M, Polychronopoulos P, et al. Frontotemporal dementia, manifested as schizophrenia, with decreased heterochromatin on chromosome 1. *Case Rep Psychiatry* 2012. doi: 10.1155/2012/937518.

¹⁴ Kerstein AH, Schroeder RW, Baade LE, et al. Frontotemporal dementia mimicking bipolar

One case of FTD receiving a misdiagnosis of a personality disorder has been reported in the literature.¹⁵

Hammond et al¹⁵ describe a case of a 59 year old female patient who was given a diagnosis of borderline personality disorder due to impulsive behaviours of a year's duration. Due to progressive memory impairment magnetic resonance imaging (MRI) of the brain was performed. It showed mild frontotemporal involution. A diagnosis of FTD was given.

Personality disorders transforming into dementias

On a different note, case reports have illustrated the difficulties faced by clinicians in recognizing neurodegenerative conditions when the clinical picture is complicated by longstanding/pre-existing psychiatric problems. Research suggests that

disorder. *J Psychiatr Pract* 2013; 19(6):498-500.

¹⁵ Hammond ENB, Malan N, Matenji P, et al. Fronto-temporal dementia: a case report. *J Mol Biol & Mol Imaging* 2016; 3(1): 1023.

the premorbid personality characteristics could have a pathoplastic effect on the behavioural symptoms and personality changes related to the neurodegenerative disease.¹⁶

Several cases of schizophrenia and depression evolving into dementia have been described.^{17 18} However, fewer cases of obsessive compulsive disorder, bipolar disorder and personality disorders developing dementia have been reported.^{19 20} Researchers have discussed the possibility of personality disorders being a risk factor for

¹⁶ Poletti M, Bonucelli U. From narcissistic personality disorder to frontotemporal dementia: a case report. *Behav Neurol* 2010; 23: 1-4.

¹⁷ Velakoulis D, Walterfang M, Mocellin R, et al. Frontotemporal dementia presenting as schizophrenia-like psychosis in young people: clinicopathological series and review of cases. *BJPsych* 2009, 194 (4) 298-305.

¹⁸ Jorm AF. Is depression a risk factor for dementia or cognitive decline? A review. *Gerontology* 2000; vol. 46 (no. 4); p. 219-227.

¹⁹ Khiari HM, Achouri M, Ali NB, et al. Obsessive-compulsive disorder: a new risk factor for Alzheimer disease? *Neurol Sci* 2011; 32(5): 959-962.

²⁰ Pavlovic A, Marley J, Sivakumar V. Development of frontotemporal dementia in a case of bipolar affective disorder: is there a link? *BMJ Case Reports* 2011; doi:10.1136/bcr.09.2010.3303.

neurodegenerative disorders such as dementias.²¹

Poletti and Bonucelli described a case of a 73 year old man with premorbid narcissistic personality disorder and perhaps also a paranoid personality disorder who presented with hypersexuality, verbal aggression, disinhibition and a decline in ability to self-care of a year's duration. MMSE score was with normal however he had a high Frontal Behavioural Inventory (FBI) score of 28/72 (a score of 17 or higher is 100 percent sensitive and 63 percent specific for FTD while a score of 27 or higher is 90 percent sensitive and 100 percent specific). FDG PET scan showed bilateral frontal hypometabolism and a less marked temporal hypometabolism. His diagnosis was consistent with behavioural variant FTD.¹⁶

Iroka et al reported a 56 year old woman with a pre-existing diagnosis of paranoid personality

²¹ Serrani D. Narcissism vulnerability as risk factor for Alzheimer's Disease- a prospective study. *Austin J Clin Neurol* 2015; 2(7): 1-6.

disorder who was admitted to a psychiatric unit with persecutory delusions regarding her neighbours conspiring against her. A CT brain and cognitive examination were unremarkable. She received a diagnosis of delusional disorder and was about to get discharged home on antipsychotics when her daughter expressed concerns over her mother's inability to function independently at home. An MRI brain showed atrophy of the frontal and temporal lobes. This led to a change in diagnosis to that of FTD.²²

Salzbrenner et al described a case of a 46 year old lady with pre-existing borderline personality disorder who presented with a 5 year history of a progressive decline in socially acceptable impulse control. Her MMSE score was 28/30 and FBI score was 21/72. MRI brain showed atrophy of the frontal and temporal

²² Iroka N, Jehangir W, Littlefield J, et al. Paranoid personality masking an atypical case of frontotemporal dementia. *J Clin Med Res* 2015; 7(5):364-366.

lobes. She was given a diagnosis of FTD.²³

Hellwig et al presented a case of a 58 year old lady with a 2 year history of cognitive impairment however she had clinical features of a histrionic personality disorder dating back to early adulthood. Her FDG PET scan showed hypo-metabolism of the temporoparietal region and of the posterior cingulate gyrus. A diagnosis of Alzheimer's disease was given.²⁴

Perhaps the most famous case of a transition from personality disorder to neurodegenerative disease is that of Ludwig II, King of Bavaria. King Ludwig was been the subject of medical speculation during his life and he still is today. He came to power in 1864 at the age of 18 years following which he displayed traits that fulfilled the ICD 10 criteria for schizotypal disorder. Towards the

end of his life, King Ludwig developed "imperial madness", a pattern of behavioural excesses including craving for power, unrestrained spending, excessive eating and an inclination for theatrical and sometimes irrational acts. His life ended at the age of 40 years when he was found dead in a lake; he was believed to have drowned. The autopsy revealed prominent prefrontal brain atrophy. Contemporary researchers suspect that a frontotemporal dementia probably contributed to the "imperial madness".^{3,25}

Personality disorder: a risk factor for dementia?

In view of only modest effects being achieved with pharmacological interventions for Alzheimer's disease, attention has shifted towards prevention or delay of onset of Alzheimer's disease and other dementias. Despite strong associations between personality and

health, few studies have looked at the relationship between premorbid personality and the emergence of dementia²¹.

Evidence from functional neuroimaging studies suggests that symptoms of borderline, narcissistic and antisocial personality disorder (Cluster B personality disorders) are related to dysfunction of frontolimbic circuits. Among subcortical limbic structures, the amygdala mediates the most extensive range of social and emotional processes. Accordingly, patients with borderline personality disorder exhibit exaggerated amygdala responses to social and emotional stimuli. Among frontal cortical areas in borderline personality disorder, the anterior cingulate cortex has impaired serotonin synthesis capacity. Anterior cingulate cortex dysfunction, in turn, may be related to both emotion dysfunction and impaired cognitive control observed in

²³ Salzbrenner S, Brown J, Hart G, et al. Frontotemporal dementia complicated by comorbid borderline personality disorder: a case report. *Psychiatry* 2009; 6(4):28-31.

²⁴ Hellwig S, Dykieriek P, Hellwig B, et al. Alzheimer's disease camouflaged by histrionic personality. *Neurocase* 2012; 18(1):75-79.

²⁵ Hacker R, Seitz M, Forstl H. Ludwig II of Bavaria: schizotypal personality disorder and frontotemporal dementia? *Acta Neurologica Belgica* 1996; 96(2):130-134.

borderline personality disorder.^{16 23 26}

Could a person presenting with frontolimbic dysfunction during adulthood develop a neurodegenerative disorder, in turn characterized by frontolimbic dysfunction? Or are the psychopathological features compatible with the diagnosis of a personality disorder the first clinical features of a slow progressive behavioural variant FTD with an insidious onset?^{16 23}

Evidence also suggests that people with Cluster B personality disorders are at risk of developing other dementias and not only FTD. A prospective study undertaken by Serrani et al on patients with narcissistic personality disorder over a 36 month period showed an association between elders with pathological narcissism and Alzheimer's disease.²¹

Other personality disorder clusters also appear to be a risk factor

²⁶ Minzenberg MJ, Fan J, New AS, et al. Frontolimbic structural changes in borderline personality disorder. *J Psychiatr Res* 2009; 42(9): 727-733.

for dementia. A case control study undertaken by Nicholas et al²⁷ suggested that the development of Alzheimer's disease was particularly associated with paranoid, schizoid and schizotypal personality traits (Cluster A personality disorders) in adulthood. Studies also suggest that dependent personality disorder (a Cluster C personality disorder) is a risk factor for dementia; people with this personality disorder are likely to be neurotic and thus prone to psychological distress. Studies have linked psychological distress to cognitive impairment and dementia. The suggested mechanism involves a blunted hypothalamic-pituitary-adrenal axis and thus lower serotonergic pathway activity which is implicated in dementia development.²⁸

²⁷ Nicholas H, Moran P, Foy C, et al. Are abnormal premorbid personality traits associated with Alzheimer's disease? A case-control study. *Int J Ger Psychiatry* 2010; 25: 345-351.

²⁸ Pillerson S, Clement J-P, Ndamba-Bandzouzi B, et al. Is dependent personality disorder associated with mild cognitive impairment and dementia in Central Africa? A result from the EPIDEMCA programme. *Int Psychogeriatr* 2015; 27(2): 279-288.

Conclusion

Miss X's case illustrates the difficulties faced by clinicians in recognizing FTD when the clinical picture is complicated by comorbid psychiatric disorders; behavioural variant FTD takes its greatest toll on personality and behaviour. The authors of the above-mentioned case reports stated that FTD could have been diagnosed in a timely manner were it not for their patients already having a pre-existing diagnosis of a personality disorder or co-existing features of a personality disorder.

Table 1 provides some basic differences between borderline personality disorder and FTD.²⁹

Studies suggest that neurobiological vulnerabilities linked to a personality disorder such as frontolimbic dysfunction could represent a risk factor for

²⁹ Ducharme S, Price BH, Larvie M, et al. Clinical approach to the differential diagnosis between behavioural variant frontotemporal dementia and primary psychiatric disorders. *Am J Psychiatry* 2015; 172(9): 827-837.

dementia. The literature also suggests that bona fide primary disorders could represent the initial or prodromal stage of behavioural variant FTD. Alzheimer's disease is now recognized as having a long preclinical prodrome of neuropathological changes beginning anything up to 25 years before the clinical presentation.^{16 27}

Some studies used personality inventories to retrospectively study personalities however they have not been developed for retrospective use and thus constitute methodological bias. The studies are also at risk of having examined prodromal rather than premorbid features. The dearth of epidemiological studies on the incidence of neurodegenerative diseases in patients with personality disorders suggests to explore this possible relationship in future studies. Such studies should be longitudinal in order to assess whether people with personality disorders are at risk of developing neurodegenerative disorders such as dementias.^{2 21}

The limited research looking at the link between personality disorders and dementia stresses the importance of the conceptualization of the multifactorial aetiology of dementia. Until there is a stronger evidence base supporting personality disorder as a risk for dementia or representing the prodromal phase of a dementia, clinicians should bear in mind the possibility of FTD being misdiagnosed due to its early onset and pathological heterogeneity.

Knowledge about FTD has grown over the past 10 years and it is crucial for psychiatrists to include FTD as part of their differential diagnosis in a wide range of psychiatric disorders. The delay in diagnosis of FTD from the onset of symptoms is on average 3 years with death usually occurring within 6 years of development of symptoms. Diagnosing the less common variants of dementia can be difficult and may mislead clinicians to undertake extensive investigational workup resulting in a delay of treatment and

greater economic burden.^{21 22 30}

Not only does the connection between personality disorder and dementia need to be studied but there needs to be a better understanding of personality disorders in later life due to limited research on the subject. Studies already indicate that the frequency of Cluster A and C personality disorders increases as people get older whereas that of Cluster B personality disorder decreases in later life. More knowledge of functional psychiatric disorders will aid clinicians in differentiating them from organic illnesses with grave consequences such as FTD.^{1 2 31}

³⁰ Mocellin R, Scholes A, Walterfang M, et al. Clinical update on frontotemporal dementia: diagnosis and treatment. *Australas Psychiatry* 2015; 23(5): 481-487.

³¹ Beatson J, Broadbear JH, Sivakumaran H, et al. Missed diagnosis: the emerging crisis of borderline personality disorder in older people. *Aust N Z J Psychiatry* 2016; 50 (12):1139-1145.

Table 1 Frontotemporal dementia vs borderline personality disorder

Frontotemporal dementia vs borderline personality disorder		
EPIDEMIOLOGY	FRONTOTEMPORAL DEMENTIA	BORDERLINE PERSONALITY DISORDER
Age (years)	35-75, rarely after 75	18-40, rarely after 40
Male: female ratio	1:1	1:3
Behavioural symptoms	Impulsivity, jocularity, executive dysfunction, hyperorality, inappropriate sexuality, apathy, hygiene neglect, apraxia	Impulsivity, recurrent suicide gestures, self- mutilation, affective instability, hypersensitivity to abandonment, anger dyscontrol
Environmental influence	Significant dysfunction independent of interpersonal stressors	Symptoms largely dependent on interpersonal stressors
Cognitive impairment	Executive dysfunction with relative sparing of memory and visuospatial functions	Generally within normal limits
Language deficits	Agrammatism, speech apraxia	None
Physical examination	Frontal release signs in advanced stages	No abnormalities

Faculty name

Choosing a new faculty name: Historical overview

by

Dr Claire Hilton

Introduction

What to call our Faculty, and its predecessors, the Special Interest Group and Section, have been topics of discussion ever since the Group's first meeting on 9 February 1973. The minutes record: 'Suggestions for the official title of the Group were requested, and after some discussion it was agreed that "Group for the psychiatry of old age" was the most appropriate.' Despite this decision, discussions continued and our official name was never unanimously agreed. For example, to some colleagues, 'psychogeriatrics' was a dignified title. It means: physician for the minds (or souls) of older people. For other colleagues, psychogeriatrics was 'not a very happy' name, or it was 'ugly' or ambiguous. Perhaps one reason for its ambiguity was that the term had no clear

origin or definition, but, rather like 'community care', it evolved into common usage.

Professor Brice Pitt offered a definition of our specialty in 1976: 'that branch of psychiatry which is concerned with the whole range of psychological disorders developing in the senium'. He also stated the practical realities: 'It ... belongs to the family of psychiatry, is married to geriatrics and conducts an often-stormy affair with social services.' We are not talking about a simple matter when it comes to choosing a meaningful name or title.

Our organisational and professional names.

In order to think about the Faculty's name, we need to consider the names of each dimension of our organisational and professional identity: the Faculty; the specialty; the team in which we

work; and our individual job title. Each has a different role to play, and each may need a different name.

The Faculty name needs to encompass what we do, who we are, what we stand for, and our aspirations for the future of our specialty. The name of the specialty is slightly different, signifying what we do in the present. Historically, it has been less consistent than the Faculty name. In 1985, Professor Tom Arie wrote in the introduction to *Recent Advances in Psychogeriatrics*: We have not been able so far... to decide whether our subject is 'psychogeriatrics', 'geriatric psychiatry', 'geropsychiatry', 'geronto-psychiatry',

'old age psychiatry' or 'the psychiatry of old age'; here, as in other usages (such as 'arteriosclerotic', 'vascular', or 'multi-infarct' dementia) writers have been left to use the term with which they are evidently most comfortable. Subsequent editions ... should reveal where consensus emerges and where diversity endures.

Clearly, we are still to reach a consensus. 'Psychogeriatrics' was the official title of the specialty in government documents in 1989, changing to 'old age psychiatry' the following year. Our colleague Dave Jolley told me: 'one of the considerations in choosing "old age psychiatry" was the wry reflection in the initials OAP - to ally ourselves with older people, old age pensioners.' The name of the team in which we work needs to incorporate the local context. A local name needs to take into account the breadth of mental health work undertaken by a comprehensive multi-disciplinary team. Some patients may only require

nursing or psychology expertise, not 'psychiatry'. Thus, our team's name may differ from the name of our Faculty or specialty. Fourthly, there is our individual job title. Some of us may call ourselves 'old age psychiatrists' or something similar, particularly if our team has become incorporated under a generic or all-age team label, but we may also just call ourselves 'psychiatrists' if our team name clearly signifies an older people's service.

Arguments for and against a name change.

An old name can continue in use for decades, even after it is officially abandoned. Sometimes we still receive referrals from a GP or a general hospital team to 'Dear psychogeriatrician', or requesting a 'psycho-geri' opinion. Continued use of the term 'psychogeriatric', hardly used today by those who practice within the specialty, helps to illustrate that new names may take many years to be adopted universally. There are additional considerations about

changing organisational and professional names, particularly when they are associated with stigma. The new name may be an attempt to dispel the stigma. However, negative connotations usually linger despite the name change, and a new name may rapidly acquire an old stigma. The discarded, previously officially sanctioned name frequently remains in circulation and may be used colloquially in a derogatory way. Examples include 'senile', 'idiot' and 'lunatic asylum'. There are pros and cons of keeping 'old age psychiatry' or adopting alternatives, such as psychiatry for older people, later life psychiatry, older adult psychiatry, or psychiatry of ageing. However, if the previous Faculty name is anything to go by, a decision to change it may have very long-term consequences: it has been known as the Group / Section / Faculty of Old Age Psychiatry for 45 years.

It might be worth holding on to an old name which has a good legacy, despite the stigma. With time, even our personal names may begin to sound old fashioned. First names are sometimes in fashion, sometimes out.

Today's babies are unlikely to be called Gertrude, Ada, Norman or Derek, but other names of the same era, like Sadie, Violet, Jack and Reuben are back in fashion. Fashion suggests popularity and trendsetting, but fashions are also fleeting and often insubstantial.

Might fashion be linked to an urge to change the name? Just because something is old, it is not obsolete. It may be meaningful, vintage and valuable, even more so now than when it was new.

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4. e.g. psychogeriatrics was not used in the same way as psycho-geriatrics.
5. Tom Arie, Anthony Isaacs. 'The development of psychiatric services for the elderly in Britain' 241-261. In: *Studies in Geriatric Psychiatry* ed. AD Isaacs and F Post (Chichester, 1978)
6. Tony Whitehead. 'Book review: Psychogeriatrics: An Introduction to the Psychiatry of Old Age, Brice Pitt' *Age and Ageing* (1976) 5: 63
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9. Manpower Committee, minutes, 14 Feb 1990 (RCPsych Archives)
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Faculty name

What's in a name: A debate to decide on what we call ourselves

by

Helen McCormack

At the Faculty Conference this year a debate was held about the name of our Faculty and whether it needed to be changed. The debate was well attended and the speakers had three minutes each to propose their name for the Faculty.

Prof George Tadros was Chair and reiterated that the debate about the change of name for the Faculty was not new. He outlined the reasons why we would not change our name, stressing that our colleagues had fought for it in the past, that we are known by that name, both here and abroad and that our accreditation by GMC is as an Old Age Psychiatry CCT.

Dr Amanda Thompsell recounted the history of development of our specialty. In 1973 Psychiatry of old Age was developed as a discipline and in 1989 the discipline was recognised for higher training. The initials OAP

were to ally ourselves with old Age pensioners. Interestingly in 1973, life expectancy was 69. Interestingly too, the Acute Frailty Network conference this year would not accept posters with the word 'elderly' in them. The historic overview is well presented in Dr Claire Hilton's update (see link)

Dr Rory O'Shea suggested the name Psychiatry for Older People. He argued this was the time to change our name, as many patients do not like the terms 'old' or 'old age'. Colleagues think the name is outdated and backward looking, resistant to change. Other bodies do not think the name fits any more. Psychiatry for older people is simple, easy to say, easy to write, describes what we do and does not have a terrible acronym.

Dr Anitha Howard put forward the name Later Life Psychiatry. She

stressed that along with her Mother-in-law she hates the words 'old', 'older' - some of our patients still work, look after children and run marathons. She suggested getting rid of the word old, and choosing something different, which is not threatening and does not give offence i.e. Later life Psychiatry.

Dr Sudip Sikdar argued for the name Older Adults Psychiatry. He stressed that the word 'people' is impersonal and later life starts at age 55 in USA. The term 'Older' gives a sense of maturity, accumulated life experience, resilience, accomplishment of overcoming obstacles in life and a sense of dignity without the prejudice of being old. The term 'Adults' displays the recognition that we treat all older people as adults, thus respecting their autonomy and balance their rights with our duty

of care towards them. It sounds much more personable than people. It also keeps our faculty as OAP.

Dr Alex Bailey suggested the name Psychiatry of Ageing. He stated that getting older is a dynamic and active process and the word 'ageing' neatly captures this. 'Older' implies passive recipients of services. He pointed out that the definition of old in dictionaries is uncomplimentary. Ageing on the other hand defines services more accurately and is a continuum. It focuses on how age interacts with health, so that we can age well.

Following the speeches of the proposers, comments from the floor were debated. There was a lively debate, with passionate views expressed. These included comments that we need to reclaim the word old and be proud of it, that we must not get sidetracked into changing name in the face of other more pressing issues, and that changing the name it was decided may have unintended consequences for us as

well as colleagues in other countries.

At the end of the debate the Conference delegates voted and the overwhelming conclusion was to proudly remain with the name we have, Old Age Psychiatry, voted for by 90% of respondents.

Features

What have STPs and ACOs got to do with me: Developing an understanding of the new NHS landscape in England

by

Dr Kapila Sachdev, Consultant Old Age Psychiatrist, East London NHS Foundation Trust

You might well ask what do those abbreviations mean or what has yet another reorganisation of NHS England got to do with me. I am busy managing an ever-increasing demand on my clinical time and I do not have time to get involved in this.

In this article I want to outline why engaging with those people who are leading the current changes is critical. This is commissioning with contracts which could last ten to fifteen years. The need for the change has come through as the NHS in its current form of episodic care in hospital is no longer sustainable due to our ageing population. In order to meet the increasing demands on the NHS and social care and manage the financial constraints; NHS in England has taken an integration approach.

What is integrated care? Integrated care happens when NHS organisations work together to meet the needs of their local

population. Some forms of integrated care involve local authorities and third sector in working towards these objectives alongside NHS organisations. The most ambitious forms of integrated care aim to improve population health by tackling the cause of illness and wider determinants of health.

Understanding the various terminologies and forms of integrated care:

Integrated care partnerships:

These are also called as **sustainability and transformation plans**. Integrated care partnerships are alliances of NHS organisations that work together by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services, GPs and Social care; independent and third sector providers may be involved as well. The two models that

have been used to provide care and provide services – **PACS (Primary and acute care systems)** is when the hospitals often take the lead in working in an integrated way with GPs, community services, mental health services and social care services. An example of PACS system is Salford, which is the part of Greater Manchester devolution programme. The health and social care services re working in partnership to provide services to a population of 230,000. **MCPs (Multispecialty community providers)** the emphasis is on the GPs to make links with community services, mental health and social care. Encompass in Kent is an example of this in which 13 GP practices are collaborating to provide services to a population of 170,000. **Integrated care systems have evolved from integrated care partnerships** (also called as STPs).

ICS were previously called as ACS (accountable care systems). ICS take lead in planning and commissioning care for their populations and providing system leaderships. **They bring together NHS providers, commissioners and local authorities to work in partnership in improving health and care in the area.** They have no statutory basis and are reliant on the organisation to break the barriers and work together.

Integrated care systems when developed will be expected to:

- Agree a performance contract with NHS England and NHS Improvement in order to improve care and identify performance goals shared between the partners
- Manage funding for the defined population
- Create collective decision making and develop governance structures
- Have clear mechanism for exercising patient choice.

NHS England has agreed the move towards

integrated care systems is complex and should occur in a staged manner.

Accountable care organisations (ACOs):

Accountable care organisations are established when commissioners award a long term contract to a single organisation to provide a range of health and care services to a defined population following a competitive procurement process. The organisation can then sub-contract to other organisations to provide various aspects of care.

Why is it important to be involved in the changes as a consultant old age psychiatrist?

As you can see the landscape is changing and these contracts would be for many years. NHSE is sending a clear message; system working is here to stay. It is essential that our voice is heard. The unique knowledge and expertise that the old age psychiatrists would bring would benefit the system.

As an old age psychiatrist, you have

knowledge of the needs of the local population and the older adult mental health service needs have to be considered from the outset. Your knowledge of the key stakeholders and key individuals is important as they would play a vital role in the delivery of the integrated care services.

As an old age psychiatrist your expertise in working with multiple co-morbidities and managing patients with chronic illnesses in the community would play a significant role in developing integrated care systems required to manage complex co-morbidities in the community.

Old age psychiatrists also have particularly honed skills in person-centred care, multi-disciplinary working, risk management, developing ethos of positive risk taking in MDTs and understanding interpersonal reactions which are needed in order for the integrated care systems to develop and work in an effective way.

How do I get involved?

In order to get involved in the integrated care it is important to use your knowledge and have a good understanding of

the local stakeholders and key individuals. There are probably people in your trust who may already be involved in this, identify and make contact with these people and get involved. Waiting

for others to decide on how to deliver services to the population we care for; in the future should not be an option.

Suggestions for further reading:

- <https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems>
- <https://www.england.nhs.uk/accountable-care-systems/>
- <https://www.kingsfund.org.uk/blog/2018/02/what-does-future-hold-integrated-care-systems>.

Features

Competition and Markets Authority: Care homes market study – the future of care homes in the UK

by

Dr Martin Curtice, Consultant in Old Age Psychiatry, Worcestershire Health and Care NHST Trust, New Haven; Princess of Wales Community Hospital, Birmingham.

In November 2017 the Competition and Markets Authority (CMA) produced a report of its market study into residential and nursing care homes for older people in the UK. It analysed how well the care homes market was working for both self-funders and those whose care is state funded. The report explained this market must be able to support the states intention to ensure that care needs are met for all those who need it and opined the industry needed to be sustainable ensuring efficient care homes providers continue to operate and importantly the market is positioned to invest to meeting growing future needs and growth.

The report found two problem areas:

1. Those needing care required greater support in choosing an appropriate care home and greater

protections when they are residents.

2. The current model of service provision cannot be sustained without additional public funding – worryingly the parts of the industry that supply primarily local authority funded residents are unlikely to be sustainable at the current rates of local authorities pay.

The care home sector

The care home sector is worth about £15.9 billion a year in the UK and has around 410,000 residents. There are around 5,500 different providers in the UK operating 11,300 care homes for older people. Around 95% of the beds are provided by the independent sector. The report estimated the average cost for a self-funder in 2016 was £846 per week (or £44,000 per year) whilst local authorities (LAs) pay on

average £621 per week. LAs have a legal duty to meet people's 'eligible needs' subject to their financial circumstances. People with assets over £23,250 in England and Northern Ireland, £26,500 in Scotland and £30,000 in Wales pay the full cost of their care needs. For those receiving LA-funding (49% with about a quarter paying 'top-ups') nearly all income e.g. pensions, is offset against state contributions. 41% of residents are self-funding and about 10% have care commissioned by the NHS. The report predicts as the population ages the demand for the care home sector will increase – the Office for National Statistics predicts a 36% growth in people aged 85 and over between 2015 and 2025 from 1.5 million to 2 million.

Support and protections for those requiring care

The report noted there were many inherent barriers to people making well-informed choices about entering care homes and being empowered to make choices or voice complaints when there. It observed there was often very little prior consideration of care needs or options by prospective residents or their families. Hence such decisions are often faced for the first time after sudden illness, injury or loss of a main carer and can be made urgently under stressful circumstances. It is at this point people discover, and can be overwhelmed by, the complexity of seeking care home placements. The report noted that once in care it was very difficult for residents to correct a poor choice.

The report described where residents faced barriers, both to moving into care homes and to complaining and obtaining redress, the consequence was they were vulnerable to 'unfair' practices. Hence, consumer protections

they need must reflect this. Recommendations by the report to improve consumer choice and protection were:

1. Helping people to make good decisions about their care options.
2. Protecting residents and their consumer rights, and,
3. Making the complaints system work well for care home residents and families e.g. embed an assessment of complaints systems as part of inspections; governments should improve advocacy services for residents.

The report recommends governments introduce stronger rules for the sector such that compliance with consumer law becomes embedded within existing regulatory regimes for care homes and monitored by sector regulators/inspectors and recommends more specific rules e.g. requiring care homes to display indicative fees and their terms and conditions on websites.

Supported decision-making and helping people consider their care needs earlier

The report calls on governments to work with the NHS, LAs, care home providers and the third sector to deliver a 'sustained and coordinated programme of actions' to help people make good decisions about their care needs which should focus on:

1. Providing people with good quality and timely support when making life-changing decisions about care.
2. Helping people quickly identify local care options that are available to them e.g. increase the use of supported decision-making.
3. Encouraging and helping people to prepare and plan for future care needs e.g. governments should develop programmes to promote awareness of, and support for, people planning for their later life needs.

State-funded care now and in the future

As part of this report the CMA undertook an extensive profitability analysis of the sector. It noted the existing pressure on public expenditure on adult social care of all types and that aggregate expenditure has declined in real terms by 8% between 2009/10 and 2015/16 in England. The sector has reported facing significant challenges to its sustainability, primarily due to low fees being paid for state-funded residents, but exacerbated by increased cost pressures due mainly to wage costs. The 2016 CQC annual report described the sustainability of adult social care as approaching a tipping point.

The report noted the large majority of care homes offered both self-funded and LA-funded places but that many homes rely on higher prices charged to self-funders to remain viable even when providing the same services – without this the public funding shortfall that currently

exists would have a substantially larger impact than it currently has. The report concluded that if LAs were to pay the full cost of care for all residents they fund, the additional cost to them of these higher fees would be approximately £1 billion a year across the UK.

The report concluded fees currently being paid by LAs were not sufficient to sustain the current levels of care under the current funding model. The consequence of this is that public funding needs to increase if the current model of funding is to continue, or alternatively, if current levels of funding do not increase, the funding model for care will need to be changed.

Meeting future care needs

The report concluded that an extra £1-2 billion a year will be needed by 2025 for LAs to meet the needs for care home places. Their assessment was the sector was not able to attract investment needed to meet the future increase in demand to serve LA-funded residents – for additional capacity to be

in place to meet future demand, LAs need to be taking appropriate proactive action to encourage investment which requires:

1. LAs need to carry out accurate and informed planning about future care provision.
2. LAs need to make commissioning steps on the basis of such plans but in good time.
3. LAs must be able to attract investment to build the required capacity.

LAs in England and Wales already have a 'market shaping' duty but the CMA's assessment is that this current duty is not proving sufficient to meet this vital task. This reflects the current pressures on LAs and their lack of long-term certainty on future funding patterns and subsequently such uncertainty affects potential investment especially in additional capacity focused on LA-funded residents.

Recommendations

The report makes recommendations throughout to governments to develop policies and practices to deliver adult social care for older people and proposes three key elements to remedy problems within the sector:

1. Enhanced planning at local level – LAs can make accurate and meaningful forecasts of future needs, and plan how best to meet them.
2. Oversight of LAs' commissioning practices to ensure LAs are supported in devising and implementing their plans; and
3. Greater assurance at national level about future funding levels, by establishing evidence based funding principles, in order to provide confidence to investors.

The expectation is that these measures will be sufficient to ensure capacity is there in the future for the increased numbers of people who will need it. Furthermore, if the recommendations were implemented they would increase the fees paid by LAs to care homes to a more sustainable level.

The report concluded the CMA was looking forward to working with

governments, sector regulators, LAs and the care home industry to progress their proposals. In particular it hopes its in-depth analysis on the issues of future care home provision shapes a green paper on care and support for older people due to be published by the government in 2018. The report does however warn that should the recommendations made not be accepted or implemented there may need to be a 'fundamental reform of the operation and funding of the adult social care system'.

Reference

[Competition & Markets Authority \(2017\) Care homes market study – Final report.](#)

Features

Council tax discount for severe mental impairment: A need for clarification?

by

Dr David Tullett, Consultant in Old Age Psychiatry, Essex Partnership University NHS Foundation Trust

Introduction

Many doctors in old age psychiatry will be familiar with the forms sent out from local authorities to authorise someone as having 'severe mental impairment' in order that they can claim a reduction in council tax. Recently this topic has been in the news with a study by the popular website moneysupermarket.com indicating many eligible people throughout the country are not claiming what they are entitled to.

In addition their investigation suggested a wide variation between the number of claimants in different councils with similar population, for example there were only 10 claimants in Spellthorn Borough Council in Surrey compared with 423 in Ashford Kent.

The issue has reached the national press with The Daily Express declaring:

'Diagnosed with dementia signs and symptoms? You could be exempt from paying council tax.

It is likely that this publicity will lead to more claims, however the decision to decide whether a patient has severe mental impairment or not is not a simple one and from a discussion amongst my colleagues it is clear that different doctors apply very different criteria in making this decision.

Some authorise all patients diagnosed with dementia others using stricter criteria based on the level of disability or even income. In view of this I feel further discussion of how these applications should be considered is warranted.

Background

To understand this issue it is important to be aware of the historical context. Prior to 1988 local government was largely funded by the

residential rates, a tax on the notional rental value of a property, there were few discounts and none for mental impairment.

In 1988 this was replaced by the radically different system, the community charge, a fixed tax levied on all residents unrelated to property value, this legislation introduced discounts for some people including those with severe mental impairment. The community charge was unpopular as it was seen by many as unfair and its introduction was largely responsible for the downfall of Margaret Thatcher.

It was itself replaced in 1992 by the council tax which is still in place today and is based like the rates largely on property value; the discount for severe mental impairment was continued however.

Claiming the Discount

In order to claim a discount as well as having authorisation of severe mental impairment from a registered medical practitioner (usually a GP or Psychiatrist) the claimant must also be receipt of one of a number of benefits one of which is attendance allowance which is widely claimed by people with dementia. The discount available is 25% for someone living with another person and 100% for someone living alone.

Definition of severe mental impairment

The Local Government Finance Act 1992¹ states that the definition of severe mental impairment for the council tax is the same as originally introduced for the community charge:

'For the purposes of the act a person is severely mentally impaired if he has severe impairment of intelligence and social functioning (however caused) which appears to be permanent' The act clarifies this to some extent by stating 'In

making a judgement on whether someone is severely mentally impaired it may be helpful for doctors to know the reason for discount from the Council tax. The aim of the council tax is to give tax payers a direct stake in the spending decisions of local authorities. Clearly this kind of accountability is much less successful in the case of someone who is severely mentally impaired to the extent that he or she does not have an understanding of local issues.

Ever since the introduction of the community charge there has been confusion about the meaning of 'severe mental impairment' and the fact that the definition used differs from that in the 1983 Mental Health Act has only added to the uncertainty. The clarification issued within the act emphasising the importance of assessing the ability to understand local issues seems to have largely been forgotten. In some of the articles recently published in the press the impression is given that the discount should be available to anyone diagnosed with dementia and I have often come

across this belief among relatives of my own patients.

Interestingly, soon after the discounts were introduced there was at least one attempt to formalise the definition by a GP in 1991 that developed a simple rating scale to help decide whether a patient is eligible or not². This suggested using three questions to assess a person's understanding of local government;

1. For what is a local authority responsible?
2. Does it matter who controls your local authority?
3. How can those in charge of a local authority be removed from office?

Conclusions

Despite the considerable cost to the tax payer of the council tax discount for severe mental impairment and the huge variation in uptake across the country this issue has until now warranted little attention since the introduction of the discount nearly 30 years ago. From my own discussions with colleagues I feel that it is an issue where there is

¹ Local Government Finance Act 1992, Liability, Discounts and Exemptions. Schedule 1;2

² Hurwitz B, Asserson T, Tax exemption for severe mental impairment. *Lancet* 1991;337:1147-8

uncertainty and more clarification from local government would be welcome.

In the meantime doctors asked to complete the forms might consider whether it is appropriate to assess a patient's knowledge of local government as part of their decision making process. Perhaps the question also needs to be asked as to whether the rationale for the discount still applies in exactly the same way as when it was introduced or whether a more understandable and fairer system could be devised.

david.tullet@eput.nhs.uk.

The changing world of the Mental Health Act and Mental Capacity Act

Faculty update

Over the last six months, the world of the Mental Health Act (MHA) and Mental Capacity Act (MCA)/DOLS has seen several consultations and proposed reviews. On behalf of the faculty, Drs Amanda Thompsell, Gianetta Rands, Hugh Series and Sharmi Bhattacharyya have been involved in developing responses to the consultations and reviews.

Review of Mental Health Act 1983

In October 2017, the Prime Minister commissioned a review of the MHA, seeking to address concerns about how the legislation is currently being used and how practice can improve, particularly in relation to rising rates of detention and disproportionately high detention rates in BME groups. The review would seek the views of service users, carers, relevant professionals, and

affected organisations in producing recommendations and will produce a report with recommendations for change in autumn 2018. Our faculty has been involved in the College submission and has focussed specifically on various aspects from an older persons perspective. We have commented on the areas of Community Treatment Orders (CTOs), Nearest Relative, Advance Care Planning, Advocacy, Tribunals, and Statutory Second Opinions. We have highlighted that from an older person's perspective the law should support modern principles and practice of care and treatment for mental health patients and specifically older adults. The faculty has highlighted that, wherever appropriate, the principles governing mental healthcare should be the same as those which govern physical health in older adults

(one important criticism of the MHA is that, if you have capacity to decide on treatment, you can refuse treatment for physical disorder, even if you die as a result, but you cannot refuse treatment for mental disorder if you are detained). Older adults must always get the care appropriate to their needs with informal treatment, and this should be preferred over compulsion.

Consultation on Liberty Protection Safeguards (LPS)

The Faculty has also been involved in responding to the Law Commission's consultation on Liberty Protection Safeguards (LPS). We have taken the view that although LPS appears to have some benefits, on balance, we do not consider there is a correct balance between protection of human rights and reducing bureaucracy and

therefore we do not feel that the LPS should be implemented urgently as currently proposed. Whilst the LPS proposals have some merits, they may not significantly reduce bureaucracy and they are likely to lead to a substantial increase in use both in the numbers subject to procedures under the Mental Capacity Act 2005 (MCA) (to include those being restricted but not deprived of their liberty) and those subject to the Mental Health Act 1883 (MHA) procedure.

The [government has recently released its response to the law commission draft amendment bill](#).

As old age psychiatrists we see a considerable number of people who can be treated under the MCA but there is also a number of people who need to be detained under MHA for treatment and to protect and safeguard their rights. The issue of 'fusion' legislation, merging MHA and MCA in a single new Act of Parliament, remains a live and contentious question. Several case scenarios have been highlighted to

stress the ongoing difficulties we face with older patients who fall in the MHA/MCA interface and we continue to seek clarification on this. We would be grateful if faculty members would continue to send us scenarios especially where patients and carers have found it hard to navigate the maze of MHA/MCA.

We have also suggested options such as removing 'objection' as a criterion for detention under MHA in hospital (because P is ineligible for DOLS in hospital, though not in care homes, if he or she objects to any part of his or her treatment). This proposal does not replace the proposals for LPS, and it does not address the bureaucratic problems with the current DOLS system. It however reinforces the existing purpose of the MHA in providing authority to treat mental disorder in hospital, but limits the extension of the use of MHA to those who happen to be in hospital but no longer require hospital level treatment.

Section 49 reports

Under section 49 of MCA, the Court of Protection can order reports from NHS health bodies and local authorities when it is considering any question relating to someone who may lack capacity, and the report must deal with 'such matters as the court may direct.' An order under section 49 of the MCA places an obligation on the NHS trust to comply, although it is for the trust to determine the appropriate person to complete the report. There is no right to charge a fee for preparing a section 49 report.

The Faculty is aware that there has been an increase in request for section 49 reports, often from trusts which have had no previous dealings with a particular patient. Our faculty understands that this is not specific to old age psychiatrists but has implications for other faculties too.

These reports take a significant amount of time to complete, especially the patient is unknown, and therefore have clear implications for workloads, job planning, time and cost

pressures on old age psychiatrists. Data are not available, but anecdotally we have heard of many cases in which section 49 reports were late in preparation and inadequate for court purposes, resulting in a request for an independent expert report for section 21A appeal.

In [RS v LCC & Ors \[2015\] EWCOP 56](#) District Judge Bellamy noted that the difficult questions arising from the provision of s.49 reports and their consequences for public bodies may ultimately have to be considered elsewhere.

Judge Bellamy said:

“What the court will do is to carefully consider resources and listen to any argument from the Trust particularly in relation to the time for compliance and the scope of the work to be undertaken. That would appear to be both a reasonable and proportionate approach.”

As a faculty we continue to raise concerns. The topic was also discussed at the Royal College of Psychiatrists' Council

meeting and our understanding from members and other Faculties is that it is a wide spread issue although there is variability, with some areas having more requests than others.

We would encourage members to keep records of the numbers and time taken to complete them should we need it in future. A suggestion at the Annual Business Meeting of the Faculty (March, 2018) was to raise it with BMA as it has serious implications for workload and job planning. This will be taken forward.

Conclusion

This is a busy time for the Faculty in the rapidly changing world of MHA/MCA and as a faculty we must make sure we are consulted and continue to contribute to the consultations.

Evidence

Why the quality network for older adult mental health services could hugely benefit your service: A higher trainee's perspective

by

Dr 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, London.

Dr Rob Chaplin, Consultant General Adult Psychiatrist, Research Fellow at the Centre for Quality Improvement, Royal College of Psychiatrists, London.

Sarah Paget, Programme Manager, Centre for Quality Improvement, Royal College of Psychiatrists, London.

Eleanor Parker, Deputy Programme Manager, Centre for Quality Improvement, Royal College of Psychiatrists, London.

Dr Jennifer Ford, Clinical Director and Consultant Old Age Psychiatrist, Essex Partnership University NHS Foundation Trust.

Over 15% of adults aged over 60 suffer from a mental disorder according to the *World Health Organisation*.¹ This percentage is likely to rise as the proportion of older adults in the UK population increases with an anticipated increase in the complexity of their mental health problems. Hence, demand for high quality old-age mental health services, which are fit for purpose and dynamic in their approach to service users, is necessary.

Quality Improvement is all about making healthcare safer, more effective, patient-centred, timely, efficient and equitable.^{2,3} In the recent past, against the backdrop of the Francis public enquiry into the serious failings at Mid-Staffordshire NHS Foundation Trust, Quality Improvement has also become a key area of national interest.^{2,3} In a

² Healthorguk. [Online]. Available from: <http://www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf> [Accessed 26 February 2018].

³ Healthwatchhillingdonorguk. [Online]. Available from: http://www.healthwatchhillingdon.org.uk/wp-content/uploads/downloads/2013/10/Francis_Report_Summary_of_recommendations.pdf [Accessed 26 February 2018].

¹ Whoint. World Health Organization. [Online]. Available from: <http://www.who.int/mediacentre/factsheets/fs381/en/> [Accessed 26 February 2018].

recent speech delivered to Essex Partnership University NHS Foundation Trust, the Secretary of State for Health emphasised his desire for the NHS to become the World's Leading Learning Healthcare Organisation. In order to foster an environment which encourages organisational learning, services must feel well supported. The Royal College of Psychiatrists' Centre for Quality Improvement is committed to working with healthcare organisations, including National Health Service Trusts from all over the UK, to help promote

Quality Improvement at local levels. The Centre has set up several Quality Networks and Accreditation Services in order to help achieve this ambition.

I am writing this article in my capacity as a Clinical Fellow at the Centre for Quality Improvement at the Royal College of Psychiatrists. This role has afforded me the opportunity to closely observe how quality networks function; fuelling my passion and enthusiasm for quality improvement.

One of the Quality Networks that has been set-up by the College is the Quality Network for Old-Age Mental Health Services (QNOAMHS). Participating in this network has several major benefits for healthcare organisations and individual inpatient units. The Quality Network offers old-age mental health inpatient wards the opportunity to have Developmental Peer Review Visits, which focus on quality improvement and learning within a warm, safe, friendly and non-judgmental environment. The peer review team consists of a mix of

different mental health professionals, which include the following: psychiatrists, service managers, service users, carers, psychologists, College Centre staff, mental health nurses etc. Peer Review Visits help to break down barriers that exist between services and help to forge links between different inpatient old-age wards and the professionals working within them. The Peer Review Visit also fosters a unique opportunity for like-minded, dedicated, enthusiastic and passionate healthcare professionals to come together and freely exchange new ideas and innovative ways of working with one another.

In advance of the peer review visit, the service under review completes a self-assessment against nationally-agreed, evidence-based standards, endorsed by the Royal College of Psychiatrists' Centre for Quality Improvement. These standards offer a benchmark, against which, NHS Trusts can assess the quality of their local service. During the Peer Review Visit, the local inpatient team can also use the standards to

direct and guide discussions specific to their individual service needs. There are also opportunities for open discussion, where topics outside the scope of the standards can be discussed in depth and innovative solutions for local problems can be sought through collaborative brainstorming sessions. All this allows the service being evaluated to receive in-depth and individualised feedback and support from the peer review team and the quality network, in the form of a comprehensive structural report and ongoing follow-up visits. The peer review process helps to celebrate successes and provide constructive and helpful recommendations on how to enhance and further build on the good work that is already being done by services locally. It also helps NHS Trusts to identify areas of substandard practice, not previously known about, for example, issues related to patient safety, and use the feedback from the peer review team to improve performance. In summary, the developmental peer review process serves to disseminate good clinical

practice and highlight areas of poor practice, which can be improved.

Following a peer review visit, individual wards can then choose to apply for accreditation.

Accreditation visits are much more structured and take place after the foundations have been laid by Developmental Peer Review Visits.

Engagement in the Peer Review and Accreditation process demonstrates an organisation's

commitment to quality improvement. The award of Accreditation Status is well respected by the Care Quality Commission (CQC) in its official reports. The decision to accreditate a ward is made by the

Accreditation Committee. This is formed of a multidisciplinary panel of professionals, service-users and carers, and is based upon the service meeting all the essential standards and the majority of the non-essential standards.

Accreditation status would then be awarded to the ward, subject to a previous satisfactory CQC report.

As an ST5, from a training and educational perspective, attending developmental peer

review visits has given me a fresh insight and new ideas into how certain ways of working can be made more efficient and effective on inpatient wards. For example, amongst the wards being reviewed, one ward ran thematic weeks in their timetable to accommodate important areas of patient care; such as driving and the DVLA, monitoring metabolic side effects of psychotropic medication, smoking cessation workshops and the benefits of nicotine replacement therapy initiation etc. Conversely, I also experienced how a service's development could potentially be hindered by a lack of resources. For example, one ward under review lacked the services of a clinical psychologist, which held back its progress towards accreditation. However, the ward plans to use their QNOAMHS report and recommendations to help support a business case for providing psychological input to their ward. This will help the ward meet an essential standard and propel it forwards towards achieving accreditation in the future.

Besides offering *Developmental Peer Reviews and Accreditation Reviews*, QNOAMHS also provides so much more to its members. It collects and presents national data in the form of annual reports that member organisations can read to gain further insight into national trends when it comes to old-age mental health inpatient services. QNOAMHS also provides educational opportunities for its members in the form of meetings and an annual conference. These meetings are hosted by the Royal College of Psychiatrists, London and are open to Healthcare Professionals from all the member organisations free-of-charge. Meetings provide an opportunity for networking and aim to bring together expertise that is present within the network itself, in order to develop a national body of knowledge and provide contacts that every service can tap into when required. This helps to develop a community of enthusiastic professionals and boosts self-confidence and passion amongst individual services and organisations, which may be struggling on the back

drop of the constant
squeeze on funding and
scarcity of resources that
exists in today's NHS.

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

by

Philip Slack, Trainee Editor, ST5 Old Age Psychiatry, Cardiff

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

Development of dementia in patients with femoral neck fracture who experience postoperative delirium—A three-year follow-up study

B. Olofsson, M. Persson, G. Bellelli, A. Morandi, Y. Gustafson and M. Stenvall. **Development of dementia in patients with femoral neck fracture who experience postoperative delirium—A three-year follow-up study.** International Journal of Geriatric Psychiatry. Jan 2018 (online first)

A three year follow-up study from Sweden of patients that experienced delirium following surgical repair of a femoral neck fracture. Cognition, delirium,

depression, psychological wellbeing and nutrition status were recorded at point of hospitalisation and over the three year follow-up period. Of the 135 patients without dementia at the point of the fracture they found more than half experienced post-op delirium. This delirium was independently associated with risk of developing dementia over the next three years. From the cohort of 135 patients one third developed dementia during this study, 91% of those that developed dementia had experienced post-op delirium. Post-op delirium was also associated with increased mortality over the study. One weakness of the study is that although dementia had not been formally diagnosed in the patients prior to this study there was of course no cognitive testing able to be performed prior to the start of the study meaning there might

already have been cognitive decline present.

Efficacy and tolerability of antidepressants in Parkinson's disease: A systematic review and network meta-analysis

Kelly A. Mills, M. Claire Greene, Rebecca Dezube, Carrie Goodson, Taruja Karmarkar and Gregory M. Pontone. **Efficacy and tolerability of antidepressants in Parkinson's disease: A systematic review and network meta-analysis.** International Journal of Geriatric Psychiatry. Dec 2017 (online first)

A systematic review of antidepressant usage in Parkinson's disease. 1893 patients were included with the primary outcome being the efficacy of antidepressant medications in this patient group. Improvement in depressive symptoms was quantified using either HAMD, BDI or MADRS.

Secondary outcomes included drug tolerability, change in motor symptoms and treatment non-compliance. There was a general outcome supporting the efficacy of SSRIs, TCAs and MAOIs though a few trials did not show superiority over placebo. There was much heterogeneity of methodology of the trials included which may in part explain this. Results suggested a significant reduction in motor symptoms when using SSRIs compared to placebo but this was not found with SNRIs. It appears further study is needed in this area.

Why do older people refuse resuscitation? A qualitative study examining retirement village residents' resuscitation decisions

Meagan Ramages and Gary Cheung. **Why do older people refuse resuscitation? A qualitative study examining retirement village residents' resuscitation decisions.**

Psychogeriatrics. Jan 2018 (online first)

This qualitative study of resuscitation preferences of older adults in care home and retirement village settings was completed in New

Zealand. The study involved a semi-structured interview around a scenario involving cardiopulmonary resuscitation, the interview results were then analysed using thematic qualitative methodology. They did exclude any older adults with active psychotic or depressive symptoms. The majority of participants did decide to refuse resuscitation (67.6%) in the case vignette. The three main themes for refusal were around ideas of "wish for a natural death", "advanced age" and "realistic awareness about the consequences of resuscitation". The two themes found in people opting for resuscitation were "wishing to prolong good life" and "unrealistic expectations of resuscitation". The paper discussed the term AND (allow natural death) as being potentially more understandable than DNR (do not resuscitate), acknowledging that the person is dying but making them as comfortable as possible.

Association between Antidepressants and Fall-Related Injuries among Long-Term Care Residents

Jennifer C. Macri, Andrea Iaboni, Julia G. Kirkham, et al. **Association between Antidepressants and Fall-Related Injuries among Long-Term Care Residents.** Am J Geriatr Psychiatry. Dec 2017, 25:12, 1326–1336

In this retrospective cohort study from Canada, published in the American Journal of Geriatric Psychiatry, the association between falls or fall-related injuries and antidepressants was studied in long-term care residents. They matched new prescriptions of antidepressants with patients who were not prescribed antidepressants in that period. The primary outcome was a fall requiring an A&E review or hospitalisation. Within 90 days of new prescription of antidepressants there was observed an increased risk (5.2% versus 2.8%; adjusted OR: 1.9, 95% CI: 1.7–2.2) in comparison with those not receiving antidepressants. The increased falls risk was observed with SSRIs, SNRIs and trazodone.

Cochrane Corner

by

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

We return to diagnostic technologies in this edition of Cochrane Corner – a subject very close to our hearts at CDCIG. Opinions still differ on the value of very early identification of dementia, but there can be little doubt that awareness-raising among the public and GPs has had an effect on the timing of referral.

Certainly, the proportion of patients in my memory clinic who have mild cognitive impairment when first referred has risen steadily over the years. It is not always easy to know what to do with these patients. Who should be reassured most firmly? Who should be followed up and for how long if they remain stable? It would undoubtedly be valuable to be able to distinguish those who will go on to develop dementia within a fairly short time from those who will not.

A set of three new reviews by Martínez *et al*

^{1 2 3} aims to determine how accurately amyloid PET using one of the three ¹⁸F ligands on the market can identify which patients with MCI will progress to Alzheimer's disease dementia (ADD) or all-cause dementia. Florbetapir, florbetaben and flutemetamol were

¹ Martínez G, Vernooij RWM, Fuentes Padilla P, Zamora J, Bonfill Cosp X, et al. ¹⁸F PET with florbetapir for the early diagnosis of Alzheimer's disease dementia and other dementias in people with mild cognitive impairment (MCI). Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD012216. DOI: 10.1002/14651858.CD012216.pu b2.

² Martínez G, Vernooij RWM, Fuentes Padilla P, Zamora J, Flicker L, et al. ¹⁸F PET with flutemetamol for the early diagnosis of Alzheimer's disease dementia and other dementias in people with mild cognitive impairment (MCI). Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD012884. DOI: 10.1002/14651858.CD012884.

³ Martínez G, Vernooij RWM, Fuentes Padilla P, Zamora J, Flicker L, et al. ¹⁸F PET with florbetaben for the early diagnosis of Alzheimer's disease dementia and other dementias in people with mild cognitive impairment (MCI). Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD012883. DOI: 10.1002/14651858.CD012883.

all given marketing authorisation by the FDA and the EMA on the basis that a positive scan indicates the presence of moderate to frequent neuritic amyloid plaques. However, these might also occur in people with neurological conditions other than Alzheimer's disease and in older adults with normal cognition. The NIA-AA criteria for the diagnosis of MCI due to AD ⁴ included amyloid PET among biomarkers considered suitable for use in research settings only. However, in 2013, a group of organisations in the US published what they called 'appropriate use' criteria for the clinical

⁴ Arnold MS, DeKosky ST, Dickson D, Dubois B, Feldman HH, et al. The diagnosis of mild cognitive impairment due to Alzheimer's disease: Recommendations from the National Institute on Aging – Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimers Dement* 2011 May; 7(3):270-9. Doi: 10.1016/j.jalz.2011.03.008.

use of amyloid PET.⁵ The concept of such criteria was in itself controversial (e.g.⁶), but even these criteria did include a clear statement that the value of amyloid PET for predicting future outcome in patients with MCI remained a subject of 'active investigation' and noted in particular that older people (e.g. >75) commonly have asymptomatic amyloid deposition which may not be related to their cognitive presentation. Nevertheless, they proposed a limited role for amyloid PET in some individuals with persistent unexplained MCI in whom the clinician considers that an (unquantified) increase in certainty about the aetiology would change management. Once a technology is available, there is of course a risk of 'indication creep'. I

⁵ Johnson KA, Minoshima S, Bohnen NI, Donohoe KJ, Foster NL, et al. Appropriate Use Criteria for Amyloid PET: A Report of the Amyloid Imaging Task Force (AIT), the Society of Nuclear Medicine and Molecular Imaging (SNMMI) and the Alzheimer's Association (AA). *Alzheimers Dement* 2013 Jan;9(1): e1-16. Doi: 10.1016/j.jalz.2013.01.002.

⁶ Booij J, Arbizu J, Darcourt J, Hesse S, Nobili F, et al. Appropriate use criteria for amyloid PET imaging cannot replace guidelines: on behalf of the European Association of Nuclear Medicine. *Eur J Nucl Med Mol Imaging* 2013 Jul;40(7): 1122-5. doi: 10.1007/s00259-013-2415-x.

have this month seen a patient whose initial work up for MCI in a private London clinic involved amyloid PET with no research purpose and no obvious management implications.

In their set of reviews, Martinez *et al* followed earlier diagnostic test accuracy (DTA) reviews we have published in using a clinical diagnosis of dementia at follow-up as the reference standard. This delayed verification design comes with some problems, which the authors discuss, but has the very great advantage of addressing the question of most interest to patients: does this test tell me if I am going to develop dementia?

I will concentrate here on the florbetapir review, which included the most studies (three) and the most participants (453). Most of the data in this review came from a single study conducted by ADNI (the Alzheimer's Disease Neuroimaging Initiative), which was financed independently; in the other two reviews, all data were from studies conducted by the manufacturers of the ligands. There was next to no evidence on

prediction of all-cause dementia (1 study, 5 participants). Among 401 participants with MCI at baseline who were followed up for 1-2 years (mean 1.6 years), 61 went on to develop ADD and florbetapir PET predicted this outcome with a sensitivity of 89% (95% CI 78-95%) and a specificity of 58% (95% CI 53-64%). In their plain language summary, the authors provide a nice illustration of what this means in practice. If 100 people with MCI had florbetapir PET, then we could expect 15 of them to have a clinical diagnosis of ADD after a mean of 1.6 years. Of these 15, 13 would have had positive scans, but so would 36 of the 85 people who did not develop ADD, reflecting the low specificity. There were another 47 participants in the review who were followed up for between 2 and 4 years (mean 3 years), over which time 9 were diagnosed with ADD.

After this longer follow-up, sensitivity was lower at 67% (95% CI 30-93%) and specificity higher at 71% (95% CI 54-85%), although note the much greater uncertainty around these estimates. Using these

figures, for a similar hypothetical group of 100 people with MCI undergoing florbetapir PET, we could expect 19 to have developed ADD after a mean of 3 years. Of these 19, 13 would have had a positive scan and 6 a negative scan, and there would also have been 23 positive scans among the 81 people who did not develop ADD. Most of the patients in the included studies were in their 60s and 70s (mean age 72), so younger than the typical memory clinic population. There is good reason to think that specificity would be even lower in older patients. Results in the reviews of flutemetamol and florbetaben were quantitatively, but not qualitatively, different.

Therefore a negative amyloid PET scan may fairly accurately identify people with MCI who will not develop ADD in the short-term. The data did not address their risk of other forms of dementia. A positive scan has little or no clinical utility. These reviews provide strong support for the argument that amyloid PET should be a research tool only; routine clinical use is currently unjustified. The reviews

make no comment on ethical considerations related to use of amyloid PET in clinical practice, but this certainly bears reflection.

Treatment

There is no disputing the need for effective non-pharmacological interventions to improve mood and quality of life and to prevent or treat challenging behaviours in people with dementia. Since the last column, we have published two reviews in this area. Professor Bob Woods and colleagues have updated their review on reminiscence therapy (RT)⁷ and Möhler *et al* have investigated the efficacy of offering personally-tailored activity programmes in care homes.⁸

The attractions of reminiscence work for people with dementia are obvious and it is widely

used in various forms. There has been an encouraging increase in the quantity and quality of research since the last version of the review was published in 2011, to the point that the authors were able to investigate some potential effect modifiers, including setting (community or care home) and whether the intervention was delivered to individuals or groups. The bottom line was that there were signals of positive effects of RT compared to no intervention on some outcomes, although the effects were small and inconsistent across settings and modalities. The most promising results were in care homes where there were probably benefits on quality of life, cognition and communication.

Individual RT was probably associated with a small improvement on depression rating scales, although it was not clear that this was large enough to be clinically important. There was no evidence of effects on functioning or on agitation. Results related to family caregivers were interesting. Six studies – four in the community, one in a care home - reported effects on family

⁷ Woods B, O'Philbin L, Farrell EM, Spector AE, Orrell M. Reminiscence therapy for dementia. Cochrane Database of Systematic Reviews 2018, Issue 3. Art. No.: CD001120. DOI: 10.1002/14651858.CD001120.pub3.

⁸ Möhler R, Renom A, Renom H, Meyer G. Personally tailored activities for improving psychosocial outcomes for people with dementia in long-term care. Cochrane Database of Systematic Reviews 2018, Issue 2. Art. No.: CD009812. DOI: 10.1002/14651858.CD009812.pub2.

carers. The only study which found benefits (reduced burden) was the care home study and this was the only one in which carers were not actively involved in the reminiscence sessions. Two large UK studies which involved carers in sessions had the smallest effects, had quite high dropout of patient-carer dyads, and may have increased carer anxiety at follow-up, so the literature offers no support for use of this type of joint RT. The review authors provide a clear discussion of the state of the evidence and conclude that it supports RT being made available as one of a number of psychosocial approaches.

Because of the quality of the evidence, Möhler and colleagues struggled to draw many conclusions from their review of personally tailored activities to improve psychosocial outcomes for people with dementia in long-term care. Almost all the participants in the eight included studies had severe dementia. The review found that such personally tailored activities may slightly reduce challenging behaviour, but may have little or no effect on quality of life or negative

affect. The level of uncertainty about effects on other outcomes was very high. The authors were unable to find any evidence that personally tailored activities were more effective than standardised activity programmes, but this was little evidence on this point. The very recently published WHELD study⁹, which took a broad approach to person-centred care, including use of personalised activities, was not included in this review, but should perhaps be read alongside it.

Look out for more reviews in the next few months, including definitive - and overdue – updates of the evidence for donepezil and memantine using current Cochrane methods.

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⁹ Ballard C, Corbett A, Orrell M, Williams G, Moniz-Cook E, et al. Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *PLoS Medicine* 2018. <https://doi.org/10.1371/journal.pmed.1002500>.