

OLD AGE PSYCHIATRIST



Newsletter
of the
Faculty of
Old Age Psychiatry

Newsletter Old Age Psychiatrist

September 2017



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From the Editorial Team

by Helen McCormack

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This autumn we have some new features in the Old Age Psychiatrist, and a new trainee editor, Philip Slack. Philip is an ST5 in the Old Age Psychiatry training scheme in Wales and currently works in Cardiff. He previously completed his core training in Gloucestershire. He is particularly interested in Liaison Psychiatry and teaching. We are hoping that Philip will be helping us to improve the look of the newsletter, and the ways in which we publish and disseminate our articles.

We are again publicising our essay competition in this edition, and would encourage you to visualise 'A World without Dementia, where would we be?', and give us your perspectives on the opportunities for us as Psychiatrists and the shape of our profession in the future.

For the first time, we are publicising 'Upcoming Conferences', and hope you will find this useful in knowing what educational opportunities are available and in planning your CPD.

In this edition, there is a special feature article, which is not typical for us either in its specific relevance to Old Age Psychiatry, or its length. However, the subject matter 'The unpalatable truth of childhood sexual abuse and what we have to do to address it' is of such importance that the authors are seeking to publicise it as widely as possible. I hope that you will take the time to read it, and bear the contents in mind in your work with patients and their families. In addition, we have a great range of features relating directly to our clinical practice, alongside two summaries of recent reports, on Health and Social Care Integration, and Health and Wellbeing in Rural Areas. Our evidence section has an added feature this time, explaining to you about the work of the National Institute for Health Research, and encouraging you to get involved.

We are very pleased with the range and quality of the articles in this edition, but we are always looking to improve. We would 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 the National Clinical Director for OPMH

by Alistair Burns

This has been an eventful few months in three areas.

First, the narrative to support work on depression in older people is taking shape with the aspiration to provide information about a variety of aspects, loosely bound by the acronym **PHIT** – Prevention and Healthy ageing, Identification and Treatment.

The aspiration is to get information on a range of measures which cover these areas. This could be indices of loneliness, aspects of ageing (Public Health England have an older person's profile), identification of depression (perhaps through the Quality and Outcomes Framework) and treatments such as antidepressant medication and referral to IAPT. In terms of a measure of treatment, I think it is that access to IAPT for people over 65, for depression, would be the equivalent of what the Dementia Diagnosis Rate is for dementia.

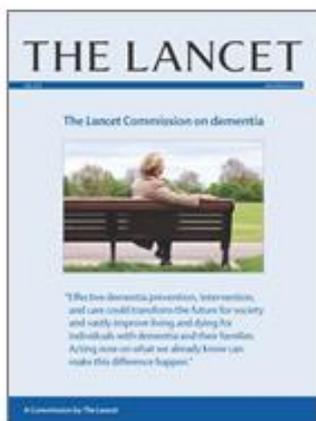
Having this information raises the possibility of being able to look at variation, whether that be for regions, Sustainability and Transformation Partnerships (STPs) or CCGs to allow information to be provided and to give good examples of good care. Using RightCare as a vehicle to raise the profile would be possible. Right Care have published our dementia narrative (<https://www.england.nhs.uk/rightcare/intel/cfv/data-packs/>) which describes two care pathways, one better than the other which are divided by significant cost differences.

Second, Health Education England (HEE) are launching a document on training (The Mental Health Workforce Strategy: Five Year Forward View for Mental Health). Our aspiration is that there will be mention of older people in it, particularly a commitment to look specifically at the competencies that the workforce should have in managing older people. Obviously, such a high-level document could not go into the detail of what locally might be regarded as an ideal old age psychiatry service, including whether services should be ageless or not. However, we hope that it will go a long way towards recognising and respecting what we have been asking for. By the time you read this the document will be published and available of the HEE website.

Third, The Lancet Commission on Dementia was published in July 2017 led brilliantly by our own Gill Livingston and presenting a significant research and policy agenda for dementia. This is a significant document (see below). Some ten key messages are there;

- recognising that the number of people with dementia will increase globally
- being very positive about the prospects for prevention and the individual risk reduction
- maximising with medication the opportunities to treat the cognitive symptoms that occur in people with dementia
- looking at good person centred care
- supporting families
- planning for the future
- looking at predicting people with dementia, one of our most vulnerable groups in our society
- managing neuropsychiatric and neuropsychological symptoms
- being careful in planning end of life care and finally
- exploring the use of technology in supporting people with dementia and their families.

A specific life course model of modifiable risk factors to dementia is presented emphasising the importance of education, hearing loss in midlife and smoking in later life among other things. The document is certainly worth a read and sets the scene for a mandate in improving



Key messages

- 1 The number of people with dementia is increasing globally**
Although incidence in some countries has decreased.
- 2 Be ambitious about prevention**
We recommend active treatment of hypertension in middle aged (45–65 years) and older people (aged older than 65 years) without dementia to reduce dementia incidence. Interventions for other risk factors including more childhood education, exercise, maintaining social engagement, reducing smoking, and management of hearing loss, depression, diabetes, and obesity might have the potential to delay or prevent a third of dementia cases.
- 3 Treat cognitive symptoms**
To maximise cognition, people with Alzheimer's disease or dementia with Lewy bodies should be offered cholinesterase inhibitors at all stages, or memantine for severe dementia. Cholinesterase inhibitors are not effective in mild cognitive impairment.
- 4 Individualise dementia care**
Good dementia care spans medical, social, and supportive care; it should be tailored to unique individual and cultural needs, preferences, and priorities and should incorporate support for family carers.
- 5 Care for family carers**
Family carers are at high risk of depression. Effective interventions, including Strategies for Relatives (START) or Resources for Enhancing Alzheimer's Caregiver Health intervention (REACH), reduce the risk of depression, treat the symptoms, and should be made available.
- 6 Plan for the future**
People with dementia and their families value discussions about the future and decisions about possible attorneys to make decisions. Clinicians should consider capacity to make different types of decisions at diagnosis.
- 7 Protect people with dementia**
People with dementia and society require protection from possible risks of the condition, including self-neglect, vulnerability (including to exploitation), managing money, driving, or using weapons, risk assessment and management at all stages of the disease is essential, but it should be balanced against the person's right to autonomy.
- 8 Manage neuropsychiatric symptoms**
Management of the neuropsychiatric symptoms of dementia including agitation, low mood, or psychosis is usually psychological, social, and environmental, with pharmacological management reserved for individuals with more severe symptoms.
- 9 Consider end of life**
A third of older people die with dementia, so it is essential that professionals working in end of life care consider whether a patient has dementia, because they might be unable to make decisions about their care and treatment or express their needs and wishes.
- 10 Technology**
Technological interventions have the potential to improve care delivery but should not replace social contact.

dementia care. Finally, the short guide for the evidence based treatment pathway for Dementia has just been published. I will say more of this next time, but for those who wish to read it, the link is; <https://www.england.nhs.uk/wp-content/uploads/2017/07/dementia-care-short-guide.pdf>.

This issue's picture quiz:



Is this scene...

- a) The auditorium before the Lancet Commission on Dementia was launched?
- b) The usual size of audience of one of my talks?

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

Alistair Burns

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

July 2017

The View from the Chair

by Dr Amanda Thompsell

As I indicated in my last "View from the Chair" the activity of the Faculty of Old Age Psychiatry is a mixture of responding to external events and progressing our own strategic aims and have not been any different during the last four months since I last wrote. Here is a round-up of what has been going on.

Event-Driven Activity

The General Election. Elections provide a chance to get important issues raised and we seized the opportunity through involvement involved in a Periscope event with BACP and Age UK and Silver Line, providing a streamed internet discussion to raise the issue of the importance of the mental health of older people. This has been followed up in our approach to the Queen's Speech, which mentioned reform of the mental health legislation. The Faculty has been represented at the College meetings convened to develop a consensus view and to ensure that the issues about the relationship between the MHA and MCA are raised.

ICD 11. A hit, a hit, a palpable hit! I mentioned in my last "View" how we have helped resist an illogical and potentially damaging proposal coming to the ICD11 committee to reclassify dementia under Neurology rather than under Mental and Behavioural Disorders. I am pleased to report that the proposal looks like it has failed and dementia will remain classified as a Mental Disorder. The recommendation to retain the status quo has been accepted by the relevant WHO joint taskforce. This cannot be considered final until approved by World Health Assembly probably in May 2018 but meanwhile it looks like a triumph for common-sense and for our effective lobbying (alongside that of others).

NHSE's five year forward view. We have continued to work on ensuring that the mental health needs of the elderly are appropriately represented in the implementation guidance for the NHS England's Five Year Forward View. Our interventions, ably supported by Professor Burns, have had an effect of allowing at least some reference and consideration of the special requirements of older people in this document – not least the *Implementation Guide for better Access to 24/7 urgent mental health care* specifically mentions it is for adults **and older adults** in the title!

The GMC's proposals on revalidation. The GMC's proposals on revalidation include proposed requirements for feedback from patients that seem extremely difficult for doctors working in old age

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liaison or in dementia only units to comply with. We took the opportunity of ensuring that our Faculty (uniquely) was represented at every one of the series of workshops on the topic arranged by the GMC so that the practical implications of the proposals would be recognised, leading to recognition that specialties like ours might have should be considered. We will see what happens but we seem to be in a much better place than we were.

Progress in implementing our Strategic Plan

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

1. To increase awareness of mental health conditions in older people

The Sisyphean task of keeping older people's mental health in the public eye continues. We took the opportunity of Mental Health Week to publish pieces in *The i* newspaper and in its online edition and in the *The Guardian*. Further opportunities arose when a paper came out showing low IAPT referral rates were for older people and my comments about blatant discrimination were picked up by the national press and TV. Dr Rao also has been in the newspapers and on the radio discussing alcohol issues in older people with the most recent piece this week in *The Sunday Telegraph*.

We also try wherever possible to leverage our influence by working with others. Work is continuing the "*Our Invisible Addicts*" report on older persons' substance misuse alongside the Addictions Faculty and we plan to launch it at our March conference. We are working with the BGS on a report on Depression in Care Homes and we hope the final document will come out in December 2017. I have had very productive meetings with Paul Farmer of MIND and with our College President Wendy Burn.

We try to use different media and Dr Bennett is completing the production of an animated video which we hope that it will help increase the awareness of Depression and which we will put on our website for you to be able to access it. We are hoping that we can get it translated into other languages as well. We have finished developing with NHSE a Mental Health Primer on Older People aimed at GPs and allied health professionals to increase recognition of mental health issues and this is due to launch soon. Most significantly we are involved (again with NHSE and HEE) in developing and promoting MIND ED, a web based site for older people, carers and families and also care staff who would like to know more about Mental Health issues in older people. We expect that we will be able to launch it at the March conference.

2. Raise the profile of the Old Age Faculty

Of course, in raising awareness of older people's mental health as outlined above, we raise our own profile. But it is also necessary to raise our profile as a Faculty within the wider profession and among other stakeholders.

We have also been liaising with the communications department about our communication strategy and our stakeholder engagement. We continue to have a real need for relevant and publishable case histories to help us engage effectively with the media so if you have anyone who could be willing to be contacted please let us know.

We are now attending the Adult Mental Health Steering Group for NHSE and, as mentioned above, we continue to work closely with NHSE on the implementation plans for the Five Year Forward View. There is also excellent work being done both in Scotland, Wales and Northern Ireland and I want to congratulate colleagues in the devolved nations on this as they continue to provide both written and oral evidence to their assemblies.

We have also provided a summary of the Faculty's work for the IPA to showcase at their conference and written a piece for the DAA on our work

We have been liaising with Parkinson's UK who are holding an All Party Parliamentary Group inquiry into anxiety and depression in Parkinson's and have been asked for input into the evidence base. We are also working with the Royal College of Anaesthetists in guidance perioperatively for people with dementia.

We are improving our links with the Liaison Faculty and I spoke at the Liaison Conference expressing my view that Liaison Services were more effective when they included both Liaison working age adult Psychiatrists and Old Age Liaison Psychiatrists.

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

I continue to be struck by how far we are truly a pan-UK body and I am in awe of the energy and achievement of our leadership within regions and nations that make up the UK. In both Hertfordshire and Falkirk I heard of particular issues which I have then been able to use as examples of the issues on the ground when talking to outside agencies. I am looking forward to visiting Kent and Northern Ireland.

We have been specifically addressing concerns raised at the Business Meeting at this year's Faculty Conference. A concern was raised about single accreditation CCT in Old Age not being recognised in the European Union. We have made contact with the GMC and found that along with Forensic, Medical Psychotherapy and Learning Disabilities our specialities are not formally on the list. We have liaised this issue with the Chairs of these Faculties and with Wendy Burn and we now have a common front to fight on this issue although I accept the Brexit may well impact on this.

Another concern related to the continued support in some health authorities for so-called "ageless services" which in effect deny the need for our speciality. To ensure we have the best possible data on this topic we have repeated the Ageless Services Survey and hope to have the results on the website by the end of September 2017. If you have not already responded to this survey, please do so.

Members also raised the issue of increasing Section 49 requests which is **affecting all Faculties**. In light of this we have raised it at College Council and they have agreed to look into this on behalf of all the Faculties.

Job descriptions remains an issue and we have inputted into the updated the "*Safe Patients; High Quality Services*" document for use with job descriptions.

We are making strides to embrace social media as a way of communicating in particular with our trainees and we have taken on board your feedback about the annual conference and we plan to have a new look conference programme for members. The conference is in Newcastle on 7th, 8th, and 9th March 2018 so keep the date!

We are aware that our members can have particular issues at time of transitions between services and we are planning over the next year to update the *Links not Boundaries* report along with an update of our young onset dementia report.

We continue to add more useful resources to the resource section on the website. Please do take a look and do contribute - in particular please share with others your good practice examples.

4. To improve Recruitment.

Starting off with the "good news" that our fill rate at CT level was up 10%. But unfortunately this still takes only from 38 % to 42% and that clearly is not adequate so we will continue to focus on this issue.

We placed an article in Student BMJ about the benefits of training in Old Age Psychiatry and we have had input into the vox box recruitment video being produced by the College along with a longer video on the working life of a psychiatrist including an old age psychiatrist. We have inputted on numerous occasions into the HEE workforce document. We have also provided information to CQC for their annual report on mental health and we have raised work force issues with NHSE.

We have an action plan to address recruitment at all levels but particularly (based on the trainee survey feedback) we are planning to develop a "resource pack" for core and higher training and develop promotional material specific to Old Age Psychiatry. Our Regional representatives are going to engage with the local PsychSocs and trainees are updating the trainee page on our website

We learnt from our survey of trainees that they experienced little in the way of formal old age medicine experience so we that are trialling a training pilot in old age medicine with the British Geriatric Society.

Conclusion

Mental health has been coming up the political agenda but whilst we have been doing our utmost to ensure that older people's mental health receives its fair share of the attention there is still a long way to go. I do however detect a greater appreciation that the population is ageing and that services need to adapt to reflect this. In the autumn, we hope to use the launch of the Mental Health Primer and World Mental Health Day to increase the awareness of older peoples' mental health.

I am proud of the role that our specialism has in improving the quality of life and helping those individuals with mental illness later in life. As the aged population increases that job has never been so important. Our role as a Faculty Executive is to support those who are fulfilling that role and to ensure that our speciality and our patients have a voice. With the support of able and dedicated colleagues both within and outside the Faculty Executive I am confident that we will continue to make a difference.

Competition



£150 for the winner and £50 for the runner up!

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

A world without dementia: where would old age psychiatry be?

If dementia were cured tomorrow what would be the role of the old age psychiatrist? Creative or original writing welcome (including essays, short stories, personal accounts and poems) with word limit up to 1000 words.

For doctors ranging from foundation trainees to consultants.

Winners to be announced at the Old Age Psychiatry Faculty Conference in March 2018 and 5 short-listed entries (including those of the winners) to be published in the *Old Age Psychiatrist*.

Please email your submissions to Anitha Howard at dranithahoward@gmail.com by 31st October 2017 along with your name, grade, work address and contact phone number.

Upcoming Conferences, Continuing Professional Development, Events of interest and other Opportunities for Faculty members

1. The Dementia Congress, Doncaster, 8th November 2017- please keep your diary free

The first day will have Wendy Burns, President, RCPsych, Liz Sampson. Sessions on end of life care, antipsychotic use, understanding distressed behaviour use of technology and films in dementia care etc.

<http://www.careinfo.org/wp-content/uploads/2017/01/UKDC-Programme-10.09-1.pdf>

2. The Lead for the Older People's Mental Health Specialist Interest Group with the Positive Practice in Mental Health Collaborative would like to hold a showcasing event (date and location to be confirmed but likely to be hosted by Sussex Partnership Trust in Brighton on October 4th or 5th). They would be interested in hearing from the members of the Faculty if you would be willing to present areas of positive practice and innovation in the areas of Older People's Mental Health.

The positive practice collaborative, are a peer led organisation (Tony Russell and his wife Angie) who aim to share positive practice in mental health services. Most NHS mental health trusts are members of the collaborative as well a lot of voluntary sector and other orgs. See the following for more information.

www.positivepracticemhdirectory.org

<http://positivepracticemh.com/category/mental-health-directory/older-people-services/>

If you would be willing to present please let Kitti Kottasz know on kitti.kottasz@rcpsych.ac.uk

3. Old Age Faculty Residential Conference 2018 – 7-9th March 2018 is in Newcastle this year – **so please keep the dates free in your diary.**

4. RCPsych in Wales Old age faculty has an upcoming conference. **"The Wholistic Psychiatrist" on 15th September 2017 at Royal Glamorgan Hospital.**

The unpalatable truth of childhood sexual abuse and what we have to do to address it

Dr Joanne Stubley and Dr Maria Eyres: Co-chairs, Historical Child Sexual Abuse working group, Medical Psychotherapy Faculty

As the news of the Manchester bombing, the London Bridge attack and the Grenfell Tower fire continue to haunt the nation, more attention than ever is currently being given to how we can protect our children as a society.

While it is vitally important that we learn how to shield our young from external terror, we equally need to learn how to better protect them from other forms of pain, an issue brought to the fore by the recent *BBC1* series "*Three Girls*" which explores the sexual exploitation of young girls in Rochdale and the inexcusable lack of response to it. The *BBC1* documentary on the subject that followed, "*The Betrayed Girls*" featured the testimonies from the victims and the shocking truth from those who spoke out and were met with professional and organizational silence.

Unfortunately, the ongoing tragedy of the reality of childhood sexual abuse and its impact on lives and mental and physical health seems to be difficult to tackle and the urgent reaction it requires from health, social care services and society in general, continues to be turned away from, denied or remains unacknowledged. This is despite a growing recognition of the widespread nature of child sexual abuse and exploitation evident in recent history.

In 2012, the Jimmy Savile scandal led to Operation Yewtree and the subsequent "*Giving Victims a Voice*" joint publication from the Metropolitan Police Service and the National Society for the Protection of Cruelty to Children (NSCCP), with evidence of over 450 complaints spanning 55 years with a victim age range from 8-47 years. Multiple police operations followed including Operation Whistle (Jersey), Operation Midland and the Wiltshire investigation into Heath.

In August 2014 Professor Alexis Jay published a review of child sexual exploitation in Rotherham. The report said: "*organized child sexual exploitation had been happening on a massive scale over many years*". The government's response was to produce the paper '*Tackling Child Sexual Exploitation*' published in March 2015. It states clearly; "*Child sexual exploitation affects all our communities. While the full extent of this crime is still unknown, we do know that it is not confined to one area. Any local authority or police force that denies that it has a problem, or thinks that it is only happening elsewhere, is wrong. As discussed in the Jay and Casey reports, a child that has been sexually exploited is likely to require long-term, specialist help. This help ranges from basic support to rebuild*

their self-esteem and resilience, to interventions that tackle more serious psychological and mental ill health on an individual and family basis." The paper also promised some additional funding to support victims and to provide specific training over the next two years in services working with sexually abused children.

In 2014, the Independent Inquiry into Childhood Sexual Abuse was established, with aims of exposing past institutional failings and making future recommendations for child protection measures. The inquiry included in its scope the Roman Catholic and Anglican churches, local councils including Rochdale (portrayed in *"Three Girls"* and *"The Betrayed Girls"*) schools, the BBC, the armed forces, hospitals and charities. The inquiry has been plagued with difficulties, perhaps unsurprisingly when one considers the nature of its investigation and the powerful emotional pulls that are inevitable in this arena.

In 2013, the Department of Education published a paper entitled *"Working Together to Safeguard Children"*. It was stated that safeguarding guidance was crystal clear and no significant changes needed to be made.

However, this was challenged following the high profile events of Savile and Operation Yewtree, as well as the Child Sexual Exploitation findings. In 2014, an Amendment to the Serious Crimes Bill was brought before the House of Lords. It was withdrawn and the government began a consultation process on the use of Mandatory Reporting (MR). Under MR, specific groups or professionals would be placed under a legal duty to report suspected cases of child abuse and neglect to the proper authorities. Failure to report reasonably held concerns would result in criminal sanctions. The consultation, which included the "lesser" option of "Failure to Act" is ongoing.

The Children's Commissioner Report on Childhood Sexual Abuse published in 2016 estimates 450,000 cases of sexual abuse in children in England between 2014 and 2016. In the same period, only 50,000 cases were known by statutory agencies. This serves to highlight the ongoing concern of what remains hidden, perhaps only coming to light in adolescence or adulthood when significant distress or functional impairment may become evident.

Recent studies suggest that around 50% of people receiving mental health services report abuse as children: one review found that "on careful questioning, 50-60% of psychiatric inpatients and 40-60% of outpatients report childhood histories of physical or sexual abuse or both" (Read 1998). Others have concluded that: "child abuse may have a causative role in the most severe psychiatric conditions" (Fergusson et al 1996: Mullen et al 1993).

A history of child sexual abuse is commonly seen in a wide variety of disorders from Depression, Anxiety, Post-Traumatic Stress Disorder, Substance Abuse and Dependence, Eating Disorders and

Personality Disorders, particularly Borderline Personality Disorder. The psychological evidence of the impact that maltreatment during infancy and early childhood has is increasingly clear. The repercussions into adolescence and adulthood can be significant and widespread with the NSPCC saying in 2010: "The impact of child maltreatment includes a wide range of many complex social and economic problems, with an increased likelihood of mental disorders, health problems, educational failure and unemployment, substance addiction, crime and delinquency, homelessness and an intergenerational cycle of abuse and neglect. *"There has also been evidence that childhood abuse is linked to physical health problems later in life which could include heart disease, obesity, liver disease, cancer and chronic lung disease."*

Although adults with a history of childhood sexual abuse may present to services with multiple medical and psychiatric symptoms and diagnoses, it is rarely the presenting complaint due to associated shame, guilt and stigma.

This is confounded by a lack of recognition within health service staff of the potential presence of such a history and the need to ask. A study by Read and Fraser in 1998 demonstrated that 82% of psychiatric inpatients disclosed childhood trauma when specifically questioned whilst 8% volunteered disclosure without being asked. A further study (Felitti and Anda 2014) showed a 35% reduction in doctor's office visits and 11% reduction in casualty visits if adults were asked about adverse childhood experiences as part of a standard medical assessment.

So what does all of this tell us about what needs to change in this difficult and emotional area? Firstly, there needs to be a significant shift in health and social care in relation to current and historical childhood sexual abuse. Much of this mirrors the recommendations in relation to children as cited above, particularly the need for work across usual boundaries within an integrated network, an active and open approach to the possibility of disclosure in all settings, management that is patient-centred with good leadership and governance.

In relation to training of health care workers, there is an urgent need to update training curricula to ensure a level of sensitive and confident interviewing skills leading to making appropriate diagnosis and signposting to treatment provisions for victims as well as perpetrators to stop the cycles of abuse.

We need to map existing clinical services that support victims of current and Historical Childhood Sexual Abuse to identify gaps as well as to recommend the best practice and care pathways from primary to tier 4 specialist care to inform commissioning. The current emphasis seems to be on child protection and safeguarding, less on treatment or prevention especially in relation to adults with historical child sexual abuse.

There is also a need to influence the direction of research into current and historical childhood sexual abuse starting with updating its definition to incorporate recent developments in digital technology. The reported prevalence is wide ranging, the current evidence base is poor and treatments are often not adequate or long enough. Child sexual abuse inevitably impacts on attachment, capacity to trust, to relate to others and form long term healthy relationships and yet the few available treatments often fail to address the need for relational intervention.

Finally, what frequently gets missed out of this kind of discussion is the need at a societal level, as well as a therapeutic level, to seriously address the issue of perpetrators. What leads to so many of our children being sexually abused or exploited? What happens in the wider fabric of our society that leads to the “creation” of abusers and what can be done in the realm of prevention and treatment of this group to begin to impact on the frightening statistics we are beginning to consider?

It is only through a willingness to face this difficult subject that we may begin to bring about some of the changes recommended and a collaboration within society to address the underlying issues which may contribute to childhood sexual abuse.

Person-centred Communication in patients with Dementia

Holly Richardson, Medical Student, School of Medicine, University of Nottingham



In my second year of medical school at the University of Nottingham, I was set the task of researching an aspect of clinical communication skills that interested me. I chose to focus on communication with people with dementia – a set of skills that, due to the UK’s aging population, is likely to be required more by my generation of healthworkers than by any generation before. The following transcript is the summary of my research and a reflection on my own first interactions with patients with dementia.

There is a growing nationwide problem regarding poor treatment outcomes of people with dementia, who fill one quarter of UK hospital beds¹, yet whose disorientation and language loss² can leave them misunderstood or overlooked by clinicians¹. To improve dementia care, the General Medical Council has recommended a style of “person-centred” communication¹ involving respect, good explanation skills and patience³, the features of which I shall now explore.

Respect can be shown to older patients by not pre-emptively assuming low cognitive function or adjusting communication in a patronising manner². Elderspeak, the “baby talk”⁴ commonly used to address older patients, including higher pitch and diminutives such as “sweetie”, has been shown to double the incidence of “resistiveness to care” such as withdrawn or aggressive behaviour⁴. Daunted by my first interaction with a person with dementia and eager to act empathetically, I began with “how are we feeling today?” and regretted this when he replied “not sure about you but I’m okay!” He, of course, must have found the use of “we” very insulting. After all, I am sixty years younger, yet my elderspeak treated him as I would a small child. When initiating future consultations I must firstly assume full cognitive abilities²; I should only adjust to simple sentences² and increase non-verbal actions - smiling and nodding⁵ - if the patient seems confused. Elderspeak should be avoided⁴.

The patient was confused when I explained my intention to take his medical history. In previous classroom explanation tasks, I had researched techniques to ensure understanding, such as minimal jargon, repetition and checking patient recall⁶, but was unsure of how to apply these to a patient with dementia. I then noticed the bright light from the window shining into the patient’s eyes, repositioned his chair in the shade, and repeated my explanation in simpler sentences, which I could tell was effective as he nodded and stopped frowning. Altering the environment like this is one technique for reducing confusion⁷. Having researched explanations in dementia further, I will consider in future using the person’s name often, using pictures, repeating myself patiently, not moving between topics too quickly⁵ and even playing soft background music, which can improve sensory awareness and concentration⁸.

The Alzheimer’s Society describes how a person with dementia may have a reduced vocabulary or become “stuck” on sounds⁹. Such barriers to self-expression can lead to loss of confidence and anxiety⁹ so the patient should never be rushed into an answer. I have previously noted my own habit of asking double questions without waiting for a response, in an attempt at clarification. This can be confusing for anyone⁶, but particularly so for those with dementia. I did not want the patient to believe that I was impatient, so when he was unsure about his medications, I suppressed my instinct of asking “any pills when you wake up? Do you have prescriptions?” and waited while he deliberated. Eventually he removed a prescription from his pocket and showed me his list of medications, proving that I must value pauses to avoid “outpacing” the patient¹⁰.

In summary, person-centred communication simply means to respect the identity of a patient with dementia¹¹. I have practised this with mild dementia through respectful language, sensitivity to the environment and interviewing at the patient’s pace. The most valuable thing that I have learned from the written testimonies of much more experienced carers is to always take the time to see things from the patient’s point of view – to put the “person” at the “centre” - so I intend to use resources

such as the Alzheimer's Society's "This is me" leaflet¹² to further allow me to place myself in my patients' shoes.

"It's useful to go out of this world and see it from the perspective of another one."

Sir Terry Pratchett, who died of Alzheimer's disease complications in 2015.

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Our experience on developing and delivering Suicide Prevention (in older people) training for Doctors

Dr Dev Lakshmanan: Consultant in Old Age Psychiatry, Lead for Suicide Prevention Training for doctors (TEWV MHSOP Trust wide), Tees, Esk & Wear Valleys (TEWV) NHS Foundation Trust

Background

In UK there are 11.4 million people aged 65 or over. The number of people aged 65+ is projected to rise by over 40 per cent in the next 17 years to over 16 million. Older people harm themselves less often than younger people. But when they do, the risk of subsequent successful suicide is greater than for younger adults. There is significant number of suicides in older people and is the second peak age after middle age. But there was no formal training in TEWV Foundation trust to improve and update the skills of the doctors in Mental Health Services for Older People (MHSOP) in assessment and management of suicidal risk. There was no previous training possibly because it was thought to be addressed in MRCPsych teaching and other bed side training. If put in context, a lifesaving training such as Cardio Pulmonary Resuscitation(CPR) training is to be completed every year but there was no regular suicide prevention training for doctors in Psychiatry to potentially save lives . By 2020/21, the Five Year Forward View for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. To reach the target and save lives effective suicide prevention training is required.

Development and Delivery of Suicide Prevention training

The expectations of training from doctors working trust wide in older people mental health services was collated. Four consultants led by Dr Lakshmanan met over 8 half days spread over 2015/2016 to devise and also review the training pack. We have delivered 5 half day trainings so far. The only cost was 8 sessions of consultant time over a one year period supplemented by work of the working group in their own time. The training has been held in three venues in West Park hospital (Darlington), Flatts Lane centre (Middlesbrough) and Lancaster road hospital (Durham). All venues had use of power point presentation, flip charts, and suitable furniture for up to 16 attendees in a training session provided by the trust. Dr Lakshmanan's previous work in 2008/2010 and training pack for non-medical staff in prevention of suicide training in TEWV in 2012-2014 is used in this training. The team led by Dr Lakshmanan acknowledge the previous work at the start of every training day and acknowledge information from documents such as National Confidential report and all research papers/other source of information.

Aims

- To improve skills and confidence in assessing suicide risk in older people and improve quality of clinical decision making
- To inform a better understanding of aetiology and assessment of Suicidal behaviour to inform a person centred approach to care
- To discuss a range of strategies that enable teams to embed training into practice and enhance team working

Content and Methods of Training:

The training includes the following:

- Pre-training questionnaire and attitude to suicide questionnaire
- Interactive Power point presentation on Epidemiology, methods of suicide, key learning points from national documents/ studies, multifactorial causes, Serious Incident reviews, learning from critical Incident reviews in the Trust, assessment and management of suicidal behaviours/ideation.
- Group work on Risk Factors - Neurobiology and Physical illness, Psychiatric disorder and Personality, Social factors and Life events and Protective factors
- Group work on scenarios of assessment of suicidal risk in community and inpatients
- Post-training questionnaire, attitude to suicide questionnaire and Evaluation forms

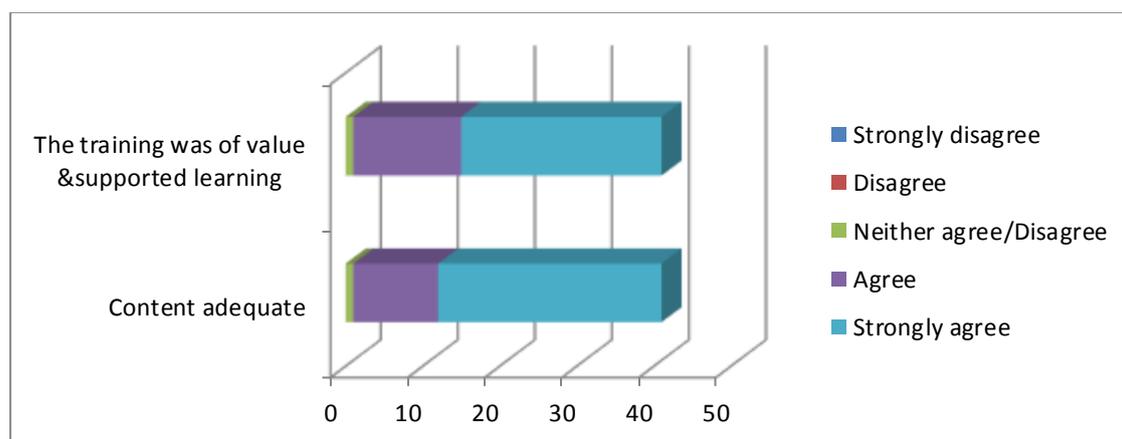
Results

Pre and post -training questionnaire

The training has been completed by 54 doctors of all grades and 95 % of MHSOP consultants in the Trust have attended. The training used pre-training questionnaire and post-training questionnaires to assess the effectiveness of the training.

Prior to training 63% doctors rated somewhat confident, 29 % quite confident and 8 % very confident in managing suicide risk. But after training the doctors showed significant improvement with 16 % felt somewhat confident, 68 % quite confident and 16 % Very confident.

Evaluation forms



10% rated very limited, 71% average, 16% above average, 3% highly developed in their current knowledge of suicide risk assessment. But after training again the doctors showed significant improvement with 18% felt average, 72% above average and 10% highly developed.

Looking Forward

The training is mandatory training to be attended by all doctors in older people mental health services in the Trust and more training days are planned. The working group meet quarterly to evaluate feedback and to consider further evidence base to add to the training pack. The assurance of training is provided in the TEWV Mental health services for older people governance group (Specialty development group) quarterly. The training has evoked interest from other NHS trusts, General Practitioners, other specialty in psychiatry such as Adult psychiatrists, non-medical staff such as accident and emergency staff, Liaison psychiatry staff who deal with older people in their job or in on calls.

Conclusion

The training emphasises recovery based approach and has proposed inputs from patients and carers to constantly improve the quality of training. The training has excellent feedback and is deemed helpful in improving knowledge/skills and confidence of doctors in older people services in prevention of suicide in older people.

Awards/Conference Workshops:

The Suicide Prevention training team won the TEWV Medical Education Innovation award in 2016, Runner up in Prevention category of 2017 BMJ Awards and the team has been shortlisted for 2017 National Patient Safety Awards.

Two three hours workshops have been successfully delivered at the Old Age Faculty conference in Bristol on 22/3/2017.

Acknowledgements

Working group- Dr Dev Anand Malayandi Lakshmanan (Lead), Dr Nawal Rida, Dr Victoria Nzekwe & Dr Aniruddha Rajkonwar, Old Age Psychiatrists &

Suicide Prevention training working group (2012-2014) for non-Medical staff, Tees, Esk & Wear Valleys NHS Foundation Trust

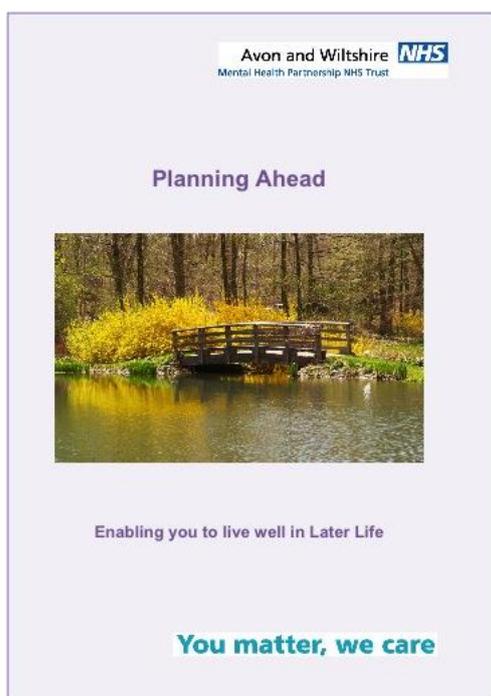
Improving Advance Care Planning in later life

Quality Improvement Project

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The aim of our project was to enable staff in the South Gloucestershire Later Life CMHT to facilitate Advance Care Planning (ACP) discussions with service users and their carers by designing an appropriate user-friendly tool.

ACP is a process of discussion between an individual and their care providers in anticipation of a future deterioration of a person's condition. It is a process through which people's wishes can be adhered to at times when expressing those wishes may be difficult or not possible. A staff survey showed that ACP was not being discussed with people with dementia and their carers despite national recommendations (Dementia Strategy, NICE)^{1,2}.

The NICE guidelines on dementia (last updated September 2016) recommend discussion with the person with dementia, while he or she has capacity, and with their carer about the use of advance statements, advance decisions to

refuse treatment, Lasting Power of Attorney and a Preferred Place of Care. It also suggests we 'adopt a palliative care approach from diagnosis until death to support the quality of life of people with dementia and to enable them to die with dignity and in the place of their choosing'².

Whilst ACP is a well-established process within palliative care setting, it is less established in the dementia population. A systematic review of 17 studies on ACP for people with dementia showed that the evidence base is limited and that we need more research to understand the feasibility and acceptability of ACP^{4,5}. Denning et al looked into end-of-life care for people with dementia and revealed that the wishes and preferences of people with dementia and their carers may differ⁴. Another study showed that professionals are hesitant to discuss ACP, there is uncertainty about who should be facilitating the process. It was also emphasised that ACP may be more about the process rather than the outcome³.

In our project, we involved a Consultant in Palliative Care (Weston Hospicecare), set up Carers Focus Group and invited a Director of Admiral Nursing from Dementia UK to collaborate with us.

The Carers Group provided personal experience of looking after someone with dementia and highlighted that ACP was an important process which they wished had been available to them at the time when they were supporting their loved ones on their dementia journey. We were also able to consider when is the appropriate time to introduce ACP and most carers felt that it would be too overwhelming if it were at diagnosis. Some of the carers had lost their loved one to dementia and some were still on their dementia journey with their relative. Their time, effort and personal experience, understandably often highly emotive, was invaluable and helped create an adapted version of the Weston Hospice care ACP booklet. Following feedback from Carers Conference we changed the title from '*Advance Care Planning for people with dementia*' into '*Advance Care Planning in Later Life*' making the project more generic. This has since become Trust wide document used by other healthcare professionals.

Feedback from a staff survey showed that they would like training in ACP. This was delivered by external experts in the field (a Consultant in Palliative Care and a Director of Admiral Nursing, Dementia UK who has special interest in ACP). We gained feedback from 15 healthcare professionals following the training and the results showed improved confidence in discussing ACP with service users and their carers compared to the results prior to training. Staff felt comfortable using the ACP booklet to help facilitate potentially emotive and difficult conversations.

At the end of our ACP implementation (we followed 3 cycles of Plan Do Study Act –PDSA) we identified that ACP was discussed with 25% of service users in Later Life CMHT and with 88% in Memory Service Team. The difference in ACP take up between the teams may indicate the

importance of timing of ACP. It may be more appropriate to discuss ACP shortly after diagnosis (Memory Service) rather than later in dementia journey (Later Life Team).

It has also been important and invaluable to see what service users and carers had to say:

"We had both thought about the future - the group gave us the opportunity to discuss it."

"Very useful tool."

"We could check that we had thought of everything to put in place."

"I found it useful so I can get my affairs in place."

From the onset of this project we promoted team ownership by adopting an inclusive approach foreseeing the relatively short time a trainee, leading on the project, spends with the team. Sustainability was also achieved by establishing an ACP Lead Nurse role. Two experienced Community Psychiatric Nurses (CPN) were identified to lead on ACP in the Memory Service and the Later Life Team.

In addition, this project is currently being expanded by the Later Life CMHT. They are developing a therapeutic tool based on this project. The tool resembles a board game and the aim is to promote difficult conversations, including end of life. The team presented the prototype at the Trust 'Dragon Den – Bright Ideas' and secured £5,000 and business mentors to develop this further.

We learnt a number of lessons from working on our project. Firstly, engaging the stakeholders (team staff, carers, service and locality managers, Trust communication and Legal department) from the onset proved essential. We felt it important to seek the views of the team members prior to embarking on this project. It allowed us to find out whether they felt this intervention would be useful and something they would want to be part of. This allowed team ownership and project sustainability. Equally, having the team, service and locality managers' approval ensured that they encouraged staff to attend training which in turn promoted motivation. In addition, the involvement of carers through Carers Focus Group provided invaluable personal experience that we could not substitute with any literature search.

We had to engage on Trust level with the Communication department and Legal department, something we did not necessarily foresee and did not appreciate the extra time this might add. However, it was worth investing this time in long term as we have produced Trustwide booklet ensuring transferability of our project.

Whilst not the goal of this project, we have gained invaluable experience in leadership, understanding how teams work and how focus groups are run.

As trainees, the challenge was always going to be the length of time the project might take. We stayed involved with the project via the Lead ACP Nurse.

The fact that staff now feel comfortable initiating difficult conversations, which may include end of life care is perhaps a measure of success itself. As might be the next level the team has taken this to – securing £5,000 and business mentors to develop a therapeutic tool resembling a board game promoting difficult conversations.

Acknowledgements

We would like to acknowledge the contribution by Edna Snaith for her invaluable insight as a carer who lost her husband to dementia. We are grateful for the enthusiasm and commitment by Cheryl Buckley, ACP Lead Nurse, Later Life CMHT and Anita Espin, ACP Lead Nurse, Memory Service, South Gloucestershire.

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The use of ECT for agitation and aggression in dementia

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The Author would like to declare there is no conflict of interests.

Agitation and aggression are frequent and disruptive complication of dementia that frequently contribute to hospitalization, premature institutionalization and care giver burden. Agitated behaviour often reflects patient's distress and are often distressing to caregivers and families. Approximately 80% will, during the course of the illness, exhibit non-cognitive symptoms and behaviour such as agitation, aggression, psychosis, wandering and sleep disturbance. The prevalence of agitation and aggression in those with moderate to severe dementia living in nursing homes has been reported to be over 50% (Barnes *et al.*, 2012).

Despite this high prevalence of these behavioural problems treatment options are currently limited. Non-pharmacological interventions are not always available and difficult to implement at times (Janzen *et al.*, 2013). Different pharmacological options, such as antidepressants, anticonvulsants, benzodiazepines, beta-blockers and antipsychotics, are often used off-label and have been found to be only modestly helpful in addressing behavioural symptoms. Unfortunately these are associated with adverse effects. The persistence of agitation and aggressive behaviour often results in polypharmacy. Several of these products have adverse effects that could readily contribute to agitation/aggression, and even to the dementia.

Electroconvulsive therapy (ECT) has been used to provide rapid and significant improvements in severe mental disorders such as severe affective disorders, and catatonia. It is also useful for refractory disorder when other interventions fail. Few retrospective and case studies have provided support for the utility of ECT as a safe treatment options for agitation and aggression in dementia. These studies not only reported effective reduction in agitation and aggression in dementia but also reported stable performance on neurocognition over time (Hausner *et al.*, 2011). One main concern for using ECT in older patients, especially those with dementia, is its adverse effect on cognitive functioning. These studies found that there was no deterioration in neurocognitive effects of ECT in older patients with dementia and any transient confusion is short term and tends to resolve within 48 hours period.

The mechanism by which ECT seizures are propagated is not well understood. Bilateral ECT appears to lead to seizure generalization through direct stimulation of the diencephalon, whereas seizures induced with unilateral stimulation may begin focally in the stimulated cortex and then generalize via corticothalamic pathways (Staton, 1981). It could be possible that synergistic effect occurs between ECT and pharmacotherapy, possible reduction in pharmacotherapy may reduce side-effects, possibly

treatment of agitated depression associated with dementia or it's possible we are simply working through another mechanism to help modify some of the brain circuitry that is leading to the agitation and impulsivity. Saver *et al.* (1996) reported that seizures produced by ECT stimulate the ventromedial hypothalamus and hypothalamic stimulation may play some role in inhibiting aggression and agitation. Grant and Mohan (2001) described successful bilateral ECT treatment of four patients with dementia who suffers agitation and aggression. Acharya *et al.* (2014) studied twenty-three participants with dementia who were referred for ECT to treat agitation and or aggression. The authors reported a significant decrease in agitation from baseline to discharge ($P = 0.006$). Treatment with ECT was well tolerated by most patients; however, discontinuation of ECT occurred for five patients because of adverse events or recurrence of agitation. Ujkai *et al.* (2012) reviewed sixteen patients with dementia and agitation/aggression treated with bilateral ECT. They also reported significant reduction in symptoms from baseline ($P < 0.001$). However, there was no significant change on the Global.

Assessment of Functioning ($P = 0.32$). It is of note that one patient discontinued ECT because of lack of improvement; eight patients showed transient postictal confusion that was resolved with forty eight hours; and two patients showed more severe postictal confusion that required modification of treatment.

The mean number of ECT sessions was 9 (range: 5 -14) and treatments were administered three times per week or less frequently if clinically indicated. Limitations of these studies include the fact they are often open-label i.e. the staff were aware that the individual had received ECT. This may bias the ratings used in these studies. These studies are usually naturalistic and did not involve a control group and they used different rating scales. Also, there was no clear description of the history of failure to other interventions as inclusion criteria. Never the less, the results of these studies are encouraging and suggest ECT as a safe and effective treatment for some patients with behavioural problems in dementia who are not responding to behavioural and pharmacological interventions.

There are some important factors to consider before administering ECT. In this patient group, brain imaging may be helpful to exclude abnormal cerebrovascular events, space-occupying lesions and increased intracranial pressure. Baseline cognitive testing is useful in following seizures-related confusion. Pre and post treatment medical assessment and management should focus on cardiac and pulmonary status, musculoskeletal problems and gastro oesophageal reflux. Careful evaluation of dental care is important. Acute closed-glaucoma or retinal detachment should be evaluated and

stabilised before starting ECT. Consent to ECT is a hurdle with those patients who lacks the mental capacity to consent to treatment; however, this can be overcome by the use of the Mental Health Act or seeking Court approval. The risk-benefit profile of ECT for dementia should be considered on individual basis. It is important to consult with the caregivers and involve them in decision making process.

Finally, randomised, double-blinded, controlled studies are needed to prove the safety and utility of ECT in dementia with agitation/aggression.

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Health and Social Care Integration - a report by the National Audit Office

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

This National Audit Office (NAO) report published in February 2017 examines the progress made towards health and adult social care integration across England by the Department of Health, Department of Communities, Local Authorities ('the Departments') and NHS England. A target date of 2020 was set to achieve integration and local authorities are required to produce a plan for how they would achieve this by April 2017. This article describes salient points emerging from the report illustrating the complexity inherent within this process.

The Departments' case for integrating health and social care

The report studies the increased pressure on local health and social care systems due to rising demand and reduced funding. It considered various aspects which are leading to this pressure such as the projected rise in population of people aged 65 and above by 21% between 2015–2025. In addition, it is estimated that there will be 2.8 million people living with long term conditions by 2018 leading to an additional annual cost of £5 billion. However, local authority spending on adult social care has reduced by 10% since 2009-2010 while NHS Trusts and NHS Foundation Trusts spending has increased by 11% between 2011-12 and 2015-16. The report noted that during this time key performance indicators for health and social care sectors were worsening. The main reasons for this increase were patients awaiting a care package in their own home and patients awaiting a nursing home placement. The report concluded such trends indicate the ageing population is clearly putting pressure on hospitals and social services.

The report was blunt in its conclusions from this section of the report that:

- After nearly 20 years of initiatives by successive governments to join up health and social care this has not led to system-wide integrated services.
- A robust evidence base to show that integration leads to better outcomes for patients has not yet been established by the Departments.
- There is still no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity.

Progress with national integration initiatives

The Better Care Fund

The report looked at the effects of this fund (launched in April 2015) in each health board area by the pooling of funding (a minimum of £3.8 billion in 2015-16 and £3.9 billion in 2016-17 across England) for the purpose of integrating services and reducing pressure on hospitals. It required authorities to come up with joint plans and agree targets against a set of national performance metrics. In February 2015, it was estimated the Fund would achieve savings of £511 million in 2015-16. The report found this savings target was not achieved due to significant increases in emergency admissions and days lost to delayed transfers of care. The report concluded the Fund had not achieved its potential to manage demand for healthcare e.g. reduce hospital activity; support out-of-hospital care; improve outcomes for patients; or save money.

Integrated Care and Support Pioneers Programme

This five-year programme, launched in November 2013, was designed to improve the quality and cost-effectiveness of care for people whose needs are met best when the different parts of the NHS and local authority services work together. A total of 25 Integrated Care and Support Pioneer sites were selected. The report found that local areas were making slow progress in implementing their plans and were not integrating services at the scale and pace envisaged. However, it did note that local areas were recognising and resolving the barriers to integration but some needed to be looked at on a national scale.

New Care Models

The report examined the NHS England's *Five Year Forward View*, published in October 2014. It aimed at moving care from hospitals to settings closer to people's homes, and from reactive care to preventative and proactive models based on early intervention by setting out plans to develop seven new care models that integrate services wrapped around the patient. It is projected the new care models will achieve £900 million in savings by 2020. NHS England is testing the new care models through 50 'vanguard' sites which are locally created health and care partnerships, comprising hospitals, clinical commissioning groups, GPs, care homes and others.

The main conclusions from this section of the report were:

- The Departments' expectations of the rate of progress of integration were over-optimistic.
- The Departments were simplifying the Better Care Fund's assurance arrangements but that more funding was due from 2017-18.

- The Integrated Care and Support Pioneers Programme had not yet demonstrated improvements in patient outcomes or savings.
- NHS England's ambition to save £900 million through introducing new care models may be optimistic.

The Departments' plans for integration

The Better Care Fund will continue till 2019-20 and the Departments will supplement it with additional money from the introduction of the option for local authorities to increase council tax by additional precept of 2% (dedicated to social care spending). The Departments however have not yet estimated whether this will be enough to meet demands of social care and the impact of social care spending on NHS bodies.

NHS England has established 44 sustainability and transformation 'footprints'. Local health bodies within these footprints must draw up plans to improve services and finances over five years to March 2021. In an October 2016 survey of hospital leaders by NHS Providers, 79% expressed concerns that their local area was not transforming quickly or effectively enough to provide sustainable, integrated patient care and financial balance.

The NAO reviewed the Departments' arrangements for managing health and social care integration and found limited oversight of ongoing work and a lack of senior-level leadership that had caused delays in implementing its policies. Hence, in January 2017, the DH said it was reviewing the Integration Partnerships Board's governance of integration pending publication of this report.

The conclusions from the third part of the report were really quite troubling and included:

- The Departments were not systematically addressing the main barriers to integration that they have identified.
- The Departments and their partners were still developing their understanding of how to measure progress in integrating health and social care.
- The Departments' governance and oversight across the range of integration initiatives is poor.
- Without full local authority engagement in the joint sustainability and transformation planning process, there is a risk that integration will become side-lined in the pursuit of NHS financial sustainability.
- NHS England has not assessed how pressures on adult social care may impact on the NHS.
- NHS England is diverting resources away from long-term transformation to plug short-term financial gaps.

Barriers to Integration

The report encourages the Departments to prioritise action to overcome three key barriers to successful integration.

Financial incentives – The national tariff (the mechanism by which hospitals are paid for each patient seen or treated) encourages hospitals to increase their activity but this mechanism works against local systems trying to reduce hospital activity through integration. In September 2016, NHS England's accounting officer announced that he was open to health economies dropping the national tariff in favour of alternative funding systems. NHS Improvement is working with NHS England to develop payment systems that incentivise integration.

Workforce challenges – As part of its inquiry into caring for people with long-term conditions, the House of Commons Health Committee recommended that Health Education England set out its strategy for adapting the workforce to integrated care. However, differences in working culture, professional entrenchment and different terms and conditions across the health and local government sectors remain barriers to integrating and developing the workforce.

Information sharing – An April 2016 review by the Local Government Association found that while there were no policy constraints preventing information-sharing, not enough had been done to explain the rules around information governance and had commissioned a further report from the National Data Guardian.

The Department of Health confirmed its priority to address these long-standing barriers.

Some way yet to go

This report is an extensive study of the national initiatives for integration and the progress made thus far. The report opines there are two main challenges still faced by the Departments, NHS England and NHS Improvement for integration of services:

1. Providing the environment within which integrated services can succeed and benefit patients, and,
2. Creating a robust evidence base demonstrating the scalability and replicability of cost-effective integration initiatives.

Whilst acknowledging the government has 'underscored its commitment' to integration the report makes a series of recommendations (Box 1).

BOX 1 – Key recommendations from the Health and Social Care NAO report

1. Confirm whether integrated health and care services across England by 2020 remains achievable.
2. Establish the evidence base for what works in integrating health and social care as a priority.
3. Review whether the current approaches to integrated health and social care services being developed, trialled and implemented are the most appropriate and likely to achieve the desired outcomes.
4. Bring greater structure and discipline to their coordination of work on the three main barriers to integration.
5. Set out how planning for integration will be on a whole-system basis, with the NHS and local government as equal partners.
6. Put in place appropriate national structures to align and oversee all integration initiatives as a single, coordinated programme.

This report highlights the main difficulties and obstacles in heralding meaningful integration and evaluating the effects of current initiatives. It provides in-depth analysis of key issues that need to be addressed to bring about successful integration. It is clear from the report, which is at times pointedly critical of the process thus far, there remains an underwhelming feeling as to the prospects of successful integration and overall much work is still to be done.

Reference

National Audit Office (2017) *Department of Health, Department for Communities and Local Government and NHS England – Health and social care integration. Report by the Comptroller and Auditor General. HC 1011 SESSION 2016-17.* 8 February 2017.

<https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf>

Health and wellbeing in rural areas – how older people are affected

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Dr Martin Curtice – Consultant in old age psychiatry, New Haven, Princess of Wales Community Hospital, Bromsgrove, Worcestershire, B61 0BB

This report is a joint publication released in February 2017 by the Local Government Association and Public Health England. It concentrates on England where 19% of the population live in diverse rural areas comprising of 85% of the land. Whilst analysing all age groups it observed that rural communities are increasingly older. Thus, it reviews salient aspects contained within the report pertaining to older adults.

Rural demographics

The patterns of settlement in demographic terms show that approximately, 23.5% of the population of rural areas is above 65 years of age as against 16.3% in urban centres. Key demographic facts:

- Largest population of older adults live in rural regions of Cumbria, Devon, Dorset Lincolnshire and Somerset
- Largest population of adults above 85 years live in the South, South-West and East Anglia.
- The rural to urban ratio of people above 45 years of age is 50%:40%
- Statistics for 2009/10 show net internal migration of people into rural areas as 54,000 and close to 75,000 people left urban centres.

These figures are important to local health authorities and healthcare providers as they help to shape policies and strategies for healthcare services in rural communities. The social demographic characteristics of people living in rural areas and positive migration into rural areas impact the composition of physical and mental health problems that are prevalent in these areas.

The report outlined socio-economic parameters that affect people's physical and mental health:

- Poverty – the ratio of the people living in poverty in rural vs urban areas is 15%:22%.
- House prices are higher in rural areas as compared to urban areas.
- Employment rates are higher in rural areas vs. urban areas. In 2015, 77% of people in rural areas were employed vs 73% in urban areas. However, due to the magnitude of

part-time or seasonal working in rural areas being greater, the incomes of people in rural communities is relatively lower.

- Rural residents spend more time travelling because they have limited access to public transport facilities.

Health risks in rural areas

The physical and mental health of people living in rural areas is better in comparison to urban population. However, as majority of rural population are older adults, and age being a significant static risk factor for many physical and mental health problems, the chances of developing problems such as cancers, strokes, coronary heart disease and dementias is higher in rural areas.

As per the report the key contributors to the rise of health risks in rural areas are:

- Older adults migrating into rural areas are much more than younger people.
- Poorer rural infrastructure results in higher cost of living for people and reduced access to public transport and health care services such as GP surgeries, community geriatric services (Dementia care and Community Mental Health Services etc.)
- The older adult may not be as technologically savvy as the youth. Lack of connectivity in terms of mobile access and internet connections in rural areas can cause digital exclusion.
- Growth in pollution level is resulting in lower air quality and respiratory conditions.
- Reduced numbers of social resources such as social groups, charities lead to lonely, isolated individuals as they are unable to meet as often.
- House prices are 26% higher on average in rural areas. Resultant, majority of people live in poor quality homes (poorly maintained, poor insulation, cost more to heat). These can be perpetuating factors leading to mental illness.
- High quality employment opportunities attract the youth to urban areas. Loss of the young population makes rural areas more skewed in favour of the older adults.

Health in rural communities

Research conducted by Department of Environment, Food, and Rural Affairs (Defra) in 2013 found many examples where, unavailability of resources led to unfulfilled healthcare needs. This was hidden due to many factors:

- Older adults, majority in rural areas, are not sufficiently vocal when it comes to demanding the necessary preventative health care services and benefits they are entitled to
- The report opined the absolute need being lower than the relative need for these services
- Older adults are reluctant to ask for help even when they are critically unwell as they have a culture of internal resilience. They can also be in denial that they are developing age-related mental and physical illnesses.

The report also states the following, showing the rural urban age gap:

- Urban population is 5.3 years younger
- The overall number of adults over the age of 85 will double in the next 20 years resulting in further increase in average age difference.
- Increased need for social and healthcare services in rural areas specifically sparse villages and hamlets
- Currently 27% of people living in such hamlets and villages are above 65 years (60% are over 45 years).

In rural hospitals, older adult patients have a longer duration of inpatient stay as several challenges exist while providing these people with safe and adequate community healthcare and social care. Poor public transport services leading to difficulty in getting to clinical appointments, understocked pharmacies with reduced access to people are some of the challenges highlighted by the report.

Access to health and related services

As per the report, 45% of households live more than 8km away from a hospital and 20% live 4km away from a GP surgery. In urban areas, these distances are experienced only by 2-3% of households. Distance is therefore inversely proportional to access to healthcare services ('distance decay'- a decreasing rate of service use with increasing distance from the source of health care).

Cuts made by local authorities and councils to important services such as public transport in rural areas, have made it burdensome for the older adults who are unable to use private transport means. This has resulted in a fall in the number of older adults reaching for clinical appointments etc. Cuts affecting other community facilities e.g. libraries, community/village halls have a negative effect on the older adults who may feel socially isolated.

Social isolation raises the risk of premature death by 30%. Poor physical health and disability raises the risk to develop mental illness. Social isolation itself can cause an increase in mental illnesses such as:

- Depression
- Organic brain pathologies such as dementia
- Act as a predisposing, precipitating and perpetuating factor leading to relapses in mental disorders such as late-onset schizophrenia, depression etc.
- Non-compliance with medications
- Maladaptive coping strategies being employed such as alcohol and illicit drug misuse.

What does this mean for Old Age Mental Health services in rural areas?

Mental health services will need to focus on:

- Widening access and coverage to the rural areas served
- Investing money and staff into the services being provided to the rural regions
- Providers and commissioners of mental healthcare need to appreciate the true demand that exists
- Rural communities need to be engaged in the process of the future planning of healthcare services and need to be provided with a stronger fabric of social care and support services
- Mobilisation and funding of local community projects and charities to help health and social care services to cope better

This report is recommended to those working in rural areas.

Reference

Local Government Association (2017) Health and wellbeing in rural areas.

http://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf

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

Philip Slack, Trainee Editor, ST4 Old Age Psychiatry (Royal Glamorgan Hospital)

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

Treatment Emergent Suicidal Ideation in depressed older adults

Pilar Cristancho, Brendan O'Connor, Eric J Lenze, Daniel M. Blumberger, Charles F Reynolds III, David Dixon and Benoit H. Mulsant. **Treatment Emergent Suicidal Ideation in depressed older adults.** *International Journal of Geriatric Psychiatry.* 2017, 32:6, 596-604.

An analysis of 233 older adult clinical trial participants with a major depression being treated with Venlafaxine to establish evidence of treatment emergent suicidal ideation (TESI). It was found that only 10% of older adults developed TESI during this study, that the onset was most likely in the first 4 weeks of treatment and that the severity of symptoms was mild (only 2.6% experienced severe or persisting TESI). Baseline characteristics such as multiple medical co-morbidities and higher severity of anxiety and depression were seen to increase the risk of TESI. It is also suggested that blood levels of Venlafaxine and side-effects experienced are not associated with onset of TESI.

Surrogate inaccuracy in predicting older adults' desire for life-sustaining interventions in the event of decisional incapacity: is it due in part to erroneous quality-of-life assessments?

Gina Bravo, Modou Sene and Marcel Arcand. **Surrogate inaccuracy in predicting older adults' desire for life-sustaining interventions in the event of decisional incapacity: is it due in part to erroneous quality-of-life assessments?** *International Psychogeriatrics.* 2017, 29:7, 1061-1068.

A study of the potential discrepancies between assessment of quality of life by older adults and carers and therefore the potential impact on making decisions in someone's best interests. 235 adults over the age of 70 were asked questions about their perceived quality of life and desire for interventions in varying health states including post-stroke and dementia. This was then compared to answers given by a surrogate or carer selected by the older person. Surrogates were found to overestimate older adults' perceived quality of life in these scenarios (however least so in dementia) and this was found to result in overestimation of the person's desire for interventions.

Apathy and impulsivity in frontotemporal lobar degeneration syndromes

CJ Lansdall, ITS Coyle-Gilchrist, PS Jones, P Vázquez Rodríguez, A Wilcox, E Wehmann, KM Dick, TW Robbins, JB Rowe. **Apathy and impulsivity in frontotemporal lobar degeneration syndromes.** *Brain.* 2017, 140:6, 1792-1807

A cross-sectional study of people with frontotemporal lobar degeneration to better understand the relationship between these symptoms and their impact upon patients and carers. There was found to be a positive correlation between apathy and impulsivity, rather than these two symptoms being seen as opposite ends of a spectrum. The presence of these symptoms was also common across types of frontotemporal degeneration rather than those specifying these symptoms in their diagnostic criteria. Patients generally showed less awareness of the cognitive and neural components of these symptoms compared with carers which is suggested to be linked with insight. Patients did show more awareness of the motor aspects of these symptoms.

Intraoperative ketamine for prevention of postoperative delirium or pain after major surgery in older adults: an international, multicentre, double-blind, randomised clinical trial

MS Avidan *et al.* **Intraoperative ketamine for prevention of postoperative delirium or pain after major surgery in older adults: an international, multicentre, double-blind, randomised clinical trial.** *The Lancet.* 2017 (online)

672 adults older than 60 were enrolled in this multicentre trial of the effectiveness of ketamine in preventing postoperative delirium. Sub-anaesthetic doses of ketamine were given during surgery as there is previous evidence that suggests ketamine can prevent delirium. Patients were followed up for the 3 days post-operation using the Confusion Assessment Method (acute onset with fluctuating course, inattentiveness, disorganised thinking, and altered level of consciousness). Although this study is awaiting final publication in *The Lancet*, early online publication shows that there was no reduction in delirium in these patients and actually an increase in some adverse events following surgery (hallucinations and nightmares).

Cochrane Corner July 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.

Diagnosis has been a focus of dementia healthcare particularly in the last 5 years following the launch of the 'Dementia Challenge' in 2012. The diagnosis rate is reported to have risen from an estimated 42% in 2010/11 to 67.7% in 2017 (<https://www.england.nhs.uk/publication/dementia-diagnosis-rate-workbook/>). Several rationales are given for promoting earlier diagnosis. It could allow for interventions which may be able to delay disease progression with its increasing cognitive and functional decline. Early diagnosis lets families plan for contingencies and, possibly, avoid or defer admission or placement with timely interventions. Identification of a 'pre-dementia' stage or prodrome would give the opportunity for targeted interventions to prevent conversion to clinical dementia. Mild Cognitive Impairment (MCI), defined by the Peterson criteria or revised criteria (Peterson 1999, 2004; Winbald 2004) or the Cognitive Dementia Rating (CDR) (Morris 1993), has been much investigated as a 'pre-dementia' syndrome, although studies indicate that, on average, only 5 to 15% of people convert to Alzheimer's disease annually. Recently, attempts have been made to improve the diagnostic accuracy of the prodromal phase of Alzheimer's disease by using biomarkers (Dubois 2014). In the new Cochrane Dementia and Cognitive Impairment Group (DCIG) review: 'CSF tau and the CSF tau/ABeta ratio for the diagnosis of Alzheimer's disease dementia and other dementias in people with mild cognitive impairment (MCI)' (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010803.pub2/full>), (Ritchie 2017), the authors assessed studies of the diagnostic accuracy of CSF t-tau (total tau), CSF p-tau (phosphorylated tau) and the ratios of CSF t-tau/ A Beta and CSF p-tau/Abeta in predicting those who would convert from an MCI syndrome to Alzheimer's disease or other dementia. They included studies which had a CSF test result for participants at baseline (the 'index test'), a period of follow up and subsequent assessment against a 'reference standard' which could be the NINCDS-ADRDA criteria, DSM III or IV and ICD definitions for dementia.

Fifteen studies with 1282 participants with MCI at baseline were identified as suitable for inclusion. Overall, the review authors considered reporting to be poor and that there were significant risks of bias in many of the studies. For example, different CSF biomarker level values were used as positive test results in the included studies and only 5 of the trials had specified in advance a cut-off level for the CSF markers. The other 8 studies used their own data to identify a threshold. This data-driven approach gives rise to a risk of bias in the direction of overestimating test accuracy.

The studies had a range of follow up times. The majority of participants were followed up for between 1 and 3 years after the index test.

The proportion of people who converted from MCI to Alzheimer's disease dementia ranged, in the studies, from 22% to 56% (median 37%). No studies specifically examined conversion from MCI to any other dementia.

The main feature of the results of this review was the wide range of sensitivities and specificities in the primary studies for all of the CSF tests. Formal assessment of the sources of this heterogeneity was not possible due to the small amount of data. The variety of test thresholds used meant that the authors decided not to generate summary sensitivities and specificities, but for t-tau and p-tau, they were able to generate summary ROC curves. They then used the median specificity as a basis for deriving estimates of sensitivity and likelihood ratios for illustrative purposes. For CSF t-tau, sensitivity for conversion of MCI to Alzheimer's disease dementia in 7 studies ranged from 51% to 90% and specificity from 48% to 88%. For CSF p-tau (6 studies) and the CSF p-tau / A-beta ratio (5 studies) the ranges of sensitivities was 40% to 100% and 80% to 96%, and the range of specificities 22% to 86% and 33% to 95% respectively. Using the median sensitivity and the median percentage converting to ADD from MCI across all studies (37%), the authors estimated that of 100 people with MCI tested with CSF t-tau, there would be 9 false negatives (tested negative, but converted to ADD; 'missed' cases) and 18 false positives (tested positive but did not develop ADD; 'overdiagnosed' cases). For CSF p-tau, the equivalent figures were 7 missed and 33 overdiagnosed. The authors emphasised that these estimates are not based on a known test threshold and were intended only to be illustrative of the data.

The conclusion of the review is that the diagnostic utility of CSF tau tests in patients with MCI remains uncertain. The data suggest that, in common with other biomarkers such as amyloid PET, these tests may be better at ruling out AD as a cause of MCI in the clinic rather than at ruling it in. The review authors believe that the new National Institute on Aging and Alzheimer Association criteria on MCI due to AD ([Albert 2011](#)) place more weight on these tests in identifying AD pathology than is justified. The studies included in the review were completed before 2013 so there may be important updates to this review in the future.

In 2017, we have a plethora of choices for the non-pharmacological treatment and management of dementia. Two new Cochrane DCIG reviews and one updated review on non-pharmacological interventions have been published recently, covering dance movement therapy (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011022.pub2/full>), music based interventions (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003477.pub3/full>) and

simulated presence therapy

(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011882.pub2/full>).

Dance movement therapy has its origins as a psychotherapeutic intervention. Dance therapists belong to professional, regulated bodies such as the Association for Dance Movement Psychotherapy UK (ADMP UK). It is defined as 'the psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration'. The review looked at dance interventions delivered by a dance movement therapy practitioner who (i) had received formal training (ii) was a dance movement therapist in training or (iii) was otherwise recognised as a dance movement therapist in the country in which the study was conducted. The search subjects included anyone with dementia, of any age and in any setting. Unfortunately, no RCTs were found which met the authors' criteria. So, for now, we do not have high quality evidence.

The review on music-based therapeutic interventions was a little broader, including but not limited to music therapy from a certified music therapist. The authors looked at studies where at least 5 sessions of treatment were provided. Music had to be the core of the therapy (rather than used in the background), there had to be a therapeutic objective and some personalisation or active participation. Simple participation, such as being in a choir, did not qualify. 17 RCTs, all in care home settings, were found to fit the criteria. The interventions ranged from the active (playing music, generating their own sounds or recording) to receptive (listening to personally devised programs of music). There was moderate-quality evidence that music therapy reduces depressive symptoms at the end of treatment (SMD -0.28 , 95% CI -0.48 to -0.07 ; 9 studies, 376 participants). There was lower quality evidence of little or no effect on emotional well-being and quality of life (standardized mean difference, SMD 0.32 , 95% CI -0.08 to 0.71 ; 6 studies, 181 participants), overall behaviour problems (SMD -0.20 , 95% CI -0.56 to 0.17 ; 6 studies, 209 participants) and cognition (SMD 0.21 , 95% CI -0.04 to 0.45 ; 6 studies, 257 participants). Agitation and aggression were not decreased (SMD -0.08 , 95% CI -0.29 to 0.14 ; 12 studies, 515 participants).

Simulated presence therapy (SPT), in which video or audiotape recordings of family members are played to the person with dementia was first investigated by Woods and Ashley (Woods 1995) and appeared to show a substantial reduction in behavioral problems. The review authors defined their intervention of interest as: "Audio or videotape recording that family members or caregivers have personalised, played to the person with dementia. The content of the recording should include positive experience from the participant's past life and shared memories involving family or close friends." 3 studies were identified, all in nursing homes. SPT in the studies varied in its content, frequency of administration and duration. The review was blighted by the overall very low quality (in

GRADE terms) of the evidence, which essentially precludes any conclusions. This is an intervention which appears superficially attractive and quite easy to implement, but there is no research out there to inform us reliably about its likely benefits or harms.

We have had a spotlight, via social media, on the latest Cochrane evidence, views on treatments and therapies for dementia and interventions for carers in July 2017. There have been some interesting blogs which can be found on Evidently Cochrane <http://www.evidentlycochrane.net/dementia-research/>. 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!

Are you interested in research? Do you have research ideas you want to share?

Then share your experience with NIHR.....

Research funded by the NIHR aims to make an immediate difference to outcomes for patients by plugging key evidence gaps undermining the decision making of patients, clinicians, allied healthcare professionals and service managers.

In order to identify the most important clinical uncertainties NIHR engages actively with patients, carers, clinicians, Royal Colleges, charities and other organisations whose work affects the health of the public. Sharmi Bhattacharyya sits on the NIHR Mental Health Advisory Panel and is gathering important topics for research from all members of the Old Age Faculty of the RCPsych. Please share your ideas with her drsharmib@gmail.com. As clinicians in daily contact with older people experiencing a range of mental health issues, your distilled experience around prescribing products, procedures or other approaches can be an invaluable guide in future funding.

When you share your topic/s with Sharmi, you need to be as specific as possible about which intervention needs more research evidence, and in which population the evidence is lacking. Please also indicate clearly the difference which new evidence could make to patients and clinicians or service managers.

Examples of NIHR research in Older Adults Mental Health

- Cognitive behavioural therapy-based intervention to reduce fear of falling in older people: therapy development and randomised controlled trial – the Strategies for Increasing Independence, Confidence and Energy (STRIDE) study

Health Technology Assessment Volume: 20, Issue:56, Published in August 2016

- The CASPER-PLUS Trial: Collaborative care for screen-positive elders with Major Depressive Disorder

Health Technology Assessment: Estimated publication date: 01 September 2017

You are also invited to join the NIHR community of reviewers and help evaluate and shape research suggestions, applications and publications in your area of expertise. Visit www.nihr.ac.uk/reviewing to register and find out more.

The active researchers amongst you might also like to know that the NIHR 2017 Theme is '*Complex health and care needs in older people*', and as we know mental health concerns are often a part of these complex pictures. Proposals are being sought for research studies into the evaluation of healthcare interventions, health services, social care or public health measures for older people with complex health and care needs.

All relevant applications are welcomed, particularly those addressing the key themes identified at the stakeholder workshop:

- Frailty,
- Transitions in care, service delivery and models of care,
- Medicines management/polypharmacy,
- Promoting healthy ageing/preventing ill health,
- Patient-centred decision making.

For more information please visit the NIHR website at www.nihr.ac.uk/themedcalls

Book Review: *Himmler's Cook*

By Franz Oliver Giesbert (translated from French by Anthea Bell)

ISBN 9781782394143, Atlantic Books; Main edition (7 April 2016)

Review by Dr Anitha Howard, Consultant Psychiatrist, Bensham Hospital, Gateshead.

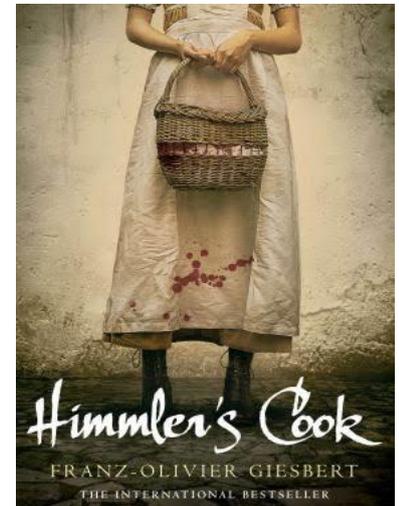
A medical student once asked me, in the middle of a busy outpatient clinic, why Psychiatrists still bothered to take a personal history in older people. This book reminds why we do.

Rose, 104, is a survivor. She has lived through the Armenian genocide, lost her husband and children to the concentration and survived the Nazi occupation by becoming Himmler's cook. She now lives a quiet life running a restaurant in Marseilles occasionally taking to the streets as a gun trotting vigilante.

This book is another addition to the growing genre challenging our views of older people and a tribute to the great generation who survived two world wars - a generation now dying out and with them a large part of our history.

The book's relevance to psychiatry lies in Rose's 'resilience' coping and managing stressful life events. Also, how significant life events from the past can present as problems in the present even though the event may have occurred half a century ago and highlighting the importance of a good personal history no matter how old your patient is.

If you can suspend your disbelief, that a frail lady well past a 100 year can hunt down petty criminals down the streets of Marseilles, this is a riveting read. It is also a reminder that life is precious at any age and in Rose's own words "I know that my lips will always go on moving, even when they are mingled with the earth, that they will go on saying yes to life - yes, yes, yes".¹



References

1. Himmler's Cook, Franz-Olivier Giesbert.

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.