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Update from the Editorial Team, Helen McCormack.

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This is the 70th issue of the Old Age Psychiatrist, and looking at the articles in the edition, I think you will agree that we are still going strong after seven decades, a very positive affirmation for septagenarianism!

Firstly, I would like to draw your attention to an invitation to complete the ROADMAP survey. This is an important piece of research aiming to assess meaningful change from minimal cognitive impairment to dementia. It is a Europe wide initiative, and input is being sought from people with dementia, their carers, clinicians, scientists, payers, and health economists, so your input will be vitally important.

We have a great range of features in this issue, particularly our lead article 'The four basic ethical principles in palliative and end of life care in Old Age Psychiatry'. This is a thoughtful article which sets out the basic principles as they relate to the people under our care. There are also results of two surveys on Old Age Psychiatry in practice which we hope you will find interesting and relevant.

There is a new section this month, entitled Working Lives, this time focussing on training and Job Planning. We would certainly like to feature more articles in this area in future editions.

In the Cochrane Corner, there is breaking news from the independent randomised controlled ATLAS Trial (Atypical antipsychotic in the treatment of very late-onset schizophrenia-like psychosis). There are some early results here which are likely to be part of a future Cochrane review.

We are very pleased with the range and quality of the articles in this edition, but we are always looking to improve. We would really value your feedback on what is of interest to you, and how you would like to access it. If you have views, or articles for consideration please get in touch.

Update from Alistair Burns, National Clinical Director for Dementia and OPMH.

My role has been expanded over the last few months in a couple of directions – I now cover not just dementia but older people’s mental health and in recent months have extended the work from NHS England to include NHS Improvement. The two organisations started life rather differently - NHS England developed from the NHS commissioning board and partially directs its activities through CCGs but has a specialist commissioning feature to it. Broadly speaking, some £73 billion pounds goes on work through CCGs, £29 Billion pounds on specialist commissioning and it has a very significant leadership role. NHS improvement was formed from two predecessor organisations, Monitor and the Trust Development Authority, both had a regulatory focus for Foundation and non Foundation trusts respectively. The rationale from my point of view was that it made sense to have an affiliation with an organisation with more direct input into NHS organisations (NHS Improvement covers all Trusts including Mental Health trusts) and this is consistent with a direction of traffic of the two organisations working more closely together (some national clinical directors having a dual role in each).

In terms of dementia, the diagnosis rate is still holding up very well and each month edges up incrementally and is now around 68%. This is a fantastic achievement and thanks to everybody who has contributed to raising the profile of dementia and increasing that headline rate. Of course, the dementia diagnosis rate is the vehicle by which we deliver high quality post diagnostic support. That post diagnostic support is enshrined in the care planning aspect of primary care and we have recently published on care planning:

<https://www.england.nhs.uk/wp-content/uploads/2017/02/dementia-good-care-planning.pdf>.

The evidence treatment pathway was launched recently (<https://www.england.nhs.uk/wp-content/uploads/2017/07/dementia-care-short-guide.pdf>) and this describes a six week ambition from diagnosis to treatment. The guide itself is relatively brief and the aspiration is for the publication of more extensive guidance in the near future.

Dementia remains a significant part of the Clinical Commissioning Group, Improvement and Assessment Framework (the CCG IAF, one of six priorities) and uses the dementia diagnosis rate and the number of care plans as a measure of the quality of services – obviously just two measures but many more exist. We are beginning to get more information on antipsychotic prescribing rates and our aspiration is to publish these soon – by the time this newsletter comes out it is possible they may have already been published. An area of particular interest I know to many members is end of life care, and we are just working in the final stages of guidance on end of life care for people with dementia.

Turning to older people's mental health, there are a number of initiatives here. The Older People's Mental Health Primer was published over the summer and comments so far have been very positive. We are running out of hard copies but it is freely available on the website. <https://www.england.nhs.uk/wp-content/uploads/2017/09/practice-primer.pdf>. Any thoughts on it would be appreciated and we are working on a few additions and extensions of it to make it more accessible to colleagues in primary care. In terms of improving access to psychological therapies, we have a specific remit to try and raise the profile of older people – many of you have heard me talk about the statistic that while people over 65 are some 24% of the adult population, only 8% of IAPT are related to that age group. We clearly need to improve on that.

The Five Year Forward View for Mental Health has a number of things in it in relation to older people's mental health and one of my jobs is to integrate the work we are doing with those larger pieces of work, whether it is on accident and emergency care, liaison, or the suicide rate. One thing we are becoming interested in is depression in the general hospital and it may be that we would aspire to have information soon on the care of older people with depression. If you have any examples of innovative services that look at this, that would be appreciated.

Finally, the Mental Health Workforce report was launched and we are working on an addendum to it, looking at the core competencies for older people's mental health. This is supported by Health Education England.

This issues' quiz breaks new ground. I was chairing a meeting on loneliness, co-hosted by Public Health England and the Yorkshire and Humber Strategic Clinical Network. I was bowled over by something called 'HenPower' – an innovation whereby chickens are brought into a number of care settings, starting with care homes. It seems to be

transformational and has certainly caught the public's imagination. (The two 'hensioners' as they are called, Doreen and Owen, have given permission for themselves to be in the photograph).

In terms of the photograph below, the question is:

- Who is more scared - me or the chicken?
- How many puns are there involving hens? For example, am I hen pecked or hen-powered?
- Is it true that my talks have all been described as poultry in motion?



I look forward to any thoughts or comments you have at Alistair.burns@nhs.net.



The View from the Chair
Dr Amanda Thompsell, Chair of the Faculty
of Old Age Psychiatry



Some of it is planned. Some of it is thrust upon us. Here is a round-up of what has been going on at the Faculty of Old Age Psychiatry and what the Executive has been doing on your behalf.

Event-Driven Activity.

NHSE's five year forward view.

We have continued to work to see that the mental health needs of the elderly are appropriately represented in the implementation guidance for the NHS England's Five Year Forward View. One welcome development is that the important community implementation guidance is now being led by an old age psychiatrist.

Less welcome was the fact that NHSE and Health Education England recently released a workforce planning document where older adults were barely mentioned. We have reached out to them on this point and they have been pleased to start working collaboratively with us to rectify this. On the topic of workforce planning, we have made a robust response to the Parliamentary Committee on Migration, urging that Old Age Psychiatry still be considered a threatened career (which is a status which provides more leeway in allowing people from outside the EU to come to work here). We have also updated the description of what Old Age Psychiatrists do for the GMC.

An All Party Parliamentary Group recently began an enquiry into the treatment and recognition of depression and anxiety in Parkinson's disease. We put in a response and took the opportunity to raise the Two Question Screen and also publicise the forthcoming MIND ED for Older People.

We are contributing to the College's advisory group responding to changes to the Mental Health Act that are being proposed by the Law Commission. This is, of course, a key issue for old age psychiatrists with a profound effect on our day-to-day practice. Members of the Faculty Executive met with the Law Commission and provided several clinical examples to discuss the MCA/MHA interface and the new Liberty

Protection Safeguards. We also separately put in a response to the Law Commission's consultation on proposed changes to the procedures for establishing testamentary capacity.

Implementing our Strategic Plan.

We continue to press forward in working towards our strategic objectives:

To improve awareness of older people's mental health issues and increase awareness of the Faculty.

The Older People's Mental Health Primer has now been published. With the support of the Communications department we achieved a fair degree of publicity for this. It was mentioned in a joint letter in *The Times* and a quote in *The Guardian*. The British Geriatric Society (**BGS**) tweeted it and put it in their e-bulletin. The Royal College of Nursing circulated it and there was a piece on *GP Online*. We do however need to continue to make people aware of it locally and we hope that the membership will spot opportunities for this.

Thanks to Dr Sophia Bennett we now have an animated video about depression in older people. This is also on our website. It is compelling to watch and I would urge you to encourage people to look at it. We have commissioned the video to be subtitled in 3 Indian languages (members of the Executive have kindly stepped in to help with the translation thus reducing the costs) to see if we could reach more of the Asian population. This is more work in progress.

We have ensured that the Faculty has been represented at numerous meetings including the BACP roundtable on the "*Forgotten Generation*" focussing on improving access to counselling for older people, Silverline's AGM, a roundtable organised by John's Campaign and a steering group meeting of the Young Onset Dementia Network. We also now have an executive member on the Adult Frailty networking board.

Executive members have provided clinical input to NHS Choices to ensure that it is up to date and accurate.

I also want to thank James Warner who did a great job explaining why old age specific services are so important during an interview on BBC Radio 4's "*You and Yours*".

To improve how the Faculty engages with its members and ensures member retention.

Our survey about the current state of services was completed and I thank colleagues for ensuring that we covered most of the UK. The key findings are on the website but further analysis is being done by Josie Jenkinson and Alex Bailey. The survey suggests that there are examples in England where services have gone from ageless back to old age specific services. We are currently tracking down the name of the medical directors of these services so that I can ask how they achieved this, what information they used to support their arguments for this, and whether they would be willing to share this information with others looking to do this. We plan to amend the questions and repeat the survey next year so that it will continue to have impact.

I have spoken to colleagues in Kent and Swansea and I am very excited to be going to Northern Ireland to see colleagues in December. Each time I meet members I learn something new and I get more ideas on how we can improve our engagement.

We have put forward ideas to Alastair Burns for research proposals into older people's mental health and I have discussed our concerns about the Section 49 reports with the College and they are investigating the current situation.

We have appointed a quality improvement lead to ensure members know who they can contact about QI issues. He is Dr Conor Barton and can be contacted through the Faculty website.

To improve Recruitment.

The *Choose Psychiatry* Campaign has clearly been a major campaign run by the College and I am pleased to say that the College video showing examples of cases psychiatrists deal with included an old age case. We also now have a couple of videos on a day in the life of an old age psychiatrist available on you tube.

Alex Bailey also had published in the *Guardian* a powerful piece on the impact of an old age psychiatrist. It was his ability to get a patient to be willing to speak to the media that allowed us to get this piece accepted. We really would benefit from having more older people wanting to speak about their experience of the benefits of having their mental illness

treated. If you have a case study that you could contribute please look on our website for the details of how to go about doing this.

We have updated the Faculty prizes to make them more relevant and we are working to clarify what a good CT and FY job looks like as well as making the trainee webpage more exciting.

We have also started a pilot training scheme where we are working the BGS to allow higher trainees from our Faculty and the BGS to obtain experience in each other's discipline.

What's coming up?

The programme for our Conference in March 2018 is on the website. It has a wide range of topics and a new format. It is important that we encourage trainees and colleagues to come to be refreshed and inspired and learn how to dance the Caleigh!

We plan at the conference to launch the *Invisible Addicts* report, MIND ED (a new module on mental health problems in older age within this popular on-line resource for people with mental illness and their lay and professional carers) and a presentation of the finding of our joint report with the British Geriatrics Society on depression in care homes. This is also our opportunity to get across to the wider community the importance of older people's mental health and what a fantastic career there is in Old Age Psychiatry.

Looking further ahead, work has already started on updating the report on best practice around transitions between services and updating the "*Need to tackle age discrimination in mental health*" report published in 2009 to aid us in our current discussions with commissioners. Krish has kindly agreed to organise a one-day event on 8th October 2018 in London with a neurological theme and where we will launch an updated Faculty report on Young onset dementia. I do hope that you will put this in your diaries.

We are liaising with the Liaison Faculty about a much-needed position statement on what "all ages" liaison services should look like, to include a clear recognition of the value of having an old age psychiatrist.

With issues emerging that include an increased the focus on outcomes; prevention of dementia using new therapies; and the green paper on

social care for older people, this is going to be a very interesting time. I am reassured however that I have people from the Executive in place to address these key areas.

Finally, and perhaps most importantly, we all need to keep an eye on the ongoing reorganisation within the NHS in our local areas and in particular that our voice is heard in relation to discussions about the integration involved in developing 'accountable care systems'. The new longer lasting contracts means this is even more essential.



Invitation to participate in the ROADMAP survey

We would like to invite you to complete our brief survey that aims to obtain views on the importance of different aspects that relate to mild cognitive impairment and dementia so that we can assess meaningful change in disease progression. Please click here [to access the survey](#).

The Real world Outcomes across the Alzheimer's disease (AD) spectrum for better care: Multi-modal data Access Platform (ROADMAP) project, is a European research consortium comprising leading academic institutions, industry partners and organisations such as the National Institute for Health and Care Excellence (NICE) and Alzheimer Europe. The overall aim of ROADMAP is to effectively use Europe wide real world evidence (RWE) data to improve the lives of people with dementia, with a particular focus on Alzheimer's disease, and to prevent individuals from developing the disease. There is great potential for RWE data is to be leveraged for informed consensus and decision-making; to this end ROADMAP is developing a European wide data platform and framework for use of RWE data related to AD across the spectrum. For more information about the ROADMAP project, please visit our ROADMAP [website](#).

We would like people with dementia, their carers, clinicians, scientists, payers, health economists, and others concerned with dementia in their professional capacity, to complete our surveys as we are interested in

identifying important aspects of dementia for assessing meaningful change in disease progression from multiple perspectives. Meaningful change in disease progression signals increasing severity of having dementia that impacts the person with dementia's life in a way that inhibits them from continuing to live their life as they were able to before having the condition. Aspects of having dementia that we ask you to assess in relation to meaningful change in our survey include: cognition, independence in complex daily activities, their use of health and social services, quality of life and the quality of their carer's and family's lives. To begin completing the survey, you can also click [here](#).

If you have any questions about the ROADMAP survey, please contact wp2.survey@roadmap-alzheimer.org.

The four basic ethical principles in palliative and end of life care in Old Age Psychiatry.

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Introduction

Palliative care or end of life care, as defined by the World Health Organisation is "an approach that improves the quality of life of individuals and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems and physical, psychosocial and spiritual support."¹ The 2017 NICE quality standard on 'Care of dying adults in the last days of life' list recognition of anticipated death, sensitive communication, patient involvement, the needs of families and individual care as key priorities for end of life care².

The four basic principles of medical ethics are paramount when providing individualised care for the dying person to meet their needs and wishes. The following discussion will provide an overview of the role of medical ethics in end of life care for older people and some of the ethical challenges encountered in clinical practice.

The four basic principles of medical ethics.

Autonomy: This principle means that an informed, competent adult patient can refuse or accept treatments, drugs, and surgeries according to their wishes. And these decisions must be respected by everyone, even if those decisions may not be in the best interest of the patient. Privacy is a concept embedded in autonomy.

Beneficence: All healthcare providers must strive to improve their patient's health and to do good for the patient in every situation. But what is good for one patient may not be good for another, so each situation should be considered individually.

Non-maleficence: "First, do no harm" is the bedrock of medical ethics. In every situation, healthcare providers should avoid causing harm to their patients.

Justice: The fourth principle demands that clinicians attempt to be as fair as possible when offering treatments to patients and allocating scarce medical resources. Justice demands that we distribute our time, expertise and resources fairly.

The ethical principles in end of life care for older people.

In old age psychiatry, dementia is an illness that is frequently encountered. It comes hand in hand with several ethical challenges given its progressive and life-limiting nature. One of the first hurdles is around disclosure of this diagnosis. There is no consensus around truth telling and dementia. A paternalistic view is that there is little to gain by informing patients that they have a progressive disease such as dementia, and a diagnosis of dementia is likely to cause them distress, which raises dilemmas with the principle of non-maleficence. However, the Supreme Court judgement in 'Montgomery v Lanarkshire Health Board' has caused a change in the law concerning the duty of doctors on disclosure of information to patients regarding risks³. In light of the Montgomery case, disclosure is based on individual assessment of what the patient wishes to know.

Carpenter and Dave⁴ reported that clinicians who suspect dementia often do not disclose or document a formal diagnosis. Caregivers also reported a sense of reluctance among doctors to disclose the diagnosis⁵. Yet most patients would wish to be told of a diagnosis of dementia in order to gain knowledge and develop a treatment plan, take an active role in managing

the illness and enhance a sense of self-efficacy, which upholds the principles of autonomy and beneficence. For these patients the preservation of autonomy outweighs the harm that the truth might bring, whilst some prefer ignorance. Hence, disclosing a dementia diagnosis is a fine balancing act between respecting the principles of autonomy, beneficence and non-maleficence.

When it comes to end of life, clinicians should respect the autonomy of patients in making end of life care decisions as they involve extensive uncertainty and are heavily influenced by personal values. Autonomy is based on capacity, which is the ability to comprehend a situation, to reason and communicate a decision. Capacity is a flexible concept that depends on mental ability, the medical issue, and both the complexity and gravity of any possible consequences. Despite memory impairment, capacity can exist, provided the decision process remains intact through consistent reasoning and understanding.

If a patient refuses treatment or does not wish the family involved in their care, this decision must be respected if they are deemed to have capacity when arriving at this decision as described under the Mental Capacity Act 2005, even when it is not in their best interest. However, as a frail elderly person nears their end of life they should not have a right to die if that decision is based on an untreated psychiatric illness and hence a lack of capacity.

For patients with dementia who lack capacity to make decisions regarding their care, it is important to check whether a valid advance directive towards future health care choice is available. A best interest meeting must be arranged to provide substituted judgement, and an Independent Mental Capacity Advocate (IMCA) should be appointed in the absence of a Lasting Power of Attorney to represent the patient's best interests as per the principle of beneficence.

In palliative care, prescribing pharmacological agents such as chemotherapy can have side-effects which means taking the principle of non-maleficence and justice into account. Yet, they can improve quality of life, which upholds the principle of beneficence and increases autonomy. Often, covert medication is used in the care of patients with dementia who lack capacity. If it lessens their distress and if the benefits of covert medication outweigh the possible harm, then this is in accordance with beneficence and non-maleficence. This decision is in their best interest.

should be taken after consultation of all relevant parties and must be clearly documented.

During the severe stages of dementia and when approaching end of life, patients may present with behavioural problems. Using restraint to administer medication in order to manage agitation may be distressing and cause psychological harm to the patient, but the principle of beneficence warrant an intervention to reduce the patient's immediate distress. Ethics requires a balanced approach utilising the least restrictive means to assist the patient as well as attention to autonomy.

Another ethical dilemma in palliative care is experimental treatment. On one hand, we should generally allow patients who are terminally ill, without other available treatment, to try experimental treatment if that is something that they or their family strongly desire. However, it would be ethically problematic to provide the treatment if it is not in the best interest of the patient, especially if clinicians could not predict the outcome or side-effects associated with the interventional drug. Careful communication with the patient and their family, sometimes with second opinion or ethics committee review, may help these issues. In rare occasions these decisions are reached in Court.

Conclusion.

End of life care is a sensitive matter that often comes with several ethical dilemmas. It is the responsibility of the multidisciplinary team to ensure patients receive care in accordance with the ethical principles when they are approaching end of life. It is important that mental health professions including doctors and nurses are not afraid of raising the topic of end of life care with older people. Efforts should be made to actively involve patients and their families in palliative care decisions, and to ensure the choices made are in the best interest of the patient. In old age psychiatry, the added challenge of treating patients with mental illnesses and dementia can lead to ethical dilemmas around issues such as disclosure, capacity around end of life decisions, and covert medication. Sometimes a second opinion, ethics committee review or even the Court of Protection might be indicated in challenging cases.

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Disclosure of dementia diagnosis: Snapshot survey of NHS memory clinic psychiatrists and training implications

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Background

Disclosing the diagnosis of dementia to patients, especially in the early stages, entails emotionally charged communication about a progressive and incurable condition that carries a huge burden of stigma, devaluation, social exclusion, reduced autonomy, and loss of status.¹ Nevertheless, the debate of whether 'to tell or not to tell' the diagnosis of dementia has moved to 'how to tell'.²

Frameworks do exist for 'breaking bad news' in oncology, such as SPIKES,³ but information is lacking in the process issues of dementia disclosure, such as when to deliver (at the end of the diagnostic assessment session or progressively over a period of time), what is said and done within the consultation, how diagnosis is delivered, and how sensitivity is balanced with honesty about prognosis. This paper presents the findings of a survey of memory clinic psychiatrists in the UK.

Method

The purpose of this survey was two-fold - to investigate clinician's self-perceived difficulties in diagnosing and delivering a dementia diagnosis, and to explore their training implications.

The questionnaire

A 10-item self-administered questionnaire (available on request) was developed based on current literature and guidelines on breaking bad news and disclosing dementia diagnosis. Participants were asked about their assessment, diagnostic and disclosure practices as well as about their self-perceived competence, difficulties and training requirements. Responses were grouped under two or three most common categories.

Participants were the old age psychiatrists attending regular meetings at their workplace in Hertfordshire, East of England regional old age faculty meeting, and executive members attending the old age Faculty of the Royal College of Psychiatrists in London. This method of snapshot survey was preferred to a national postal survey to improve response rate and to capture representative samples at all levels.

Results

The survey was conducted face-to-face on three groups of 34 Old age Psychiatrists in Hertfordshire (n=12), eastern region (n=8) and the old age faculty of the Royal College of Psychiatrists (n=14) in March to July 2017. Apart from 5 trainees (specialist registrars in old age psychiatry), the remaining 29 participants were consultant old age psychiatrists working in the NHS memory clinics. The response rate was 100%.

Table 1 provides psychiatrists' views on assessment, diagnosing dementia subtype and difficulties in diagnostic process. Most clinicians believed that they would need, on average, around 110 minutes to complete assessment and communicate the diagnosis. However, the majority of them (56%) spent less than 10 minutes in discussing diagnosis with patients and the same duration discussing prognosis including driving, and drug treatment separately. Only one-third of clinicians spent 10-20 minutes in actual delivery of diagnosis of dementia.

The most frequently diagnosed dementia subtypes were Alzheimer's disease, vascular and mixed dementias (up to 50%), whereas Dementia

with Lewy bodies and Frontotemporal dementia were least diagnosed. It may be because clinicians are keen to prescribe acetylcholinesterase inhibitors.

Table 1. Views of memory clinic psychiatrists on assessment, diagnosis and communication

Questionnaire items	Total score N=34(%)		
	10-20	>20	<10
<i>Time taken (in minutes)</i>			
History taking:	14(41)	15(44)	5(15)
Mental state exam:	8(24)	2(6)	24(70)
ACE III cognitive exam:	21(62)	6(12)	7(20)
Discussing diagnosis:	11(32)	4(12)	19(56)
Prognosis and driving:	5(15)	0	29(85)
Drug treatment:	13(38)	0	21(62)
Post-diagnostic support:	4(12)	0	30(88)
Clinical admin & letter:	17(50)	7(21)	10(29)
<i>Diagnosing subtypes (%)</i>	10-50	>50	<10
Alzheimer's disease:	33(97)	0	1(3)
Vascular dementia:	33(97)	0	1(3)
Mixed dementia:	34(100)	0	0
DLB:	2(6)	0	32(94)
FTD:	1(3)	0	33(97)
Others:	1(3)	0	33(97)
<i>Most difficult tasks</i>			
Disclosing diagnosis:	6(18)		
Diagnosing subtype:	6(18)		
Discussing driving:	14(41)		
Post-diagnostic support:	5(15)		
Discussing prognosis:	1(3)		

For the question 'Which task do you find most difficult in the diagnostic process?' a relatively large proportion of participants (41%) identified 'discussing driving' as the most difficult task, followed by 'disclosing diagnosis' (18%), diagnosing subtypes of dementia (18%), 'planning post-diagnostic support' (15%), and discussing treatment and prognosis (3%).

Table 2 presents the results of the questions on participants' difficulties in disclosing diagnosis and their training needs. None of the clinicians

reported using any specific systems or methods for breaking bad news in their memory clinics. However, 61% had used several techniques/tactics but without any overall plan. About three quarters of participants (N=24; 76%) had received some formal training in breaking bad news, and almost all had rated their ability to disclose the diagnosis as very good, good or fair. For the question on their future training needs, clinicians identified disclosing diagnosis, best practice examples, educating to live with a chronic condition, responding to patients' emotional reactions, and other related topics.

Table 2. Self reported practices and training needs of memory clinic psychiatrists

Questionnaire Items	Total score N=34(%)
1. Ability to breaking bad news Very good: Good/Fair:	8(24) 26(76)
2. Had any training in breaking bad news Yes: No:	24 (71) 10(29)
3. Had training in responding to patient's emotions Yes: No:	20(59) 14(41)
4. Own comfort in dealing with patient's emotions Quite comfortable: Not very comfortable:	30(88) 4(12)
5. When sharing the diagnosis, do you have a consistent plan or strategy Yes: No: Several techniques but no overall plan:	10(29) 3(9) 21(61)

Discussion and Conclusions

The results from this survey involving 34 old age psychiatrists provide insight into their self-perceived views on current practices and difficulties. The first part of the survey investigated the assessment and diagnostic practices of clinicians. In reaching a diagnosis of dementia, almost all psychiatrists seem to perform a thorough diagnostic assessment following the standard sequence of history taking, mental state examination, and cognitive tests, but there were some variations in the length of time spent on each component. Clinicians reported spending more time in history taking and cognitive assessment (from 10 to 20 minutes each), but <10 minutes in components of disclosure and discussion. This is consistent with previous findings that despite the presence of cognitive impairment suggesting the need for greater attention to disclosure, very little time is spent on elaborating or explaining the diagnosis.⁴

Results of the second part of the survey provide information on the self-rated dementia disclosure competence indicating an urgent need of advanced communication training for the clinicians.

To be able to successfully implement MSNAP⁵ standards in routine clinical practice, both current and future generations of clinicians require a simple step-by-step guide to diagnostic communication supported by regular training opportunities. Lecouturier et al.⁶ provide a list of 'best practice' behaviours in the disclosure of dementia, with the eight main behavioural categories being preparing for disclosure, integrating family members, exploring the patient's perspective, disclosing the diagnosis, responding to patient's reactions, focusing on quality of life & wellbeing, planning for the future and communicating effectively. There is a need for a patient centered communication framework⁷ based on the principles shared decision-making approach⁸.

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What are GPs views on the management of Behavioural and psychological symptoms of dementia (BPSD)?

Dr Aisling Jennings, GP/ PhD Candidate, PREPARED research project, University College Cork, Ireland. aisling.jennings@ucc.ie

Behavioural and psychological symptoms of dementia (BPSD) affect the majority of people with dementia at some point in their illness. General Practitioners (GPs) play a pivotal role in managing BPSD but how do they manage people with BPSD? What aspects of care do they find challenging? How do they overcome these challenges? To date there has been very little research that explores these questions.

In our recent study from University College Cork, published in *Age and Aging*, we investigated the challenges GPs experience when managing people with BPSD, we explored how these challenges influenced GPs' management decisions in BPSD and what strategies GPs employ to overcome these challenges. We conducted semi-structured interviews

with 16 GPs in the southern region of the Republic of Ireland. In Ireland, GPs provide care to people with dementia in the community and a subset of GPs also care for nursing home residents. GPs' nursing home commitments can range from providing care to a few patients in the nursing home to providing care to all the residents in the nursing home. The GPs interviewed had a wide range of experience of managing BPSD in the community and in nursing home settings.

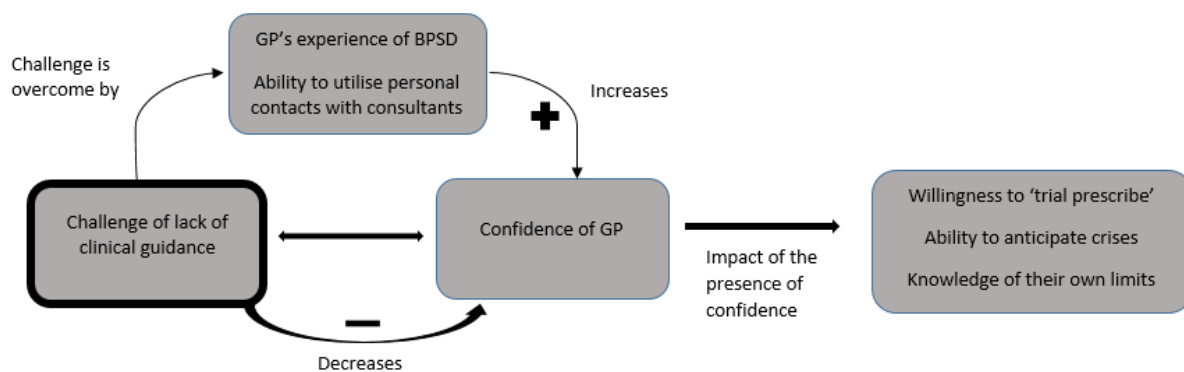
What did we find?

Overall we found that GPs find managing BPSD to be complex and challenging. Many GPs struggled at a professional, and sometimes at a personal level, with what they saw as the limited treatment options available. Rather than deciding on the 'best' treatment option, they felt they were merely making a decision on whether or not to sedate the person with BPSD. In this context three main challenges of managing BPSD in general practice were identified.

Clinical guidance

GPs found the lack of clinical guidance on BPSD to be challenging. In the absence of what the GPs considered to be implementable guidelines for the management of BPSD they felt they were often making decisions in a vacuum. The GP's own experience with a drug emerged as the critical factor that influenced their prescribing decisions. Additionally, GPs found the lack of clear referral pathways to secondary care challenging. GPs managing BPSD in the community struggled to identify who was the appropriate person to refer to with these symptoms and behaviours. Others, described how they often relied on personal contacts to access advice. Where the participating GP had a large nursing home commitment there was often an established relationship with either a geriatrician, or old age psychiatrist who attended that nursing home. This relationship gave GPs what they sought most from consultant colleagues-reassurance. GPs who had significant experience of managing dementia and who were supported by access to consultant advice appeared to have more confidence in managing BPSD. This confidence influenced their management (Fig 1). However, this confidence did not seem to extend to non-pharmacological management strategies. Even the GPs with extensive professional dementia experience often lacked confidence in recommending non-pharmacological strategies to family carers.

Fig 1



Stretched resources

Inadequate resources was identified as another challenge of managing BPSD. GPs reported that the paucity of resources in the community and in nursing homes made the implementation of non-pharmacological strategies unfeasible. Insufficient access to home-help in the community and the chronic under-staffing of nursing homes were two significant resource constraints identified. As a result of inadequate resources GPs felt under increased pressure to prescribe sedative medication.

Conflicting expectations

Managing conflicting expectations, both in community and nursing home settings, was another challenging aspect of BPSD for GPs. The GPs described how tensions arose when the family had unreasonable expectations of what they could do to improve these behaviours. However, in the context of inadequate resources, it is possible that a reasonable request for support from a family member was seen by the resource-poor GP as being an unrealistic expectation. Managing the expectations of nursing home staff was also challenging for GPs. Some GPs described how they struggled to maintain their advocacy role for their patients in a nursing home setting. However, when there was a long-standing relationship of trust between the nursing home staff and the GP their priorities were more aligned.

In the context of rising dementia prevalence the demand for community-based dementia care will increase. This study helps to explain the apparent discrepancy between best practice recommendations in BPSD and real-life practice. We are using these findings to inform the design of educational and resource interventions to support GPs in the management of BPSD.



Calling all trainees and trainers – your Faculty needs you!

Alex Bailey, Consultant older adult psychiatrist and Chair of the Old Age Faculty Specialty Advisory Committee.

Warm greetings to you all from your 'new' SAC; the Faculty Specialty Advisory Committee. This committee replaces the old 'FECCs' (I know, the College do have a way with their acronyms!) and is intended to standardise some of the activities and policies in relation to education and training.

This is an article with a two-fold intent; one is to inform you about current work the Faculty is doing in relation to education and training, but the other I'm afraid is far more selfish and is a plea to all members of the Faculty to help us. You will all be aware of the huge challenge facing us in terms of recruitment (both to training and consultant posts); this is high on the agenda of the College itself and is an issue that the Old Age Faculty is acutely aware of. Given the current low national fill rates into psychiatric training, we need to develop innovative solutions to increase recruitment and safeguard our services. It is certainly no mean feat to try to address this, but I have no doubt all of you reading this are just as passionate about the survival of our specialty as we are. Further down you will find some ways that you can help us! There's too much going on for me to talk about everything, but here's a few of the big things happening in the world of postgraduate training at the moment.

Recruitment and recent survey

Higher trainees amongst you may remember the survey we commissioned looking at reasons for choosing or not to training in old age (the one where we shamelessly bribed you with John Lewis vouchers!). The survey is still being written up as there is a huge amount of data (we had well over 300 responses, possibly as a direct result of the JL kickback!), but there is some interesting (although perhaps not too surprising) stuff in there. The high level messages appear to be:

1. Physical health care of patients appears to be a big driver in to training, with very few trainees saying they did not enjoy this aspect of the specialty
2. Working with older people itself is probably the biggest driver into choosing to train in old age psychiatry, which is if nothing else good to hear!!

3. Having an influential mentor or patient, or having a positive experience working in old age psychiatry at FY or core training level, were also hugely important when choosing old age as a career

Whilst perhaps none of this seems particularly unexpected, it does give food for thought when planning any strategy to improve recruitment. We recently hosted a 'recruitment' workshop which produced some good ideas to be developed - watch this space. But in the meantime, as supervisors please continue to enthuse your trainees with your own passion for the specialty, particularly your core trainees who are 'ripe for the picking'! The faculty has a recruitment lead, Sheena Mackenzie, who is also co-opted to the SAC recognising how recruitment rates and the training we offer are intimately linked.

Curricula changes

The GMC have now mandated that all postgraduate medical curricula are rewrite, in part to conform with their recent guidance on 'generic professional capabilities'. This is clearly a huge task for all Colleges. It has been decided that the core curriculum will likely be the first to be rewritten, followed by higher training curricula. It appears that some of the curricula that have been submitted to the GMC (non-psychiatric) are just over two pages, which sounds fabulous to me! The SAC chairs will likely lead on the core curriculum development which means that we will be in a good position when it comes to rewriting our own. Again, more to follow in the near future.

Foundation years

As a training programme director for foundation doctors in psychiatry, I have seen first-hand how successful foundation posts can have a hugely positive influence on FYs choosing to train in psychiatry. Old Age Psychiatry represents an obvious choice for these posts, given the large degree of physical health competencies we have in the specialty and the enormous breadth of psychiatric presentations. Sadly, though, we have far too few old age posts in foundation nationally. Being a foundation supervisor is rewarding and fun, and it may well be that there are further increases in foundation training in psychiatry, particularly in Scotland. **Please** consider taking on the role of clinical supervisor for a foundation doctor if the opportunity arises in your service – for any more information or advice, please contact me directly, or Rekha Hegde for Scotland (Rekha.Hegde@lanarkshire.scot.nhs.uk).

Where we want to get to?

Our aim is to ensure that training in old age psychiatry is the 'go to' option for all psychiatric trainees. The rise of ageless services, amongst other factors, means we have a fair way to go with this, but we all know how joyful it is to work in old age psychiatry, and getting that message across to trainees is a core part of our strategy. We have had some recent successes, such as getting the liaison curriculum in old age approved, but again with the rise of Core24 liaison services there is still some work to be done to iron out what this means in practice. We need to consider how we can work more closely with our geriatrician and neurology colleagues to ensure that we and our trainees are highly skilled in providing both mental and physical health care for our patients.

We recognise also the huge importance of a good experience at undergraduate level; we know there is considerable disparity in terms of how old age psychiatry teaching is delivered at medical schools across the UK (and in some cases may not be delivered at all); addressing some of these issues is also part of the SAC's remit.

In line with the executive's aim of improving engagement with the wider faculty, we want the SAC to be a 'hub' of information for supervisors and trainees as well as a repository of innovative practice. The College has perhaps for too long felt 'distant' from its core membership – we want to change this for education and training in old age psychiatry!

How you can help.

We want you to see the SAC as a port of call for all issues related to training that you cannot resolve locally; it may be that we have dealt with similar problems previously (both for trainees and supervisors). So, please use us!! We can be reached via the committee manager, Tony Roche, or directly to myself (contact details below).

However, beyond just dealing with training issues, we are passionate about developing old age training in to the envy of all psychiatric specialties! We are aiming to develop a repository of 'excellence in practice' to be available to all the Faculty. We would really therefore love to hear from you about what is happening locally; both successes and challenges in education and training.

I am hoping to come along to the old age trainees' conference in Newcastle in January 2018 to answer any questions and gather some

intel! Furthermore, the SAC is keen to engage much more with local training programme directors to understand nationally what's working well and what's more challenging.

Contacting us

We see the newsletter and the Faculty webpage as really useful ways of reaching our members to provide information. However, we also really want to hear from you, both trainees and supervisors alike! Please contact us with any queries or comments. Alex, the SAC chair, can be reached on alex.bailey@nhs.net, and the committee manager Tony on tony.roche@rcpsych.ac.uk. We can't do any of this without you!



Would the Royal College of Psychiatrists approve your Job Plan if it was advertised now?

Dr Mike Walker, Consultant Old Age Psychiatrist, Hertfordshire Partnership University NHS Foundation Trust, Logandene, Ashley Close, Hemel Hempstead, HP3 8BL , Old Age Regional Representative, Eastern Region and Chair of the Regional Representatives Group, Faculty of Old Age Psychiatry, The Royal College of Psychiatrists
Michael.walker@hpft.nhs.uk

Background

Regional Advisors of the Royal College of Psychiatrists consider Job Descriptions submitted to the College by Trusts for approval with the help of Specialty Regional Representatives. There is a good level of concordance with Royal College advice by managers in trusts who see Royal College approval as an important quality mark. However, we know little about what happens to the candidates after they are appointed. Most consultants in the NHS have an annual job plan review and *New Ways of Working* means that jobs have changed a lot in the last few years and may be very different from one another.

The College does not have a significant role in the management of job plans beyond the appointment of a new consultant. While some aspects of a job plan would be more a matter for the BMA, i.e. industrial relations, the College has a role in maintaining professional standards and therefore the many aspects of a job plan we scrutinise before appointment, e.g. SPAs and study leave, remain important throughout the career of a psychiatrist.

Questions

- 1) Do job plans approved by the RCPsych change soon after appointment?
- 2) Are current consultants working to job plans we would approve if re-advertised?

Methods

Consultants working in Old Age Psychiatry across the UK were invited to complete a Survey Monkey poll based on the Royal College of Psychiatrists checklist used to approve new posts. This was sent out via Old Age Regional Representatives.

Results

Some Regional Reps maintain mailing lists, but not all. Some areas passed the poll link around trusts. Seven devolved nations and English regions contributed to the survey and four did not. 79 Old Age Psychiatrists completed the poll between April and September 2017. 11 respondents had been in post one year or less, 16 one to five years and 52 had been in post five years or more.

1) Change from Job Plan at Appointment

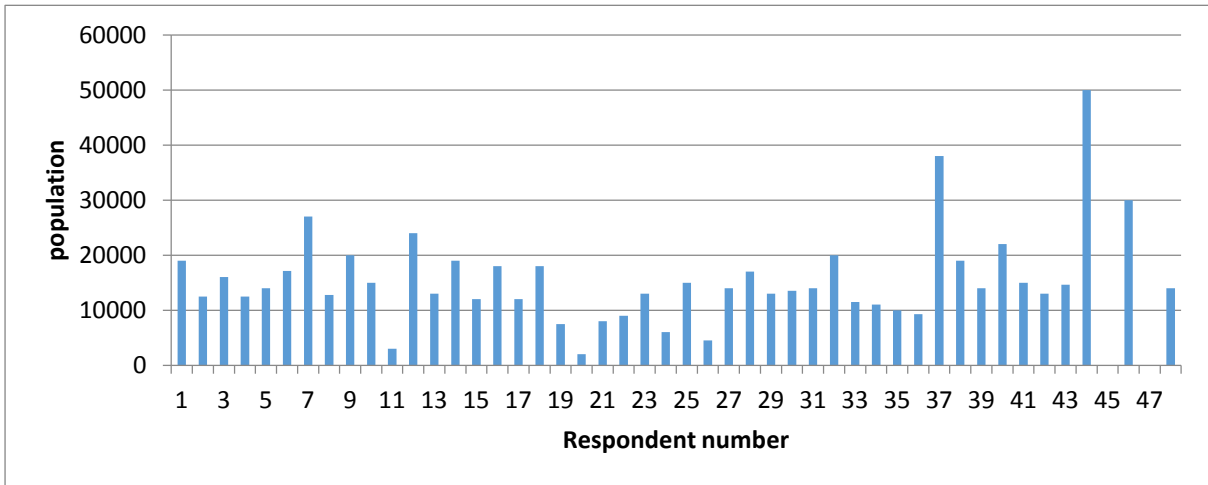
62% of respondents reported that their job plan had changed since appointment. More worryingly, this included 5 of the 11 respondents who had been in post a year or less. Of the 41 respondents who reported that their job plan had changed, only 71% reported that this was agreed in a job planning meeting.

2) Would the College approve the Job Plan now if it was advertised as a new post?

SPAs¹ - 38% of respondents had 2.5 or more SPAs in their job plan. 46% had less than 2.5 SPAs. Most of the remainder were working part time with variable numbers of SPAs.

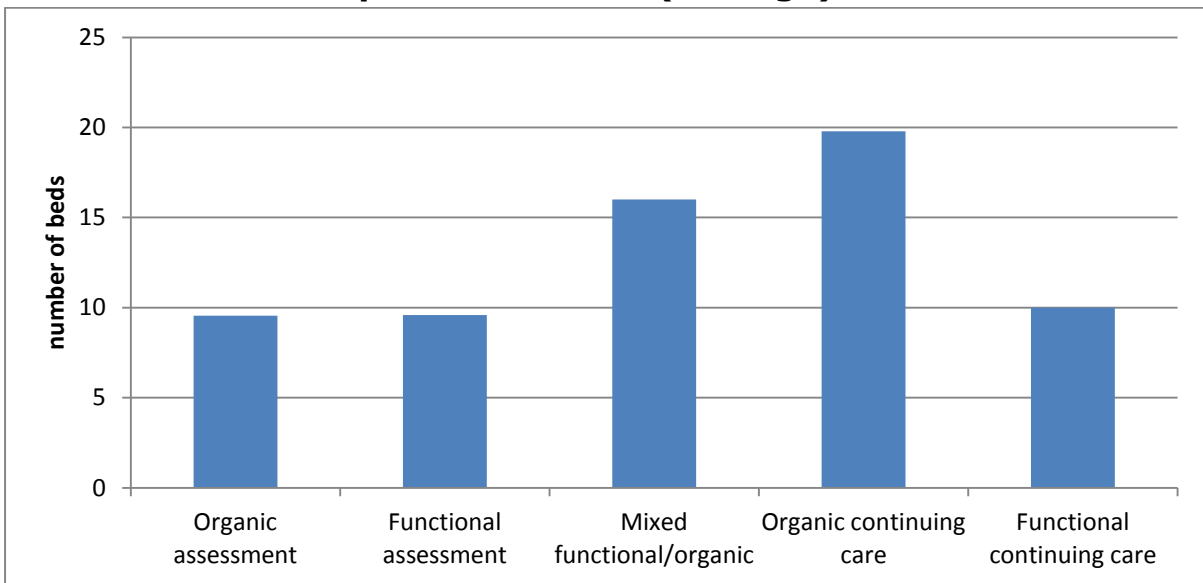
Type of post - Only 24% of respondents were in a traditional catchment area post.

Catchment area size ² - 80% of catchment areas were greater than 10000 over 65s (the College recommendation for a sector-based post), 35% were greater than 15000 and 13% were greater than



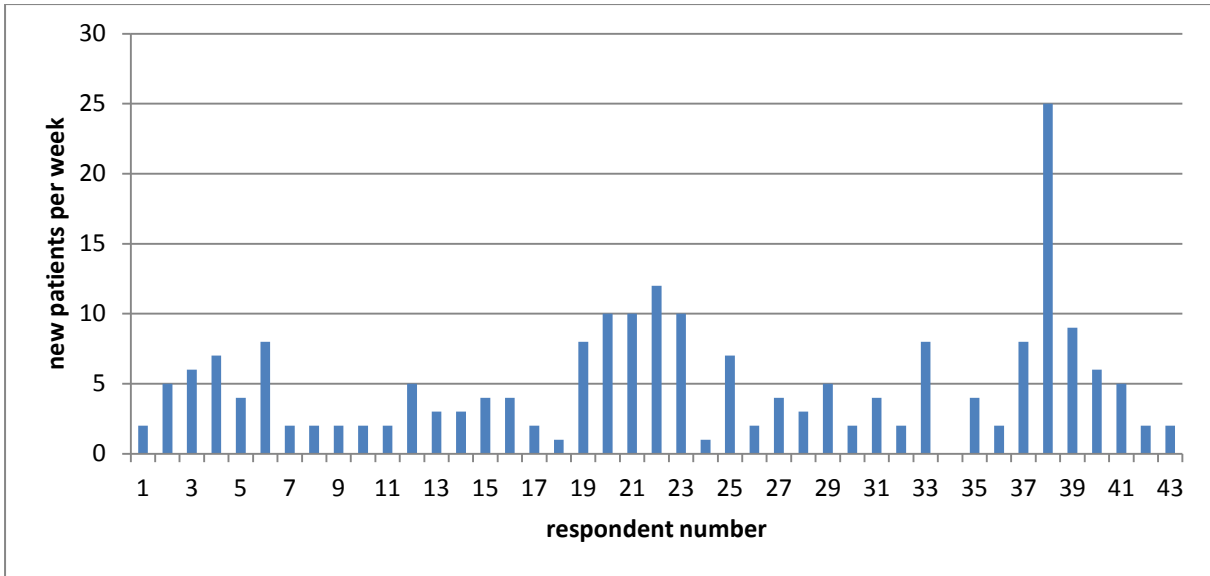
20000.

Number of beds per consultant ² (average)



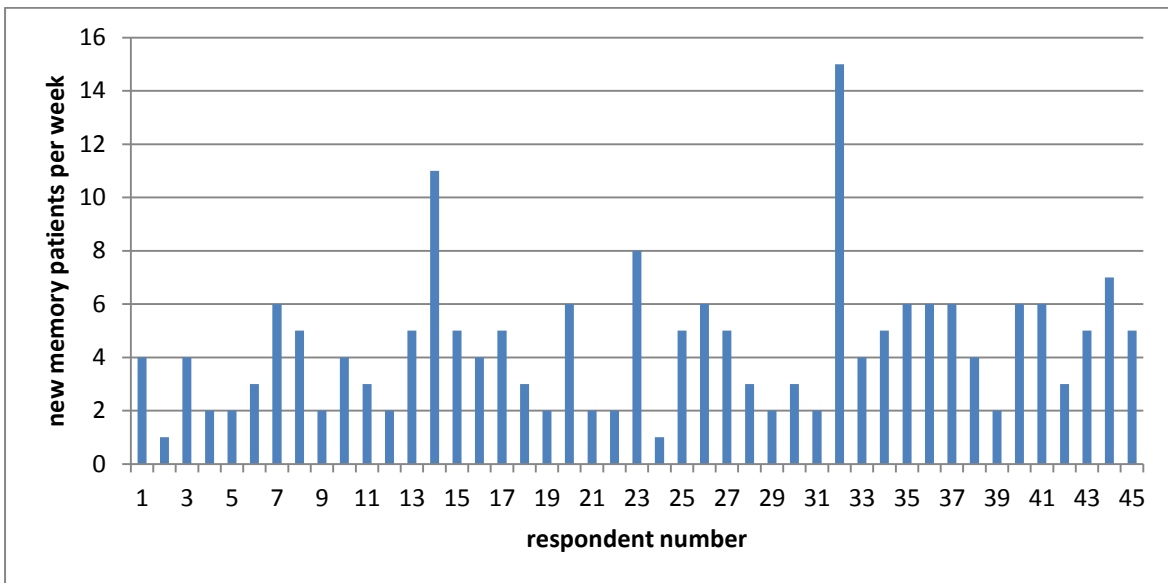
Day hospitals – only 14% of respondents worked in day hospitals.

New patients per week for consultants with community duties



The Faculty recommendation for a community post is roughly a PA for each new referral per week, and so about 7.5 referrals per week (and this would be for a purely community post)²

New memory clinic patients per week ²



Medical support² – this was variable. Only 6% of respondents reported no other medical staff in their team, but a further 13% had less than a whole time doctor in support.

Secretarial support³ – 35% had their own secretary, 37% shared a medical secretary and 25% had access to Multi-Disciplinary Team admin.

Office accommodation³ – 69% had their own office, 16% shared with other consultants, 4% had their own desk in a shared office and 7% had only hot-desking facilities.

CPD – 96% of respondents were required to be in good standing with the Royal College for CPD and 100% had a CPD peer group.

Study leave⁴ – the majority of respondents had 10 days a year. 4% had no study leave funding and a further 12% reported that they were often unable to get requests for study leave funding.

Job plan review – 80% of consultants had an annual job plan review, and a further 10% had job plan reviews less than annually. Job plan review was with a medical line manager in 70% of cases, a non-medical line manager in 4% of cases and both in 15%.

Appraisal. 7% of consultants reported difficulty getting an annual appraisal (and so putting their licence to practice at risk).

Line Management – 54% of respondents were line managed by an Old Age Psychiatrist, 29% by a Psychiatrist from another specialty and 13% by a non-medic.

Teaching¹. Only 21% had 0.5 PAs per trainee in their job plan. A further 36% had less than this and 35% had no trainee supervision time in their job plan.

Research – 10% of respondents had research or academic sessions in their job plan.

External duties¹ – 26% had explicit time in their job plan for external duties and a further 26% reported having support but not explicit time.

On Call – 10% of respondents were on a specialist Old Age rota, 66% for other specialties as well as Old Age and 24% were not on call.

Vacancies – 49% of respondents reported working beyond their job plan to cover vacancies. 21% of the total covered absent consultants, 12% other grades of psychiatrist and 6% reported working beyond their job plan due to vacancies in other professions.

Conclusions

1) Do job plans approved by the RCPsych change soon after appointment?

5 out of 11 respondents who had been in post a year or less reported changes to their job plans. This raises concerns about whether job descriptions approved by the College for appointment are not adhered to for long after the appointment.

2) Are current consultants working to job plans we would approve if re-advertised?

There is a very good degree of support in the respondents job plans for some important aspects of maintaining professional standards, e.g. 100% are in a CPD peer group and 96% are required to be in good standing for CPD with the Royal College. The majority reported a good level of study leave, but financial support for study leave was patchier. A majority reported not having 2.5 SPAs.

In general, the workload aspects of the job plan scored less well. A significant minority of respondents reported working well in excess of Faculty guidance² in areas including catchment area and numbers of referrals. 49% reported working beyond their job plan due to vacant posts.

References

- 1) Safe patients and high-quality services: a guide to job descriptions and job plans for consultant psychiatrists - Laurence Mynors-Wallis Registrar, Royal College of Psychiatrists - College Report CR174 - November 2012
- 2) FR/OA/03 - Guidance for job planning - Faculty of the Psychiatry of Old Age - June 2015
- 3) Guidance for office accommodation and administrative support for consultant posts - Position Statement PS06/2016 - November 2016
- 4) Joint Guidance on the Employment of Consultant Psychiatrists – Department of Health - January 2010

The state of health care and adult social care in England 2016-2017 CQC report: a summary of the aspects relevant to older adult care

Dr Jessica Two – ST6 in old age psychiatry, Worcestershire Health and Care NHS Trust

Dr Martin Curtice – Consultant in old age psychiatry, Worcestershire Health and Care NHS Trust

In October 2017 the CQC published the report 'The state of health care and adult social care in England 2016 to 2017', in which inspection and ratings data were analysed to assess the quality of current health and adult social care services, based on the 5 key principles of how safe, effective, responsive, caring and well-led a service is. The report was wide reaching and commented on the state of adult social care, hospitals, community health services, the ambulance service, mental health, primary medical services, equality in health and social care and the Deprivation of Liberty Safeguards (DoLS). This article looks at issues pertinent to older adults contained within the report.

Managing growing demand

The report acknowledges the difficulties of providing adequate adult social care for an aging population, with the number of people aged 85 or over in England set to more than double over the next two decades. It found that more than a third of people aged over 85 have difficulties with five or more tasks of daily living and are therefore the cohort most likely to be in need health and care services. The issue of adult social care for older people was described as "one of the greatest unresolved public policy issues of our time" and identified 1.2 million (one in eight) older people with unmet social care needs. This represents an increase of 18% since last year and a 48% increase since 2010. It found this growing demand for healthcare was also reflected within the prison system, where an ageing prison population has resulted in increased pressure on healthcare staff and resources. Age UK estimates that an additional £4.8 billion a year is needed to ensure that every older person, who currently has one or more unmet needs, has access to social care, with this set to rise to £5.75 billion by 2020.

Quality of services provided

The CQC found a significant disparity in the quality of services offered to older adults. 52% of core medical care provided by NHS acute hospitals, which includes older people's care, were ranked as inadequate or requiring improvement. This was second only to urgent and emergency care services at 55%. However, in contrast to this, community-based mental health services for older people were found to be performing particularly well, with 75% of services rated as good and 10% as outstanding. 71% of older adult mental health wards were rated as good, with 1% as outstanding. As well as huge variation in the quality of care provided across different services the report also highlighted the negative impact of fragmented care and identified problems within older adult mental health services, where there was found to be a lack of integration of physical and mental health care.

New initiatives

As described in the NHS Five Year Forward View, the CQC recognises that in the current economic climate and with ever increasing demand for care, services need to develop and change if the population's needs are to be met. The report found that a range of health and social care providers were therefore beginning to reassess the way they provided care to the public, with the development of initiatives such as GP 'super practices' and specialist teams offering more support in patients' homes. TeleMed systems, which link care homes to hospitals via a webcam, so appointments can be carried out virtually are being used by some providers to reduce the need for in-person appointments. The CQC found that early results show a reduced number of older people admitted to hospital. Other digital technology mentioned in the report included the use of a nocturnal monitoring device in Drovers House in Rugby, a care home ranked 'outstanding for responsiveness'. This listening device was switched on at night and pre-set so that it did not react to background noise but would trigger an alarm if any unusual sounds were identified.

The report also details the creation of new roles with general practice which have improved care for older and more vulnerable patients, such as the position of care coordinator, an externally funded position that enables an employee to work across several GP practices. They provide support to older and socially or physically isolated patients, offer advice about services that these patients may not be aware of, support people to access primary care services in the community rather than being

transferred to secondary care and communicate any concerns about a person's health directly to their GP.

Despite innovations in services, the CQC found wide variation in the use and success of these schemes and identified that some groups have been better served than others. It emphasised that health care for older people is a particular focus for the new care vanguards and detailed a recent example of good practice in Sutton, an area that was part of the 'enhanced health in care homes' vanguard scheme pioneered by NHS England, where integrated and partnership working was being used to improve care for older people in care homes in order to both reduce hospital admissions and to enable rapid and safe discharge from hospital. One such initiative was the 'Red Bag', which was used to transfer paperwork, medication and personal belongings of a care home resident when they were admitted to hospital. The idea was that the bag stayed with them while they are in hospital and then returned with them to the care home, with any updated information included as necessary, thereby ensuring everyone involved in that person's care understood their personal needs and medical history. This and other initiatives, including better coordination of care, enhanced training of care staff, and better health care support for older people in care homes, led to an overall reduction in care home residents attending A&E, despite a 14% increase in the number of care home beds covered by the CCG.

Variation in applying DoLS

The CQC found that, as in previous years, there continues to be variation in the appropriateness of the use of DoLS by providers across the health and adult social care sector. They suggest this uneven practice often occurs because of a lack of understanding as to certain aspects of the legislation, partly due to its complexity, and partly as a result of not enough training or difficulties translating that training into practice. The report detailed an example of good practice where an older adult community mental health team took the lead on DoLS authorisations for nursing homes as a way of keeping applications moving quickly. This resulted in a positive culture at the Trust where staff stopped feeling like DoLS were someone else's business and instead took ownership of the process.

Conclusion

Throughout the report there is clear acknowledgement by the CQC of the current pressures faced by services endeavouring to provide health and

social care in a climate of increasing demand and diminishing resources. Although the report highlights significant disparity in the quality of care offered to older people across different services the message is primarily a positive one, with the focus being principally on areas of good practice, where new initiatives and creative ways of working are being utilised by services to provide outstanding patient care.

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https://www.cqc.org.uk/sites/default/files/20171017_stateofcare1617_report.pdf

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

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.

Specific depressive symptoms predict remission to aripiprazole augmentation in late-life treatment resistant depression.

Marie Anne Gebara, Elizabeth A. DiNapoli, John Kasckow, Jordan F. Karp, Daniel M. Blumberger, Eric J. Lenze, Benoit H. Mulsant and Charles F. Reynolds III. *Specific depressive symptoms predict remission to aripiprazole augmentation in late-life treatment resistant depression. International Journal of Geriatric Psychiatry.* Oct 2017 (online first).

This paper describes a secondary analysis of data collected on the randomised treatment of adults over the age of 60 with aripiprazole augmentation with the main outcome being remission of depression. Depressive symptoms were assessed in clinical interview and using the MADRS tool. All patients first received monotherapy with Venlafaxine before potentially being augmented. 91 participants were treated with the augmenting agent and 90 received placebo. Symptoms of sleep disturbance, lack of apparent sadness and inability to feel predicted a positive response (remission of depression) to augmentation with aripiprazole. This was however a reasonably small cohort of patients from

the USA and exclusion criteria did include dementia, psychotic symptoms and substance misuse.

Frailty and depression in centenarians

Oscar Ribeiro, Natália Duarte, Laetitia Teixeira, Constança Paúl. *Frailty and depression in centenarians. International Psychogeriatrics*. Sept 17 (online first).

A Portuguese study of 91 centenarians describing the links between frailty and depression in this group. Frailty was described as at least three symptoms from the syndrome of weight loss, exhaustion, weakness, slow walking speed and lack of physical activity. Those with cognitive impairment on the MMSE had been excluded. Depression was assessed using the Geriatric Depression Scale. Frailty was particularly common in this age group (51.6%). Depression was found to be most common in the frail group at 51.1% in comparison to 21.1% in the pre-frail group. Robust centenarians (5.5% of patients) showed no evidence of clinical depression. The person's subjective view of their physical health was found to be significant in this study, specifically if the person's health was below what they expected it to be at this age then this appeared to associate with depression.

Behavioural activation for depression in older people: systematic review and meta-analysis

Vasiliki Orgeta, Janina Brede, Gill Livingston. *Behavioural activation for depression in older people: systematic review and meta-analysis. The British Journal of Psychiatry*. Oct 2017 (online first).

Recent studies of behavioural activation in adults suggest that it can be as effective as CBT however most studies have few older adult participants. This systematic review aims to examine the evidence that exists for the use of behavioural activation as a psychological therapy for depressed older adults. There were 18 studies that data was pooled from. Trials included were quite variable due to the lack of trials in this area. The trials included older adults in community, in-patient and care home settings. There was also some variation in what behavioural activation programme was used though most had an average of 8 to 10 sessions. Overall there was evidence of a clinically significant reduction of depressive symptoms from use of this therapy. It was noted that the small number of trials and evidence of bias may have influenced the outcomes and there is a need for further research in this area.

Methylphenidate for Apathy in Community-Dwelling Older Veterans With Mild Alzheimer's Disease: A Double-Blind, Randomized, Placebo-Controlled Trial

Padala PR, Padala KP, Lensing SY *et al.* *Methylphenidate for Apathy in Community-Dwelling Older Veterans With Mild Alzheimer's Disease: A Double-Blind, Randomized, Placebo-Controlled Trial.* *Am J Psychiatry.* 2017 Sep 15 (online first).

This study was of a randomised control trial of 77 veterans living in the community with a diagnosis of mild Alzheimer's disease. Treatment was randomised between Methylphenidate and a placebo and continued over the course of 12 weeks. The aim was to study low dose methylphenidate in patients where first-line treatments of apathy (cognitive enhancers and anti-depressants) were unable to resolve symptoms. There was seen to be reduction in apathy symptoms in comparison with the placebo group without an increase in adverse events.



Cochrane corner November 2017

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

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

In this edition, we are looking at some Cochrane reviews of treatments for common functional mental health problems: firstly a review which set out to look at treatments to prevent relapse of depression in older people, secondly a review of psychological interventions to help manage anxiety in people with COPD, and finally a review of risperidone for schizophrenia, which may be of interest and perhaps illustrates the need for more research activity in our speciality.

'Continuation and maintenance treatments for depression in older people,' (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006727.pub3/full>) is a review from the Cochrane Common Mental Disorders Group (<http://cmd.cochrane.org/>). It was published in September 2016 and is an update of the authors' 2012 review. The aim was to examine the efficacy of antidepressants and psychological therapies in preventing

relapse and recurrence of depression in older people. This is an important review as we know the prognosis of depression in older adults is poor, with a quarter relapsing within two years of remission and a third experiencing one or more relapses after two years. Treatments have been shown to improve outcome in younger adults where continuing medication after remission reduces risk of relapse by 70% persisting up to 36 months (Geddes 2003). The review included trials with arms of medication alone, psychological therapy alone or both together, compared to placebo.

Wilkinson and Izmeth found no new trials which met the inclusion criteria therefore their analysis was based on their previous search from 2012 which had yielded 7 studies. The main reason for exclusion was a lack of separate data for those over 65. Three included trials which compared tricyclic antidepressants with placebo, and three, a selective serotonin reuptake inhibitor. One trial used a more naturalistic approach, with patients remaining on whichever antidepressant they had been prescribed to attain remission. This trial also had a cognitive behavioral therapy arm. One other trial included a psychological intervention (interpersonal psychotherapy). All but two of the studies had links to, or were directly funded by, pharmaceutical companies.

The review found a statistically significant benefit of antidepressants in reducing recurrence at 12 months (three RCTs, $n = 247$, RR 0.67, 95% CI 0.55 to 0.82). This translated to an NNTB of 5. The review authors considered that the quality of evidence for this result was low, due to imprecision and risk of bias. There were also significant differences in relapse rates at 36 months but not at 6, 18 or 24 months. It is not clear why the effects appeared to fluctuate, and again the overall quality of the evidence was low.

Two trials involving 98 participants compared a combination of continuation/maintenance antidepressant and a psychological therapy, with antidepressant alone. One study was of group CBT and one of IPT. The studies were consistent in finding no significant difference between the groups in terms of recurrence of depression.

Managing mental disorders in people with significant physical comorbidities is one of the skills and challenges of old age psychiatry. *'Psychotherapy for treatment of anxiety in chronic obstructive pulmonary disease (chronic bronchitis and emphysema) (COPD),'*

(http://www.cochrane.org/CD010673/DEPRESSN_psychotherapy-treatment-anxiety-chronic-obstructive-pulmonary-disease-chronic-bronchitis-and) is a new review (March 2017) from the Cochrane Common Mental Disorders Group (<http://cmd.cochrane.org/>). Usami and colleagues looked for studies using any form of psychotherapy to treat anxiety disorders in people with COPD. The authors note the high rates of anxiety disorder in this condition, higher the more severe the COPD, with rates ranging from 13% to 51%. Having comorbid anxiety with COPD is linked to poor health outcomes in terms of exercise tolerance, quality of life, number of exacerbations and admissions to hospital. Persistent smoking may be a coping strategy. Primary outcomes for the review were reduction in anxiety symptoms and secondary outcomes were concerned with improvement in COPD such as exercise tolerance, FEV1, hospital admission/length of stay and quality of life.

The authors identified only 3 studies which met their criteria. They were all single centre, parallel-group RCTs from Brazil, Norway and the USA. Two studies reported that they had struggled to recruit their target number of participants. The Brazilian study (de Godoy 2003) included 30 participants with a mean age of 60 who had weekly sessions of psychotherapy for 12 weeks added to the physiotherapy, exercise and education which the control group also received. Hynninen (2010) recruited 51 participants with a mean age of 59.3; the active intervention was weekly CBT group sessions, each lasting 2 hours, for 7 weeks while the control group received enhanced standard care for COPD with regular telephone contacts. Kunik (2008) recruited 238 participants with a mean age of 66.3 and compared weekly hour-long sessions of CBT to weekly exercise sessions over 8 weeks. All studies recruited participants who may have been depressed as well as anxious.

The ability to draw conclusions from the review was limited by the small number of studies and participants, and there was also substantial heterogeneity between the studies, so the overall quality of evidence was low. However, anxiety did improve within the psychological arms of the trials (a benefit of 4.41 points on the 63-point Beck Anxiety Inventory, 95% CI 8.28 points better to 0.53 points better) at 3-12 months. The effect of the psychological interventions appeared larger at longer term follow-up after the intervention had finished (Kunik 2008 and Hynninen 2010), so it may take time for the benefits of treatment to be fully realised. There was no evidence of any effect on the secondary outcomes.

Risperidone as a treatment for adults with schizophrenia was compared with placebo in the next review, published in December 2016 (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006918.pub3/full>). This review is being discussed as Risperidone is a commonly used antipsychotic for older patients; off license in 2007 and regarded as a 'standard' medication for us to treat not only schizophrenia but also other psychoses. It is used increasingly as the comparator in new antipsychotic treatment trials.

Outcomes were grouped according to the length of trial (3, 6 or 12+ months). 15 studies were included of which only one study was longer than 12 weeks (16 weeks). Pharmaceutical companies funded 8 of the 15 trials with the majority of these funded by a company that would profit from the sales of risperidone. Data were poorly reported, often presented only in graphs, or as percentiles or 'p' values. For most outcomes, only a few studies contributed usable data. There was evidence that risperidone was more effective than placebo in the treatment of symptoms of schizophrenia (reduction in BPRS and PANSS scores) but more likely to cause adverse effects. The quality of evidence for all outcomes was low or very low.

Of particular interest to us, seven studies had specifically limited participation to subjects aged 18 to 65. Mean age - where reported - was between 30 and 50. No study included participants aged over 69. The dose of risperidone was between 2 and 10mg a day. Major concerns for us, as old age psychiatrists, aside from the poor quality of the data, are the unanswered questions about generalizability, tolerability and optimum dose for our population.

These three reviews illustrate the challenges presented to clinicians in making decisions about treatment for people over 60 with functional mental illness. The evidence from trials is limited and often has significant quality problems. Data are usually unavailable or insufficient to conduct subgroup analyses by age. We hope the article shows how important it is for our speciality to advocate, research and review treatments for people in the older age group.

Addendum:

The Cochrane Schizophrenia Group (<http://schizophrenia.cochrane.org/>) published an updated review in 2012 of '*Antipsychotic drug treatment for elderly people with late-onset schizophrenia*'

(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004162.pub2/full>) Late onset Schizophrenia is becoming more common with the ageing population. There are a variety of different classifications for 'late' and it can be defined as over 40, 45, 60 or 65. ICD 10 makes no restrictions in diagnosis based on age. The international consensus in 2000 (<http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.157.2.172>) describes 'late onset' of Schizophrenia as around the age of 40 and a 'very late onset' of Schizophrenia-like psychosis after the age of 60. They point to the significant differences from 'early onset' schizophrenia in terms of demographics (the illness is more common in women in later life), prognosis (less impairment of educational, occupational and relationship outcomes the older the patient) and genetics (the risk of developing schizophrenia is not as high for relatives of those with late onset vs early). The role of sensory deficits is stressed, particularly that of hearing, in increasing the risk of late onset Schizophrenia. Treatment, as we know, is different for older people with changes in pharmacokinetics and dynamics.

The original search for articles looking specifically at late onset Schizophrenia in 2002 produced no studies which could be included. The updated search in 2010 identified 88 studies only one of which met inclusion criteria and was of acceptable quality. Studies were excluded as the psychotic illnesses were early in onset (not after the age of 40), the intervention was not a neuroleptic medication or the studies did not include older people at all. The included trial by Huang 2007 (http://en.cnki.com.cn/Article_en/CJFDTOTAL-LCSX200701001.htm) was a randomised trial looking at the effects of either Risperidone or Olanzapine treatment in 44 people over 60 with a diagnosis of Schizophrenia and an average illness length of less than 2 years in an in-patient ward. Outcomes though were not benefits or tolerability of different treatments or reduction in symptoms but effect on BMI, triglycerides and cholesterol. We had no high level evidence for any treatment in improving symptoms and functional outcomes in people with 'very late onset' Schizophrenia-like illnesses.

However, there are now results coming through from the independent randomised controlled ATLAS Trial (Atypical antipsychotic in the treatment of very late-onset schizophrenia-like psychosis) which was supported by many members of the Faculty in England and Scotland which are likely to be part of a future Cochrane review. Professor Howard writes that, 'although the main outcomes paper has still to be published, the trial

recruited 101 participants and showed that 100mg per day of amisulpride was a well-tolerated and highly effective treatment for psychosis symptoms and hostility with a strong effect size of around 1.0 standard deviation on the Brief Psychiatric Rating Scale. Recruitment and retention of this patient group into the trial was something of a nightmare, but the successful results should encourage all of us to persevere with antipsychotic treatment in this group who are often allowed to slip back to the care of their GP without active treatment. Huge thanks to everyone in the Faculty who helped with delivery of this trial which demonstrates that we can all make a contribution to the evidence base that guides and improves treatment for our patients.'

Get involved by joining Cochrane: <http://join.cochrane.org/what-you-can-do>. Cochrane Crowd is a great place to start (<http://crowd.cochrane.org/index.html>), or take a look at TaskExchange (<http://taskexchange.cochrane.org/>). Keep in touch through Facebook <https://www.facebook.com/CochraneUK> for updates. Get involved and be kept up to date on twitter @cochraneDCIG , and via our website <http://dementia.cochrane.org/> . We look forward to hearing from you!

Book Review - Improving Psychiatric Care for Older People

Dr Anitha Howard, Consultant Psychiatrist, Gateshead.

Improving Psychiatric Care for Older People

Barbara Robb's Campaign 1965-1975

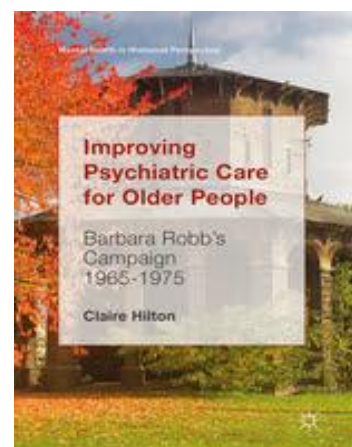
Claire Hilton

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This book is available as an open access book and is free to download from

<https://www.palgrave.com/de/book/9783319548128>

Hardcover £20



Claire Hilton's book brings to life the story of a remarkable woman's crusade to improve services for older people in the 60's and 70's.

Old age psychiatry has been well established with dedicated services for a number of decades. This book serves as a reminder of a time when this wasn't the case and the seeds of a modern service didn't start, perhaps in academia, but by a visit to an old friend.

Barbara Robb visited her friend Amy, who had agreed to an admission for her anxiety, and was shocked to see the conditions of the ward and hospital she was being held in. This book, not only, describes Barbara's campaign with AEGIS (Aid for the Elderly in Government Institutes), the pressure group she established to bring attention to the plight of older people with mental health problems who were often neglected in a shiny new NHS but also the stories behind the anonymous people who had voiced their concerns and observations to Barbara.

The book discusses the role of Barbara's book 'Sans everything' in challenging existing services in those times and how public perception in response to her work led to a change in the way services were delivered. Even though this book is about a specific period of time between 1965 and 1975, modern day readers will recognise themes around austerity, whistleblowing, age discrimination which are still, unfortunately, relevant today. The Mid Staffordshire inquiry and recent panorama programmes on care for vulnerable people still show us that many of the issues Barbara described in her book are still prevalent today.

Anyone working with older people or anyone interested in the history of services for vulnerable will find this book a fascinating book with useful insights to help improve future services.



Writing for the Old Age Psychiatrist

Helen McCormack, Sharmi Bhattacharya, Anitha Howard, Editors.

We welcome articles or features on a variety of topics for example

- Innovative service developments including those that worked and those that didn't.

- Case reports (with the written consent of the patient and anonymised).
- Book (fiction and non-fiction) and film reviews relating to older people, old age psychiatry or psychiatry.
- Reviews of relevant clinical and research topics not readily found in text books or academic journals including relevant policies or reports.
- Recent experiences/spice of life/what has angered or inspired you.

Research articles, audits, features with lots of statistics are not suitable for the newsletter.

Do's	Dont's
Use MS word, verdana font (size 12)	Exceed the word limit
Word limit 800 to 1200	Use illustrations without the copyrights holder's permission.
Use the Vancouver style of referencing	Use more than four references
Use headings to structure your article	Use unexplained abbreviations
Include Title, name of all authors, contact details	Submit to more than one Royal college of psychiatrists' newsletter
Make sure your article has a clear message	

Submission Deadline

January Edition	November 15 th
May Edition	March 15 th
September Edition	July 15 th

Tips on Writing

- Use language which shows you are passionate about your subject.
- Is your argument crystal clear and logical?
- Do not send an article after a first draft. Re-read it, and think about the style, the argument and the message you are trying to put across and improve it.
- Get someone else to read it through and give you feedback.
- If you are submitting a book (or any other review) include the title, author, ISBN number or the Director and year released if it is a film review. Don't summarise the whole book, discuss its strengths and weaknesses.

The editors reserve the right to edit the articles to suit the style of the newsletter and make suggestions or reject articles to that

effect. Please don't ignore our suggestions and finally, drop us an email, if you are not sure about your article or changes suggested.

