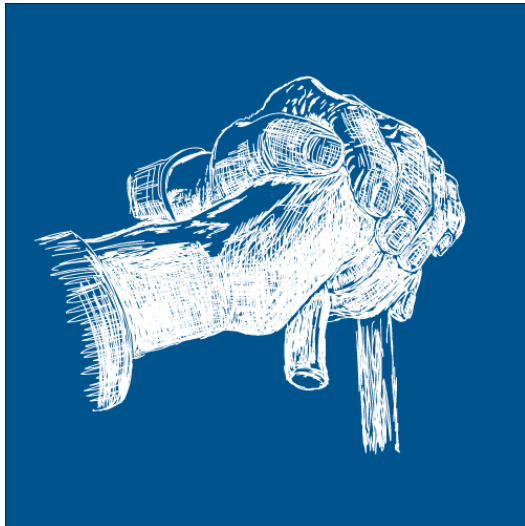




The Old Age Psychiatrist

Issue 83, May 2022

Old Age Psychiatry Faculty
Newsletter



The Old Age Psychiatrist

Issue 83, May
2022

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Update from the Editorial Team

by

Sharmi Bhattacharyya

Editor, The Old Age Psychiatrist, Royal College of Psychiatrists

drsharmib@gmail.com

Hope you are all keeping safe and well. The May 2022 newsletter has arrived and as always has a variety of updates and articles and hope you enjoy reading them. The Faculty conference in March 2022 was a huge success however hoping next time we could all meet and network in person.

In this edition the Chair's report highlights all the current relevant issues.

The update by Dr Amanda Thompsell, the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement and Prof Alistair Burns *May a thousand flowers growA time to consider what is new in the Garden* provides an interesting and informative update.

This edition contains the essays of the winner and runners up for the Newsletter essay competition, the title was *The Media: Friend or Foe to Old Age Psychiatry* – this was very well coordinated by our trainee Editor. All the essays submitted were of a very high quality and we are very grateful to our judges for taking the time to read and judge the entries. Similarly, the medical student essays are also of very high quality and interesting to read.

This edition contains our usual Cochrane corner and research update and has an important update on the curriculum by Dr Alex Bailey. If you are interested in legal aspects there is an article on Supreme Court ruling on sexual consent and its relevance to our discipline.

Our book and film reviews as always provide food for thought.

We are advertising for our new trainee Editor from September 2022. Catrin has been an excellent trainee Editor and interested applicants may wish to contact her to see what the role entails. The last date for application is 15th June 2022.

The next newsletter is September 2022 so the last date for submission of articles is 31st July 2021.

As always let us know what you think of the newsletter, and feel free to email me on drsharmib@gmail.com with ideas, suggestions and of course articles for the future newsletter.



Trainee Editor Vacancy



Would you like to become the next Trainee Editor for The Old Age Psychiatrist, the official newsletter of RCPsych's Old Age Faculty?

We're looking for an enthusiastic, creative and organised trainee with experience of Old Age Psychiatry to join the team **from September 2022**. Being the Trainee Editor is a great way to develop your leadership and publication skills as well as having opportunities to get involved with the RCPsych Old Age Faculty.

To apply, please send your CV and a brief description of why you want to apply for the role to our Editor, Dr Sharmi Bhattacharyya at drsharmib@gmail.com. To find out more information about the role please feel free to contact the current Trainee Editor, Dr Catrin Thomas at catrin.thomas@doctors.org.uk.

The closing date for application is the **15th June 2022**.

View from the Chair

by

Dr M S Krishnan (Krish)



Dear colleagues

Since I wrote in January, we have had a very successful faculty annual conference in March.

Thanks to our outgoing Academic Secretary Mohan and the conference subgroup from the faculty who had put up an amazing program. We announced various prizes at the conference including awarding lifetime achievement award to Prof Peter Connelly. Congratulations to all the winners.

We continue to tackle pressure of workload and waiting lists and as clinical leaders we have seen a very tired and exhausted workforce. Please signpost colleagues about this service. This is a free, confidential, and rapid peer support via telephone for colleagues.

<https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service>

Our faculty election results were out on 21 April. We are joined by 9 new executive committee members I congratulate them on winning the election and welcome them to our dynamic exec team. Dr Mohan Bhat was elected as our new Finance Officer. All will take up their role from June 2022 after the college AGM.

Our Vice Chair Josie collaborated with our Liaison faculty is leading a second informal network webinar on 28 April. The last one was a true interprofessional educational event. The recording is available for those who could not attend.

Josie and I attended our faculty conference from our college building and after 2 years we met with few college staff including our amazing faculty manager Kitti.

On 8th of September our faculty will collaborate with Northern and Yorkshire division to host one of the Dean's Grand rounds. Details will be shared in due course. We will also be hosting a half day digitization webinar in December. The College events team is gearing up to host hybrid conferences at the college building. We are hoping that our next faculty conference be face to face.

I was privileged to attend the launch of the Public Mental Health Implementation Centre. [Public Mental Health Implementation Centre \(PMHIC\) | Royal College of Psychiatrists \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/public-mental-health-implementation-centre)

I am looking forward to meeting our exec member face to face at our November committee meeting after over 2 years.

Please continue to engage with our faculty twitter page @RcpsychOldAge.

Krish

Chair of the Faculty of Old Age Psychiatry
@deliriumkrish



May a thousand flowers grow...

A time to consider what is new in the Garden

by

Professor Alistair Burns, alistair.burns@manchester.ac.uk

&

Dr Amanda Thompsell, Amanda.thompsell@nhs.net

As Winter blossoms into Spring and Spring into Summer, we take from the world of horticulture the theme of growth.

As I am sure you are all aware we are eagerly awaiting the new National Dementia Strategy being worked on by the Department of Health and Social Care. In the expectation of a more dementia focus to the next newsletter update we have decided to focus this article on issues of particular relevance to older adults' mental health

The Garden path

Specialist community pathways are being developed at pace. Pathways for those with complex emotional needs and for eating disorders are particularly receiving attention at present.

To support local services in planning for this FPOP and the Faculty have developed a list of suggestions of key points to consider to ensure that services developed locally for people with complex emotional needs can meet the needs of older adults: <https://future.nhs.uk/AdultMH/view?objectID=23985744>.

We are also looking at developing a similar document for eating disorder services.

Erased beds

Virtual frailty wards are being developed in every local Integrated care system with an initial focus being on older adults.

The definition of a virtual ward is that of a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards will support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital, or supporting early discharge out of hospital.

The virtual ward is not however a mechanism intended for enhanced primary care programmes; long-term condition management; intermediate or day care; safety netting; proactive deterioration prevention; or social care for medically fit patients for discharge. *There is more information about virtual wards later on in the newsletter.*

This framework [Frailty Virtual Wards \(england.nhs.uk\)](https://www.england.nhs.uk/frailty-virtual-wards/) was published late January 2022 and aimed to use **care homes** to support those (predominately older people) who could recover/ receive rehabilitation or reablement support instead of residing in a hospital bed. It is envisioned that these would be 10 or so bedded units and that NHS staff (therapists, GPs etc) could then wrap their support in a concentrated way around these units. The stay would be for around 4 weeks. The clear outcome in mind for the patient would be to discharge them home with little or no onward reablement support needs. Care home providers and local health and care systems were told that should plan for these care units to be sustainable and flourish beyond the immediate winter period.

I am not sure how much your local systems have proceeded with commissioning new services of this type, but in my opinion, it is likely to stay.

Share cropping - making shared outcome measures work

At long last there is an agreement on the outcome measures that will be used to evaluate the impact from the investment in the community mental health transformation.

These are:

- REQoI 10 (10 questions)
- Goal based outcomes (3 questions) and

- DIALOG (11 questions).

DIALOG [DIALOG Scale | East London NHS Foundation Trust \(elft.nhs.uk\)](https://elft.nhs.uk) is used in particular when evaluating the development of **personalised care plans**. This tool asks the patient about their satisfaction with different aspects of their life.

DIALOG includes many areas that old age psychiatrists routinely ask about such as physical and mental health, accommodation, leisure, job/finances, relationships, friendship, personal safety, medication along with the practical health they receive and the meetings with the mental health professional.

It has however been acknowledged that DIALOG has not been optimised for, nor used widely with, older adults (although it has been extensively studied for use with working age adults). The National Team are talking to the developers in relation to this.

Digitalis obscura

Digital transformation is expanding at a pace.

As far back as 2018, the report *"Future of Healthcare: Our Vision for Digital, Data and Technology in Health and Care"* recognised that *"the potential of cutting-edge technologies to support preventative, predictive and personalised care is huge"*. This was then followed by a clear vision in the NHS Long Term Plan for a "digital-first" approach: *"People will be empowered, and their experience of health and care will be transformed, by the ability to access, manage and contribute to digital tools, information and services."* (Page 93)

The planned merger of NHSX and NHS Digital with NHSE&I has led to an even greater focus on digital delivery, and this focus applies as much to mental health as to other disciplines.

Currently a Digital Mental Health Strategic Delivery Plan is being developed. This deals with far more than the traditional concerns regarding connectivity, equipment and equipment interoperability and ensuring digital inclusion (a potential particular concern with older adults). This is also about developing the skills of the workforce and working with others to develop supportive

apps/immersive virtual reality tools to deliver quality care to patients and provide training.

To help colleagues with development of any new digital solutions NHS Digital has developed a very useful service manual which you can find at [NHS digital service manual \(service-manual.nhs.uk\)](https://www.nhs.uk/service-manual/).

The key messages around the development of apps/immersive therapies being that to develop a useful tool the programmers need to fully understand the brief and that is why it is so important that clinicians and experts by experience are involved from the outset. This is an exciting area that is developing fast and is likely to become the focus of further research and funding. It will increasingly affect our practice.

Levelling the field

Quite rightly addressing inequalities is at the heart of the long term plan.

The Core20 PLUS5 national approach to reduce health inequalities has become a key planning tool. It is worthwhile taking a minute to understand how this operates.

The approach defines a target population cohort – the 'Core20PLUS'. The Core 20 is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (**IMD**).

The IMD has seven domains with indicators. These account for a wide range of social determinants of health.

The PLUS refers to population groups experiencing poorer than average health access, experience and/or outcomes, which are not captured in the 'Core20' alone. These groups are based on population health data in the Integrated Care System (**ICS**). These PLUS groups covers a broad category of needs including some cohorts that might be of particular relevance to old age psychiatry such as people with multi-morbidities and protected characteristic groups. The five clinical areas of focus include one of ensuring annual health checks for 60% of those living with serious mental illness (bringing SMI in line with the success seen in learning disabilities). Here is the link to the infographic [CORE20PLUS5 A4 \(england.nhs.uk\)](https://www.england.nhs.uk/core20plus5-a4/).

A resource developed to support this is the Equality Evidence repository. This provides links to key evidence sources for assessing equality issues across the nine protected characteristics of the Equality Act. One section of this relates to the protected characteristic of age and can be found at this link: [Age - Equality and Health Inequalities Network - FutureNHS Collaboration Platform](#).

What about the workers?

Any garden is only as good as its gardening staff. As regards staff in the NHS the older adult team at NHSE&I has just completed a survey across all staff groups (physical and mental health staff) asking how confident staff felt on the topics listed as the chapter titles within the HEE core competencies.

We have had over 900 + responses and we are now looking at what training the workforce is wanting and how as a National Team we can support services in providing this training. This is very much in its embryonic stage but I hope to have more to say about this next time.

Should you want to do a similar survey locally and would like the word document then you will find it on the Futures page:

<https://future.nhs.uk/AdultMH/view?objectId=34332912>.

Growing together

Just as laying a hedge requires getting different plants to merge, there is a continued focus on integrating health and care services including workforce and finances as the way to improve health and care outcomes

The latest White Paper "[Health and social care integration: joining up care for people, places and populations](#) - " came out in early February 2022. This is part of a wider set of mutually reinforcing reforms set out in the Adult Social Care Reform White Paper and the Health and Care Bill and indeed forms part of the levelling up agenda.

Successful integration is seen as the planning, commissioning and delivery of coordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Interestingly the chapter subject headings in the most recent white

paper mentions outcomes, digital and workforce. If you are getting a sense of déjà vu you read about these topics earlier on in this article.

Final thoughts

As always, any feedback or comments, please let us know.

Goodbye, and to channel Bob Flowerdew "good gardening".

The Old Age Psychiatrist Newsletter Essay Competition 2022

by

Dr Catrin Thomas, Trainee Editor, RCPsych Old Age Faculty Newsletter.
ST5 in Old Age Psychiatry, Betsi Cadwaladr University Health Board.

The title of this year's competition was *The Media: Friend or Foe to Old Age Psychiatry*. Entrants were asked to write about their thoughts and opinions on the media's influence within old age psychiatry including the media's portrayal of older people and their mental health needs, and the media's impact on older people and old age psychiatrists. We are pleased to say that we had a fantastic variety of entries including essays, short stories and poems.

We would like to thank our three wonderful judges for their time and thoughtful reflections. Our judges were: **Professor Wendy Burn CBE**, Consultant Old Age Psychiatrist and former President of the RCPsych (2017-2020); **Dr Carmelo Aquilina**, Consultant Old Age Psychiatrist in Australia and founder and original editor of this newsletter; and **Dr Tony Rao**, Consultant Old Age Psychiatrist and international expert on alcohol misuse and dual diagnosis in older people. The judges noted that all entries were of a high standard and were highly commended. As such, we have decided to print the top 5 entries in this edition of the newsletter and I'm sure you will all enjoy reading them as much as we did.

Congratulations to the competition winner **Dr Ayesha Bangash**, Consultant Old Age Psychiatrist; and runner up **Dr George Hawker-Bond**, Academic Foundation Doctor.

Competition Winner

The Media: Friend or Foe to Old Age Psychiatry?

by

Dr Ayesha Bangash, Consultant Old Age Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust.

The term media commonly refers to communication outlets used to deliver information such as the radio, newspapers, television, and the internet. It can be used to increase knowledge, create favourable attitudes, and change behaviours.¹ Does it affect the mental health of older people? Furthermore, what impact does it have on old age psychiatry?

How the media portrays older people and their mental health needs

Social media demonstrates a tendency to devalue older individuals however the Covid-19 pandemic has sparked a proliferation of negative comments. The news suggested that they are unworthy of adequate medical care.² The pandemic triggered a relapse in symptoms of people whose mental health had been stable for decades. Many older people had to increase their medications.³ Older people undergoing self-isolation experienced depression, neurocognitive problems and anxiety.⁴ The NHS Mental Health Implementation Plan 2019/20 – 2023/24 refers to health inequalities experienced by older people and states that services will address this through an integrated approach focused on the person's identified care and support needs across mental and physical health.⁵

Counter to expectation, the media also suggested that older adults showed more resilience, less stress reactivity and better emotional regulation during the pandemic. Resilience may reflect an interaction among internal factors (eg, cognitive capacity, personality traits) and external resources (eg, social status, financial stability). Reports indicated that, although loneliness increased during the pandemic, mental health levels remained unchanged.⁶

What is the media's direct impact on older people's mental health?

Research shows that negative age statements on social media can cause depression.⁷ They can predict older individuals' levels of anxiety up to four years later.² Facebook and Twitter present accessible and low-cost mechanisms to

enhance social connection, and therefore life quality, at older ages.⁸ While they do not replace the physical contact of holding hands, when physical location or a pandemic are barriers, such platforms can offer relief and a sense of connectedness.⁴ The frequency of supportive interactions with others is protective of the onset of dementia and cognitive impairment.⁸ Social media use can lower the risk of depression in cases where social interaction has been inhibited by pain.⁹ Social media has made it convenient to obtain health knowledge thus improving one's health literacy.¹⁰ The NHS has worked with Google and Twitter to counter misinformation about Covid-19.¹¹

Does the media influence our practice in old age psychiatry?

COVID-19 catalyzed the previously reluctant movement of healthcare to telepsychiatry which includes psychiatric evaluation and psychoeducation.¹² Clinicians began to rely on the media for their education, training and support in running community and inpatient services. Using technology has saved clinicians' time and improved productivity.¹¹ The Royal College of Psychiatrists (RCPsych) has produced online resources ranging from staff wellbeing and support to guidance on the Community Mental Health Framework. It has also arranged free educational webinars and virtual conferences. Various NHS Trusts and social care have made use of the FutureNHS Collaboration Platform OPMH services to share their learning.¹³ A JISCmail email distribution list was set up for RCPsych members and allied professionals for a similar purpose.¹⁴

Should we do more to utilise the power of the media as a tool for change and education?

Editors of social media should be made aware of the adverse consequences that it can have for older individuals as well as the importance of positive framing of information.² Clinicians should guard themselves from spreading pessimistic attitudes about older people and could stress more on old age being linked to wisdom, experience, and respect.⁷ The use of social media by older people, though increasing, is still limited.¹⁵ Clinicians should address any barriers to the use of social media.¹⁶ When professionals interact with the media, they should debunk myths and instruct older people on how to avail services when in need. Educational videos and newspaper articles written by professionals need to get dispensed more through mainstream channels utilised by the public.¹

Through videoconferencing, we have been able to reduce delays in care and improve continuity of care.¹² Since the start of the pandemic, clinicians have had to adapt their ways of working and, for better or worse, some of these are here to stay for the foreseeable future.¹³ The hybrid way of working has become popular as it ensures better work life balance.¹⁷

No matter how advanced new technologies become, they will never live up to face-to-face interactions in our ability to build a rapport with others.¹³ The fast pace at which technology was introduced means that steps including evaluation and co-design with patients will necessarily have been shortcut. There is still a need for services to continuously adapt to unpredictable pandemic demands. As we emerge from the pandemic, the NHS must evaluate and improve technology-based approaches before locking them in for the future.¹⁸ Research suggests that while remote options offer a convenient service for patients, a 'blended offer', which incorporates remote alternatives while focusing on the individual's needs and circumstances, will be needed. Increasing use of digital health tools might exacerbate health inequalities if people cannot use digital alternatives.¹¹

The functions of social technologies include cognitive processes such as recollecting and reminiscing. How social technologies may shape cognitive processing needs further research. Studies should examine whether ongoing support for older people might be helpful in sustaining higher levels of social media use, once training on the use of social technologies has concluded, and which type of support might prove optimal.⁸ Studying the influences of different internet use behaviours in older adults can tell us what kind of internet activities should be encouraged in later life.¹⁰

Conclusion

We need to find ways of optimizing the role of media in society. It can be an important non-pharmacological intervention to ensure wellbeing. In the field of old age psychiatry, the media has shown its advantages and drawbacks. It is crucial for professionals to be mindful of any negative impact of media on society and endeavour to create positive outcomes instead. Working on the positive public image of psychogeriatrics in a unified manner is vital for the future of the specialty.

References available on request.

Competition runner up

The Media: Friend of Foe to Old Age Psychiatry

by

Dr George Hawker-Bond, Academic Foundation Doctor, Oxford University
Clinical Academic Graduate School

It is difficult, if not impossible, to discuss any current topic without the contextual backdrop of the COVID-19 pandemic; as expected from a seismic shift in the social paradigm. Millions in the UK tuned in to daily government television briefings as their source of information for the pandemic. Scattered through the death tolls, line graphs and r-values were reminders to look after ourselves and each other; both physically and mentally. Older people were much more likely to be hospitalised by COVID-19 at the beginning of the pandemic compared to the rest of the population.¹ This was epitomised by then Health Secretary Matt Hancock stating on BBC Radio, 'Don't kill your gran', to encourage younger people to comply with social distancing guidelines in September 2020.²

This messaging is not only provocative, but has been shown to have a negative affect on the mental health of older people. Yale's School of Public Health conducted, what is believed to be, the first experimentally demonstrable affect on mental wellbeing through the reporting of statistical data and personified reports.³ Negatively-stereotyped media messages (i.e. death rates in older people) led to older people experiencing more anxiety, where as positively-stereotyped message (i.e. survival rates in older people) led to older people experiencing less anxiety. Interestingly, this same affect of negative-age-stereotyping media message is not seen in younger people. This should prompt further discussion into how messaging is disseminated in traditional media formats to ensure accurate and safe reporting of information whilst limiting institutional ageism.

Nevertheless, the change in the basic functioning of society has shown the potential uses for media and technology to have near-infinite capability: from video conferencing software to the weekly shop; and home workouts to book clubs. At the core of these advents was bringing about a sense of familiarity and

togetherness in a bid to bolster mental wellbeing. However, there is a need for prerequisite technology literacy. Naturally, this has the propensity to isolate a significant number of patient groups; those in rural areas with poor internet access, low-income households, and the elderly to name a few. Older people can be, and are in fact more likely to be, part of a number of these groups.⁴ Internet usage in older people has conflicting information on its' benefits in improving mental wellbeing. A recent longitudinal study has shown that regular internet usage was predictive of a better life satisfaction, particularly if used for communication.⁵ On the other hand, simply using the internet for information gathering decreased life satisfaction. This distinctly shows the need for media to be both for communication and information.⁵ Similarly, there have been enormous advances in technology to support older people's physical health. Apple's smart watches include basic ECG functions to detect atrial fibrillation, and even gait analysis to predict the likelihood of a fall.⁶ However, this information requires sharing to be useful. Studies have suggested that families sharing health data via remote recording introduces a power dynamic that has the potential to significantly reduce the autonomy of older people who could otherwise be making decisions about their healthcare and wider needs.⁷ Myriad evidence recognises perceived autonomy to improve wellbeing in all population groups, and in particular, vulnerable populations.⁸ Even so, there is a limited evidence pool to determine if this perceived encroachment by health technology from smart devices has on older people has affects on their mental health. Again, it appears as though the intention of being able to support older people in a digital world has the correct intentions but does not fully consider the wider implications of its usage. Paradoxically, these messages of improving mental wellbeing; digital health information; and internet provision; have the potential to isolate those who were most affected.

That said, there are great efforts of the wider use of media to have a therapeutic impact in older people's mental health. One example is music therapy in dementia. An initial narrative synthesis of the evidence in 2012 highlighted that music therapy has the potential to improve psychological, physiological and social wellbeing.⁹ 10 years later, there still has been little high-quality evidence to elucidate a mechanism by which music benefit. Meta-analysis data now suggest that whilst music therapy has short-term benefit in cognitive function and quality of life, there is no benefit after 6 months.¹⁰ Clinical trials that aim to

establish efficacy, mechanism and protocols for music therapy in depression and dementia are in progress (NCT03496675). Unlike most therapies in medicine, music does not increase pharmaceutical burden, has no known side-effects, and doesn't necessitate a physical or cognitive requirement.

In summary, there is enormous potential for media to have a positive impact on the mental wellbeing of older people; yet, this can easily be negated if not utilised properly. More needs to be done to advocate for older people in a time where a radical digital shift has been precipitated by the COVID-19 pandemic. However, media can also be used as a therapeutic tool that can be easily incorporated into the lives of older people, should that potential exist. Media's influence on daily life is significant; and old age psychiatry is not excluded from this. The relationship between the two is complicated, multifaceted and evolving.

References available on request.

Commended Competition Entry 1

The Media: Friend of Foe to Old Age Psychiatry

by

Dr Naomi Tomlinson, CT3 in Psychiatry, South London and Maudsley NHS Foundation Trust

"Ah Major Tom!" exclaims a mother, the English phrase standing out starkly from the flow of Spanish directed at her young children. My own mum catches my eye and we smile. We're all stood, me, my mum, my partner, his mum and the Spanish family, around a statue of an elderly man, saluting a thumbs-up with one triumphant hand and holding onto his zimmer with the other. Captain Tom¹.

We're taking our mums on a day-out around the Royal Academy Summer Exhibition. This is the second Captain Tom² we've crowded in front of, demonstrating the power of his image throughout the pandemic. When the country felt suddenly too aware of its own fragility, Captain Tom captured the public imagination, giving us a bright image of all the things we admire about old age. Independent, stoic and kindly, he was the heart-warming story at the end of the news and then, as the press caught on to the power of his image, he was the news. "An inspiration" my mum concludes. My boyfriend's mother, stood in a mirror imagine with her own zimmer frame nods, "and handsome when he was younger."

"Here now," my mum leads us through the busy room "we need to see the Tracey Emin, in case we don't get all the way round."

There are four pictures, the titles all beginning with "mother." We all look at them in silence. Scrawling line drawings, full of frenetic energy. They form a woman, contorted on a bed; "Mother – a time of confusion³." The next shows two shadowy forms standing over the bed, the woman fallen still - "Mother – we always knew you⁴." "It looks like the morgue" I whisper to my partner, also a doctor. "Looks like the dementia ward" he sighs. "Exactly!" say the mums. "How horrible, how revolting." There's an uneasy silence, until the attention is drawn off by a pair of shoes made out of tunic teacake wrappers.

I'm still thinking about it the next day. 'Something quite off-putting about those dementia pictures wasn't there, love?' texts my mum. I google Tracey Emin, somehow surprised to read her mother died of bladder cancer, throwing a different narrative onto the drawings. Why did we all assume it was dementia? Something in the tortured, scratchy lines, evoked an uncomfortable feeling of a person breaking down, of something undignified you wanted to avert your eyes from. As an aspiring Old Age Psychiatrist, my reaction bothered me. Despite all the fantastic experiences of working in the specialty - with inspiring colleagues, wonderful and interesting patients and a myriad of success stories - dementia clearly evoked this uncomfortable feeling in me. So what did it evoke in my Mum, the wider public, patients and carers?

Alzheimer's disease and cancer frequently rank as the most feared diseases in polls, but the rhetoric behind them in the media is different. We "Stand Up To Cancer" but we sink slowly into senility. Of course, some of this may be powered by the natural history and current available treatments for the two disorders. Certainly, the hyperbole around the promised "wonder drug" aducanumab this year reminded us that the media narrative might be different in the future. At the moment though, what the media does is to pick out opposing archetypes of old age and solidify which ones to value, and which to push away.

Positive images are often filtered through the eyes of the younger consumer, representing someone who is young-at-heart, *refusing* to age. They might be dancing on their granddaughter's Tik-Tok. What an absolute legend! I'm going to be like that when I'm old! Or perhaps they portray a blissful retirement, something for those in their middle age to aspire to and invest in. They go on cycling holidays in the French riviera and smile with radiantly white teeth from adverts for life insurance. Seventy is the new forty! You're only as old as you feel!

Others, typified by Captain Tom or even Queen Elizabeth, are depicted positively for qualities more associated with old age. They maintain their independence and dignity. They have bright minds, swept clean by a daily routine. Stoic, rarely sad, angry or scared and certainly in possession of all their faculties.

What these narratives have in common, most importantly, is that the people they depict are never a burden. Because the insidious narrative around mental health difficulties in later life is that they make you a burden.

When we hear individual stories about dementia, the sufferer themselves is often not given a voice. We see through the eyes of the carer, highlighting the pain, the exhaustion and the financial strain. These narratives are hugely important, drawing vital attention to the need for carers support on a social, economic and political stage. They are told with love and admirable selflessness. However, I have seen how the narrative of a devoted carer can also breed guilt. The fear of those developing dementia that they will force their loved ones to give up their lives completely. And, from the other side, I've spoken to many tearful relatives, eaten up by a feeling of inadequacy and shame that they cannot provide unconditional around-the-clock care for a family member, feeling that to do anything else would be to "dump" the parent who once cared for them.

I look to our mums, both of whom would fall under an Old Age team if they need support. What media messages could help them feel more hopeful or supported? One day soon, stories of new disease modifying agents might do the heavy work for us. But in the meantime, more nuanced representations of older people, told in their own words, could help us escape the two-dimensional pictures we often have of old age. Furthermore, honest representations of care - showing how the NHS, social care and third sector can help - might start to dissolve some tensions and guilt around providing care and being cared for.



1. "Captain Sir Tom Moore"
Richard Mossman, sculpture in bronze and slate



2. "In memory of Captain Tom Moore"
Charlotte Walton, drawing in pencil



3. "Mother 2; a time of confusion"
Tracey Emin, print of india ink hand
painting on lithograph



4. "Mother 6 - We always knew you"
Tracey Emin, print of india ink hand
painting on lithograph

References available on request.

Commended Competition Entry 2

The Media: Friend of Foe to Old Age Psychiatry

by

Dr Thomas McConnell, ST4 Older Adult Psychiatry, Lancashire and South Cumbria Foundation Trust.

Into the 'metaverse'

The world is changing all about us and all about our patients too. The traditional media of papers, TV and radio are in persistent and seemingly irrevocable decline and in their place the bright new star of social media is rising¹. The participatory and user generated appeal is clear with 49% of UK adults using it to access news in 2021². Social media platforms have not proved oblivious to this shift into the online world and companies are investing heavily in creating the so called 'metaverse'^{3,4}. The core technologies of the metaverse are 'Augmented Reality' (AR) where users experience simulated additions to a real environment and 'Virtual Reality' (VR) where an entire simulated world is created. Essentially; the metaverse is social media experienced in a virtual or semi-virtual world.

The idea of a life lived in a virtual environment is by no means new. Since the term was first coined three decades ago⁵ there have been various attempts to create a metaverse⁶ and augmented reality worlds⁷ with mixed levels of success. However, the large injections of cash reflect a situation where the technology is at an inflection point. The cost of AR/VR technology has dropped while the computational ability has increased to a point where mass adoption of a metaverse is possible. There can be little doubt that when we talk about the 'The Media' in the future it will be in that expanded metaverse sense.

Uses of metaverse technologies

The relevance of a metaverse for ourselves and our patients in old age psychiatry is perhaps most acute in relation to dementia. Some applications are obvious, others less so. An immediate advantage of metaverse technologies is in assessing cognition where it can create immersive and naturalistic environments to explore cognitive deficits. Several studies have demonstrated the usability of

this increased ecological validity in assessing spatial navigation⁸, episodic memory^{9,10,11} and executive function¹². For example Ouellet and colleagues created an entire virtual shop and found the time taken to complete an object-finding task correlated well with other standard measures of cognition¹³. In a similar vein, Sauz on and colleagues constructed a virtual city which participants navigated around and were asked to recall the place, time and details of programmed 'incidents' that occurred on their travels¹⁴. The possibility for early detection of cognitive difficulties could be enormous, especially when the scope and fidelity of information that Facebook plans to collect are considered^{15,16}.

The use of metaverse technologies as part of interventions has shown promising results. Several studies have explored the use of VR to improve wellbeing for people with dementia. For instance Moyle and colleagues found that spending time in an immersive 'virtual forest' increased alertness and was pleasurable for older adults with dementia in residential care¹⁷. Studies exploring VR for environmental enrichment in older adults have found improvements in apathy¹⁸, depression¹⁹, mental wellbeing and stabilisation of cognitive decline in Mild Cognitive Impairment²⁰. Relatively less work has been undertaken on AR/VR for cognitive training. Although not specifically in relation to dementia, Cho and colleagues demonstrated utility in cognitive training post stroke for both abstract measures and functioning²¹. Other results so far have been more mixed²².

Beyond these uses there may be huge opportunities to more directly compensate for cognitive deficits. Where a dementia syndrome has robbed a person of their ability to recognise friends and loved ones through prosopagnosia, AR glasses combined with facial recognition software could provide prompts²³. Difficulties with sequencing tasks could be overcome in a similar way with machine learning detecting stages of a task and prompting the user²⁴. More simply, the ability to access specialist services in high fidelity virtual environments could give all patients access to the most appropriate specialists and support wherever they are^{25,26}. As the barriers to socialising and spending time with others are reduced by these technologies, inclusion could increase.

Research into the nascent field of AR/VR in dementia shows technologies which, although far from ready for mass adoption, have clearly enormous potential. With the huge push towards creating a metaverse these could rapidly become much more available and useful.

Risks in the metaverse

There are of course risks associated with all these possibilities. The first is whether people with dementia will be able to access a metaverse in the first place. Accessible features in the digital domain are often slow to arrive, function poorly or are just forever delayed^{27,28}. This may leave people with dementia permanently excluded from an important and valuable new technology. But even with access there may still be risks. The first is that a clear pattern has emerged that new technologies often repeat, amplify and entrench pre-existing prejudices²⁹. Conscious thought and advocacy are likely to be needed to avoid repeating these same mistakes in the metaverse. Secondly, safeguards will be needed on this digital frontier. This environment could prove ripe for exploitation; something of which people with dementia are already at higher risk³⁰.

A call to action

And in all this we must ask, what is our role as old age psychiatrists? Based on the current state of the technology and our responsibilities to advocate on behalf of our patients it seems clear that we have much to do. Firstly, in advocating for technologies which are, by design, accessible to people with dementia. A faculty position statement might do much to highlight this need. Secondly, supporting innovative research in this area through grants and collaboration. Lastly, using the colleges influence at a national level to highlight the need for appropriate safeguards to protect those vulnerable to exploitation.

So, friend or foe? Ally or enemy? Perhaps at this stage the fledgling new social media metaverse is neither, and we must play our part in ensuring when new worlds are built, they are more useful, more accessible and safer for our patients.

References available on request.

Commended Competition Entry 3

Poisonous antidote

by

Thoqeer Hussain, Medical Student, University of Leicester

“Unfortunately, Mr. Smith, I believe you are showing signs of Dementia. We will be referring you to see a psychiatrist.”

Mr Smith:

So, I'll be imprisoned in my own mind?
Experience of which, I have accrued
I suffered social distancing before the pandemic
Loneliness, not solitude

What if I start to wander?
Like a zombie in a trance
Will I remember who I am?
How quickly will this advance?

Daughter:

I love my father dearly
But with shame, I must confess
I cannot tolerate his absent presence
His aggression will give me stress

And now they want to discard him
To the deranged and malevolent
Will they incarcerate and shock him
Until his cries are resonant?

Doctor:

I can tell he feels a burden,
Depression and anxiety have picked him
I can see his daughter's misinformed,
The media's claimed its victim

A double-edged sword obscuring fact and fiction
With the power to emote
The media may be poison
But it could be its own antidote

Accompanying piece

My piece, 'A poisonous antidote', is a short poem that encapsulates a holistic view into the damaging effects of media narratives in the context of old age psychiatry. Like its title, the aim of this was to juxtapose the media's damaging effects with the thoughts evoked by the reader in response to the character's reactions to the diagnosis. I chose dementia, a primary care setting and the view of psychiatrists as the focus of my poem due to all three being both historically and presently at the forefront of media scrutiny and misrepresentation.

The poem begins with an Elderly male being referred by a GP to an old age psychiatrist in a memory clinic, as he is showing signs of dementia which likely needs pharmacological intervention. Upon hearing the word 'dementia', the patient is overwhelmed by his thoughts which have accumulated from media depictions of the condition; mostly negative and illustrating deviance^{1,2,3,4}. His comparison of dementia to imprisonment reflects how literature and films about the topic mostly tell the story of an individual whose story ends in institutionalisation³.

I mentioned the COVID-19 pandemic to highlight the psychological consequences of social restrictions, lockdown and media reporting during this period; particularly towards vulnerable populations such as the elderly⁵. As a demographic, being identified as a high-risk group endorsed the existing anti-aging sentiments that are rife in western populations, leaving this group to be misrepresented as a homogenous and burdensome group^{6,7,8}. Internalisation of such attitudes ascribed by the media could be damaging to the mental health of the elderly. Dealing with the stress of pandemic was also difficult for many older

adults^{9,10}. This could be due to limited access to resources such as technology, cognitive or biological inability to physically exercise or maintain a routine and a reduced social circle¹⁰. I feel that social media could have been a friend to old age psychiatry in this situation - by widening access to mental health services as well as enhancing the social connections and support of vulnerable individuals.

The patient then starts to question the sequelae of his diagnosis and the progression of his symptoms. I used a simile to liken 'wandering' to that of zombie to highlight metaphors used to depict dementia in the media¹¹. Such comparisons are damaging as they could perpetuate feelings of death being more preferable than living with dementia, whilst also obscuring a patient's agency^{7,11}. Memory loss is also one of the first things questioned which is consistently reported in the media as an early symptom which foreshadows further difficulties^{3,8}. I included this as Alzheimer's disease is overrepresented as a type of dementia in the media, with instances of the words dementia and Alzheimer's being used interchangeably^{8,12,13,14,15}. This evidences how the media can confuse and fail to educate, leading to a lack of understanding and appreciation of the condition.

I included the perspective of the patient's daughter as such diagnoses have implications on the wider family. She has pre-formed negative thoughts, likely due to negative media portrayal where carers are expected to be self-sacrificial whilst bearing the economic and societal costs associated with care¹⁶. Although there's no cure for dementia, both the patient and daughter are expressing therapeutic nihilism despite there being strategies to help manage the condition. The use of militaristic terms in the media such as 'Fight against Alzheimer's' whilst personifying dementia as a deadly killer can make people feel helpless if there are limited stories on any victories in this 'war'^{8,17,18}.

There is also inclusion of offensive and damaging views on psychiatrists in general, which I feel have suffered from poor representation in the media and pop culture. Psychiatrists have historically been portrayed as incompetent, crazy and expected to violate moral and ethical boundaries^{19,20,21}. There is also mention of 'shocking' which refers to her understanding of ECT; which has been depicted cinematically as a punishment/torture method with ineffective results as a treatment modality¹⁹.

The doctor mentions depression and anxiety as both conditions can be comorbid with dementia, but often overlooked in the case of diagnostic overshadowing²². He also refers to the daughter as a victim which has a dual meaning; she is a victim of media misinformation, but is also victimised by the media as carers are often portrayed to have lost their independence⁸.

The poem concludes with an important message; whilst there have been instances where the media has been positive in the portrayal of old age psychiatry and has helped elderly patients cognitive functioning^{23,24,25}, we are simply not using it effectively and our historical mistakes will evidently be difficult to rectify.

Like the media, poisons can be ingested by different means and their affects can be both acute and chronic. I believe early and effective utilisation of an antidote i.e., using all forms of media to educate, reduce stigma, and accurately portray mental health conditions is the only step forward in promoting advocacy and reversing the damage.

References available on request.

Medical student essay Prize competition winner

Does Music Therapy play a role in the management of Alzheimer's Disease?

by

Chirag Rao, 5th Year Medical Student, University College London

'I am seeking, I am not lost, I am forgetful, I am not gone' – Koenig Coste

In light of the UK's ageing population, one of the core problems of this century involves the effective care for those with chronic conditions. As we make inroads into the primary prevention of cardiovascular illnesses, we must not neglect one of the principal ailments affecting the mental health of the elderly population: dementia.

Globally, more than 50 million people suffer from dementia. In the UK alone, it is estimated that a third of people born in 2015 will develop dementia during their lifetime[1]. The fight against this illness has incurred annual total costs of £26.2 billion in the UK alone. This is equivalent to £32,250 per dementia patient per annum.[2] Comparatively, treatment for hypertension, an example of one of the many common cardiovascular diseases, only accounts for 8% of these costs[3].

As the disease progresses, one is often unable to conduct simple daily activities, and even experience changes in personality and behaviour. This is distressing both for patients, as well as loved ones who also suffer while witnessing the progression of symptoms.

Firstly, it is worth providing a brief precis into dementia, in particular, Alzheimer's Disease (AD). This is a progressive neurodegenerative disorder leading to memory loss, reduced cognitive ability and an overall functional decline. Theories for the pathophysiology of AD fall under two main categories: (1) intracellular neurofibrillary tangles and (2) extracellular beta-amyloid deposits in plaques. It is thought that neuronal destruction commences in the

hippocampus, leading to various neuropsychiatric effects in patients including depression, agitation, apathy and psychosis. These effects signify the severity of dementia, highlighting reduced quality of life for patients.

As stated in a commission by the Lancet in 2020, 'wellbeing is the goal of much of dementia care.' To improve such care, we must explore cost-effective, low-intensity methods that improve their wellbeing. Potential interventions would involve improving specific neuro-psychiatric symptoms. Thus, it is important to understand the theories behind these effects.

Depression is a common comorbidity in AD, affecting 20-30% of patients[4]. This consists of a vast spectrum of symptoms: traditionally, it is characterised by a triad of anhedonia, anergia and low mood. It manifests itself in different ways as the disease progresses. It can be differentiated from apathy in the early stages, with its involvement early-morning waking and sad thoughts. This advances to agitation and aggression as symptoms intensify[5], leading to a potential crossover with the neuro-psychiatric effects of AD.

There is a strong case arguing for AD's link to both early-onset and late-onset depression, as demonstrated by the Rotterdam Scan study[6]. Specifically, the study showed that those suffering from early-onset depression (onset before 60 years of age) had an increased chance of developing AD with a hazard ratio of 3.76. The corresponding risk for those with late-onset depression was 2.34. The study was robust, using a large sample size of 503 and a moderate follow-up period of 6 years. Depressive symptoms were assessed with a validated scale. However, results found no significant association of amygdala or hippocampal size.

Furthermore, a recent Delphi consensus considered depression to be so inextricably linked to AD that it was almost a prodrome[5]. Many argue that vascular changes such as hypoperfusion in the left frontal lobes[7] are the common denominator between late-onset depression and AD. The link with early-onset depression is much more ambiguous. A correlation between Beta-Amyloid (Ab) and depression, as mentioned previously, has been argued. Early studies have found a significantly increased serum Ab40/Ab42 ratio in those with both early and late-onset depression[8]. Notably, the serum ratio was negatively correlated with age of onset, indicating a potential link between metabolism of

Ab and early-onset depression. An association between depression and both grey and white matter has also been suggested[9].

Agitation is one of the more troublesome manifestations of AD. It is often associated with sundowning, a phenomenon in which patients experience irritability, restlessness and even aggression as the day goes on. Dysregulation of serotonin receptors, dopamine receptor alleles along with the GABAergic and noradrenergic systems are of particular importance [9, 10]. Other sources have attributed aggression to locus coeruleus damage[11]. Agitation has a widespread impact, negatively affecting both the patient and the caregiver. Rates of caregiver stress are shown to increase as symptoms of sundowning intensify[12]. For example, simple activities such as toileting, bathing and getting ready for bed are much more difficult.

Moving further, apathy induces behavioural change through a reduction in motivation and goal-seeking behaviours. It follows similar pathophysiological patterns as depression with hypoperfusion to the frontal lobe, but specifically in the left orbitofrontal area. Direct lesions, or other damage, to the frontal-subcortical circuits are thought to be involved. Other theories are also considered such as genetics and patterns of white matter atrophy. Due to the similarity between apathy and depression, in both their manifestations and pathophysiology, it is difficult to disentangle the two. Thus, the specific consequences and severity of apathy are challenging to assess.

The last of the 4 main AD symptoms, psychosis, can have harrowing implications including hallucinations and delusions. Patients exhibiting psychosis are thought to be at heightened levels of AD-induced neurodegeneration. Thus, psychosis can be used as an indicator of deteriorating AD. The pathophysiology of psychotic disorders is most strongly linked to dopamine. Additionally, serotonin and cortical atrophy are once again implicated, as with the pathophysiology of previous symptoms discussed. There is a further involvement of tauopathy in this decline.

Having considered the 4 major neuro-psychiatric symptoms, it is important to consider methods of amelioration. From personal time spent on the wards, care homes and in my own family, I have seen the devastating effects of this condition. Pharmacological management is often taken as the first port of call, with the use of medications such as acetylcholinesterase inhibitors, such as

donepezil, glutamate receptor antagonists, such as memantine and even newer potential biologic treatments such as aducanumab. The Delphi consensus states that psychological interventions should not be taken solely without medication[5]. Does there lie an opportunity for music therapy to reduce the impact of these factors on a patient and their family, in a low-intensity intervention?

Various studies have highlighted the effectiveness of music therapy in its reduction of symptoms. These include improvements in cognitive function, specifically with regards to memory. There are robust grounds to establish an intrinsic link between improvement in symptoms and enhanced memory. Through triggering emotion, music stimulates the anterior cingulate cortex. Thus, it is recommended as a common intervention for those suffering from AD[13–16].

There are many different methods of Music Therapy, the most simple being Receptive Music Therapy (RMT) where a patient is played selected music. Forms of engagement may include singing along or clapping, although this is not a requirement. Other types of music therapy involve neurologic music therapy (NMT) where music is used for neural entrainment [17]. This relies on transmission of information from the auditory and motor centres of the brain leading to improved motor symptoms in certain neurological conditions. Further studies have tried NMT to aid the psychosocial symptoms of dementia. Techniques such as Musical Sensory Orientation Therapy (MSOT) and Musical Attention Control Therapy (MACT) use specific elements of musicality, such as rhythm and melody. This orients participants in time and space, as well as augmenting attentive functions. Though not always successful, such trials aim to ascertain the causal effect of participant responses to the music therapy experienced. The importance of various factors, such as patient familiarity with the music as well as the composition and melody of songs, are assessed[18]. With this in mind, it is worth considering how to tailor music to most effectively reduce symptoms.

RMT improves happiness and decreases sadness in subjects. This is achieved through the mechanism of reduced cortisol concentration and increased melatonin levels, which decreases stress and enhances quality of sleep[19, 20]. Furthermore, the association of music with specific tasks was found to reduce

neuropsychiatric symptoms. This is especially true when patients complete a task and listen to the same music every time that the task is completed, thereby intensifying the association[21].

Numerous studies have demonstrated the means by which music evokes memories. For example, Schulkind et al found that an older group of participants had a stronger connection to the music of their youth[22]. This strength of attachment can be explained by the significant association of this music to childhood memories and happiness. Thus, when participants experienced something to which they shared a deeply personal bond, in this case music, a much greater emotional response was elicited. This provides a rationale for personalised music in RMT. One such study by Costa et al found a reduction in depression scores among a sample of care home residents after personalised music was played. Similar studies have been conducted with people suffering from AD. For example, Murphy et al demonstrated that personalised music therapy improved goal-oriented activity and emotional expression during sessions. This provided interesting evidence in favour of the potential for music therapy as a cost-effective, accessible tool to improve quality of life and improve the ease of care, though from a small sample size [23, 24].

I was recently given the opportunity to work with a charity, Music for my Mind (MFMM), to lead a research study exploring the reminiscence bump in memory and quantifying this period of time in one's life. We worked on the principle that a personalised music playlist could be curated from this period, which could then be used to provide a soundtrack for RMT. Our results concluded that music from the teenage years of one's life was best recollected, and thus evoked the greatest response in participants. This prompts further questions regarding practical, clinical applications of these findings [24].

MFMM are working on personalised playlists for dementia, alongside an application to assist in the creation of these playlists. This would be a useful, cost-effective intervention for those with AD. As seen in the previously mentioned study by Cunningham et al, patients could be exposed to music from this era whilst completing activities of daily living, such as toileting and clothing. Levels of agitation and aggression would be reduced, providing lucid intervals for these patients. The burden on caregivers would also be significantly reduced, with improved ease of care. In addition, the low intensity of this intervention

allows for its implementation in many environments including hospitals, care-homes and residential accommodation.

I myself have struggled often with basic tasks, such as venepuncture with patients suffering from AD. Considering the vast number of patients needing care in a hospital setting, it is sadly very easy for health-care workers to consider a patient as a condition rather than a human being. Those suffering from debilitating conditions such as AD can be particularly incapacitated, rendering some of the simplest tasks almost impossible to conduct. It is in those periods that we must remember the aforementioned quote:

'I am seeking, I am not lost, I am forgetful, I am not gone' – Koenig Coste

In my own practice, I have found patients to be much more relaxed and comfortable after a short conversation about music, or even television. The key is to connect with the patient through familiarity, evoking a floodgate of memories from their past. This allows patients to tap into their lucidity and become more involved in their care.

I can specifically recall one moment, whilst taking a history from a patient with AD. This patient had presented with a fall in their residential home and was sent to the emergency department during my evening shift. Initially, the patient appeared lucid. However as time passed, they began to manifest progressively intensifying agitation and sundowning. This increased the difficulty of conducting a history and examination. I was asked to care for this patient and during my attempt at a social history, I noticed their eyes light up whilst talking about their work in the past. The patient was rightly proud of their hard work and remarked 'I never took a day off in my life.' As this conversation continued, the patient seemed less restless and agitated. I was then able to complete my history in a more cogent manner. This is just one of the countless examples in which simple techniques of reminiscence are effectively used to ameliorate care.

Outside of the hospital setting, music therapy can improve relationships between care-givers and care receivers. Family care-givers are often described as the second victims of this disease due to the psychological and physical strain of this role.(25) The multifaceted symptoms of AD often take up a large proportion of the life of the care-giver, as they aid with day-to-day care and attention. Studies have shown that the power of music therapy can be extended to care-givers. For

example, when dementia patients partake in music therapy alongside care-givers, outcomes are improved for everyone involved (26). Care-givers are thus granted the opportunity to reconnect with their dementia-stricken relatives, providing further evidence for the holistic effect of music therapy in dementia care.

AD is a multifactorial ailment with a large disease burden. Although pharmacological interventions are present, these have problems of accessibility and side effects. Music therapy provides a compelling opportunity to implement low-intensity techniques, such as RMT, which ameliorate neuro-psychiatric symptoms of dementia patients. Of course, this is not without issues and further questions. Part of the complexity of providing personalised music therapy to patients is the difficulty in designing these playlists as well as costs incurred. Harnessing the reminiscence bump era creates a simple method of providing RMT, requiring simply the age of a participant. Patients are then exposed to playlists from this period, implementing a low intensity form of RMT. It would be valuable to conduct studies ascertaining the significance of this reminiscence bump in different groups of participants, e.g. raised in different geographical regions or following alternative cultural scripts. There is a further opportunity to assess the effect of classical or religious music, which has less of an obvious chronology.

Ultimately, music therapy shows compelling potential in the relief of both care-givers and care-receivers. The effective implementation of this treatment, with minimal economic burden, advances the patient-centred approach to care.

References available on request.

Medical student essay Prize competition entry 1

The COVID-19 Pandemic and its Impact on the Mental Health of Older Adults

by

Ella Maxwell

COVID and Older Adults

It is known that pandemics have significant psychosocial impact on most, if not all, individuals that survive, and the COVID-19 outbreak has been no exception. Health, anxiety, depression, insomnia, and chronic stress are all common outcomes. Many factors play a role in this but feelings of not being in control and uncertainty about the future are what seem to worry people the most. This leads to an overall decline in the mental health of a population and those most risk are said to be adolescents and the over 65-year-olds (Banerjee, 2020).

The process of ageing results in psychological, social, and environmental challenges which some may struggle to cope with even without a global pandemic. Adding prolonged periods of social isolation with reduced care input into the mix has resulted in many older adults reaching crisis point.

Studies show that the pandemic had led to many older adults feeling increasingly lonely due to lack of contact with family and friends and disruption to their usual activities. Family stressors such as children losing jobs or getting sick have also been found to cause prolonged periods of low mood and hopelessness. Many people put off presenting to their GP or hospital as they felt anxious about leaving the house or being seen as a burden on others to by accessing appointments (CDC, 2021). This has led to individuals presenting later than usual with more severe forms of depression, anxiety disorders and self-harm or even suicide attempts.

During the height of the pandemic many outpatient appointments were cancelled and so follow-up for long term health conditions was delayed. This led to greater

declines in the elderly population's physical health, which is resulting in more individuals presenting with poorer mental health.

Many older adults did not have access to resources that others used to help them deal with the stress of COVID-19, such as smart technology, family, and friends. They were not as able to engage in physical activity or daily activities outside the home (Vahia, Jeste, Reynolds 2020). The role of technology was particularly important for the population as a whole, as many used it for maintaining social contact with others and for accessing health care services that had moved online. Whilst for most this was successful in preventing the negative effects of reduced healthcare access, for the elderly population such improvements were not seen (Martins Van Jaarsveld, 2020). Those who could not access online services were not as able as others to continue to engage in healthcare follow-ups resulting in large declines in functional performance.

The impact of this can be seen in a recent survey conducted in Ireland which showed that almost 40% of older adults reported they felt that both their physical and mental health had worsened since the beginning of the pandemic. With over 57% of participants expressing that they felt lonely and hopeless about the future (Bailey *et al*, 2021). It was found that prolonged social isolation not only had negative impacts on the mood of participants but also caused disturbed sleep, reduced physical activity, and increased unhealthy behaviours. When these patients were then subsequently followed up it was found that the decline in both their physical and mental states had increased since the onset of the lockdown.

Since the lifting of lockdown rules across the UK there are reports that many older adults are still too afraid to venture outside their own homes and are continuing to socially isolate after spending so long indoors (Mistry *et al*, 2021). This is concerning as reduced contact with the outside world combined with a lack of health input for physical conditions has been linked to increased cognitive decline and a greater risk of developing Alzheimer's disease (Bailey *et al*, 2021). Whilst many are worrying about the current backlog that services are having to dealing with, others suggest we need to prepare for the future and the long-term impacts.

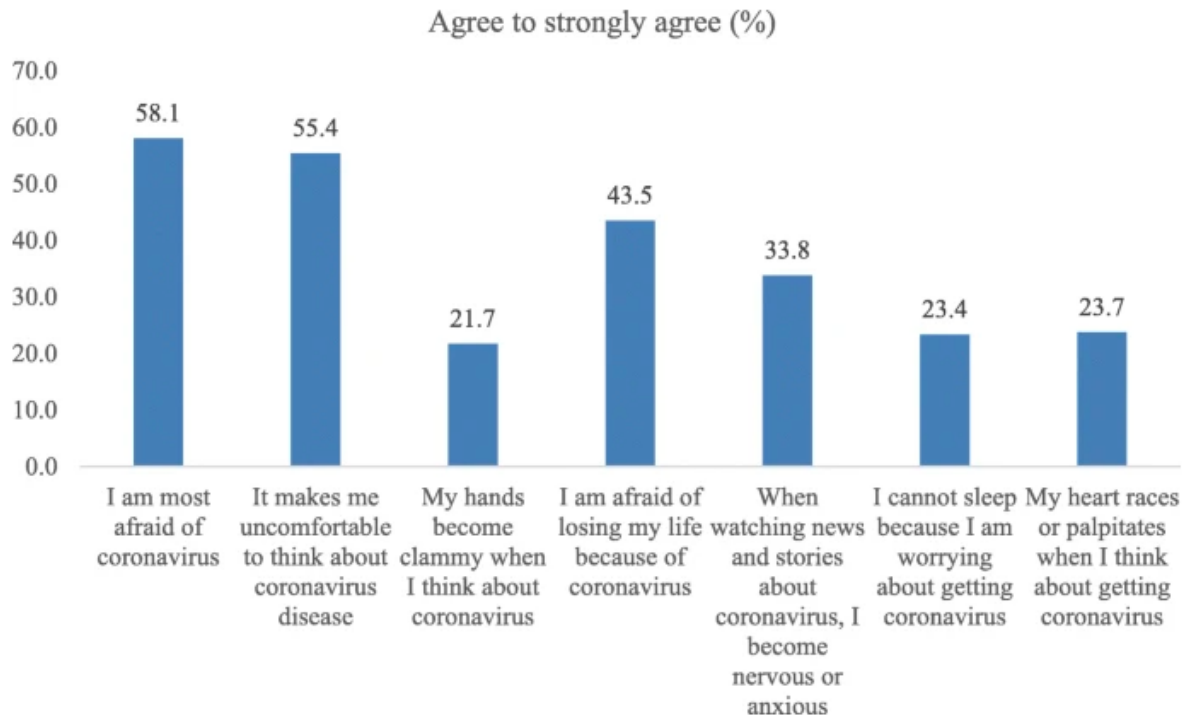


Figure 1: Graph showing responses from participants involved in the 'Exploring fear of COVID-19' study (Mistry *et al*, 2021).

Presentation to Services

At the start of the pandemic, mental health services saw a decline in presentations. This was thought to be due to a lack of understanding of services that were still accessible combined with fear of asking for help from an already pressured system.

Towards the end of the lockdown numbers started to increase again as services resumed and people realised the need to ask for help. It was clear that individuals who were presenting had suffered with symptoms for longer than normal in the community before seeking help. Higher numbers presented with psychotic symptoms (23.3% compared to 17.7%), delirium (7% compared to 3.6%) and a higher proportion were admitted to inpatient units (22% compared to 18.3%) (Mukadam *et al*, 2021). Whilst this had been expected the sheer volume of cases was something that the healthcare system wasn't ready for.

Other studies were conducted looking at first time presentations compared with those presenting with a previous history of psychiatric illness, and as expected both categories increased. COVID-19 illness was also seen to play a part as a

great proportion of individuals requiring input had previously contracted the virus when compared with having six other health events (Taquet *et al*, 2021). The variety of presentations didn't seem to differ massively but the number of anxiety disorders, cases of insomnia, and dementia increased slightly compared with earlier on in the pandemic. The results of this data have been questioned as to whether the increase was due to individuals eventually engaging with services or an actual increase in cases due to the pandemic itself.

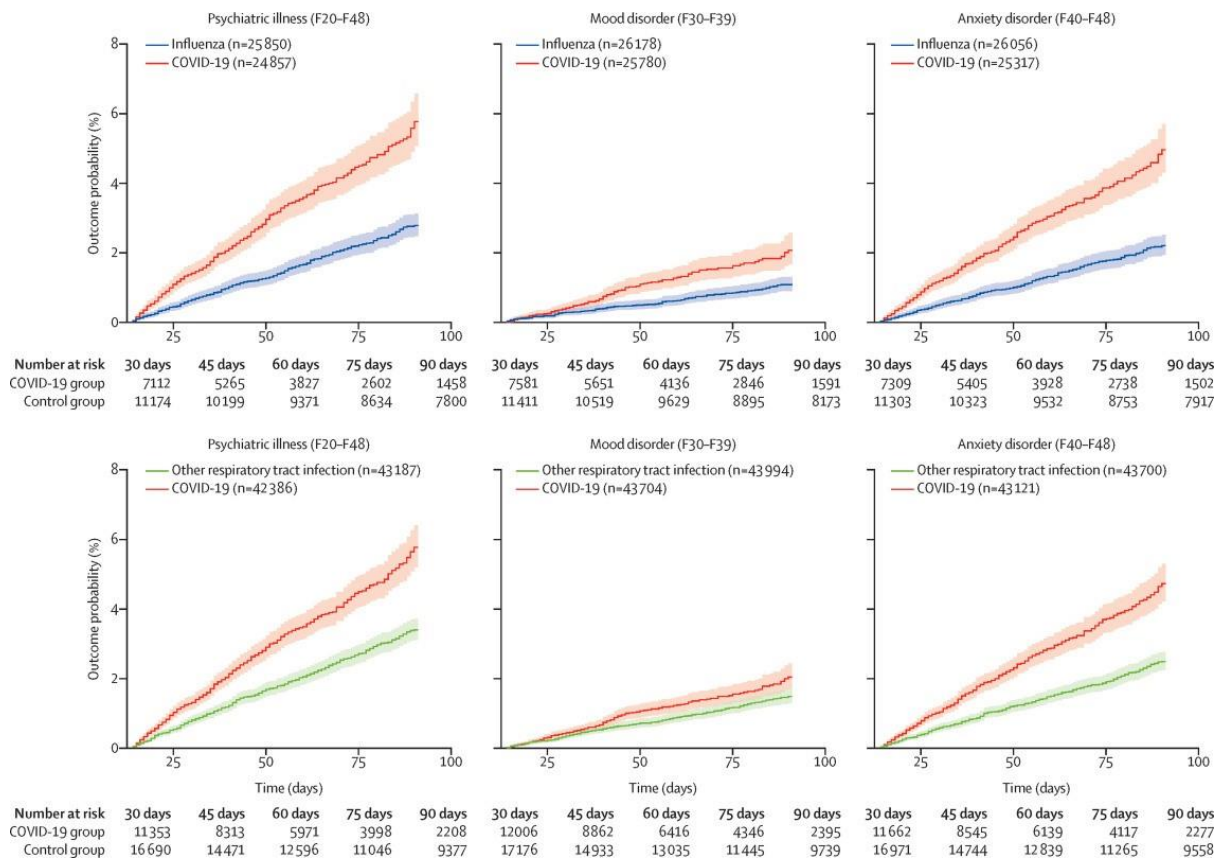


Figure 2: Kaplan-Meier curves for onset of first psychiatric diagnoses after COVID-19 diagnosis compared with influenza and other respiratory tract infections. (Taquet *et al*, 2021)

Following the trends of previous pandemics, it is thought that as life begins to return to normal and individuals realise the extent of the stressors that they must now deal with suicide rates will increase (Sher, 2020). Data suggests that those who have contemplated or attempted suicide in this age range often feel like a burden to their family, are fearful about their physical health, anxious about the future, socially isolated, and psychologically distressed, all of which the pandemic may have exacerbated.

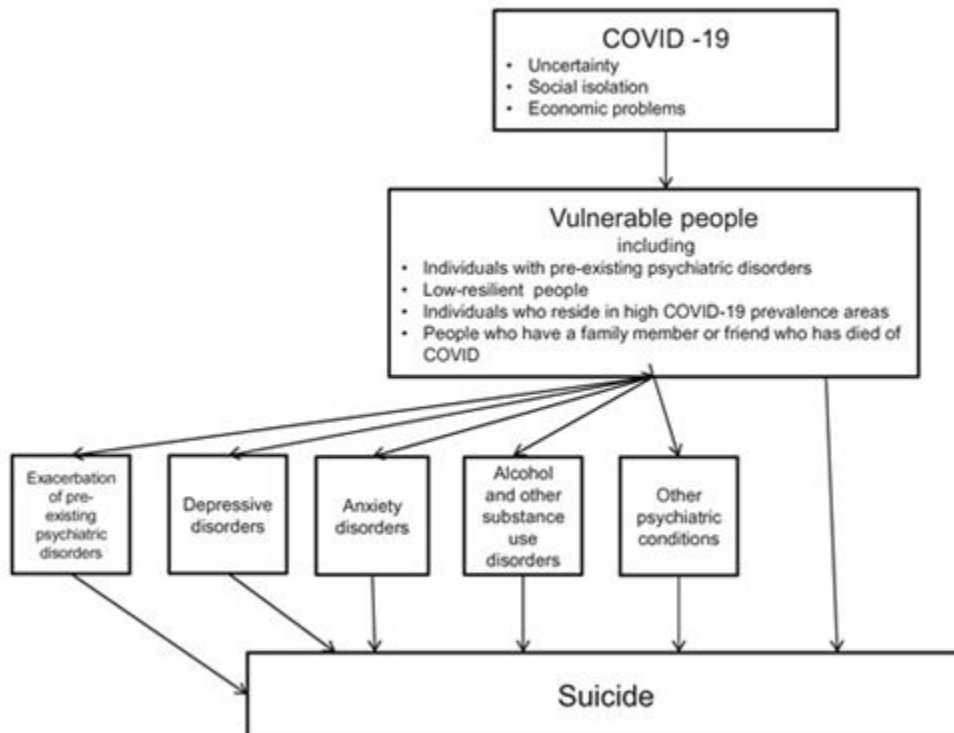


Figure 3: Diagram showing suicidal behaviour in the vulnerable populations such as older adults. (Sher, 2020)

Literature discusses the importance of individuals having personal contacts they feel able to approach in a crisis. However, with many organisations running on reduced workforce and visiting not allowed in most hospitals and social care facilities, the older age groups seem to suffer the most (Van Tilburg *et al*, 2020). This has since led to an increase in crisis situations needing hospital admission that may have previously been easier to resolve.

A Clinical Encounter

During my 4th year Old Age Psychiatry rotation, I was able to see the backlog of patients first-hand that were presenting as lockdown began to ease. One patient whose story really touched me was a 67-year-old female who had presented to A&E with her husband following a polypharmacy overdose. After assessment in the hospital, it was deemed that she needed admitting to the psychiatry unit. I went to speak to her shortly after she arrived in the unit.

She began to tell me about how the pandemic had led to money troubles and a loss of contact with her family. Her husband had accumulated over £7,000 worth of debt on credit cards, and she felt helpless as her family and husband were not wanting to engage. This lady was not known to services which surprised me. When I asked about her feelings towards the overdose now, she described the shame she felt towards herself for allowing things to get to this stage and not asking for help. I then questioned why she had not approached services and whether the pandemic had affected this. She described how the constant negative stories in the press combined with her own issues and lack of support from loved ones had made her life not seem worth living anymore. She told me after seeing and hearing about others being so ill, she felt like her own issues seemed petty and irrelevant and this had stopped her from reaching out.

I wanted to highlight this patient because I am sure that many other people are feeling or have felt the same way and I am sure that as time goes on, we will see more and more people presenting like her. Stressors surrounding illness, death, job loss, financial crisis are increasing which are all recognised risk factors for suicide (McDowell *et al*, 2021). During the 2003 SARS outbreak escalations in presentations were seen in suicide ideation, suicide attempts and completed suicides to as much as 30% increases in suicide rates within the older adult population.

It now becomes increasingly important to recognise these risk factors in all areas of medicine when treating older adults. If we can detect mental health issues and act on them at an early stage in hospital then the benefits to the individual, their family and friends, the wider community and to healthcare services in general would be significant.

Service Change During the Pandemic

There has been a significant change in the delivery of mental health services during the pandemic as many clinics and consultations moved online. This has been very successful for most patient cohorts, but similar results were not found with older adults. A recent study conducted in a group of > 65-year-olds reported around 40% of participants were unable and unprepared to use online resources mainly due to a lack of skill and knowledge about how to do so (Martins Van Jaarsveld, 2020). Despite the elderly population having the

highest number of hospital appointments, overall, the uptake in this cohort remains the poorest.

Undertaking a mental health assessment remotely with any individual has its challenges but even more so with the over 65-year-olds. One problem that has been highlighted by healthcare professionals is difficulty in observing appearance and behaviour of patients online due to problems with video connection and access. This raises issues for conducting consultations as both are essential components of a mental state examination. It is even harder in this population anyway as many older adults live alone and it can be hard to get a good collateral history.

Within the over 65-year-old cohort those with cognitive impairment were particularly affected as they were found to have a reduced ability to master new skills such as learning how to set things up online when compared with counterparts (Sorinmade, Kossoff, and Peisah, 2020) Equipment failure and dropped calls were problematic and this reduced the effectiveness of the remote consultations conducted. Obtaining privacy and reducing background noise frequently created challenges when staff were trying to carry out capacity and risk assessment online which was seen to be far from ideal.

There was also difficulty reported when trying to carry out physical examinations remotely with individuals struggling to understand what was being asked of them. Many also struggled to upload photographs and videos that were necessary to guide diagnosis, and this was found to delay and reduce the quality of treatments.

Interestingly though, when asked, older patients did seem to prefer telephone or online video consultations as they could remain in their own homes. However, questions have been raised as to whether this is due to the reduced logistical issues individuals experience by remaining in their own homes, or whether they do find these methods of consultation better.

The Benefits

Aside from all the negativity, online health services have provided many individuals with more convenient access to routine care without exposure to the risks seen with hospital attendance. For those who have

been able to access online services it has proved a much safer and time effective option.

There are also benefits for service delivery. With multiple professionals sitting in on clinics and reduced travel times for staff there appears to be more free clinic spaces and therefore an increased capacity for services.

Another benefit seen has been in remote areas where patients may have struggled to access healthcare previously. By consultations occurring online more people have been able to engage with services and can be supported better in the community (Wang, 2019). The pandemic has also led to a greater multidisciplinary team working style which has had led to many positive impacts for both patient care and outcomes.

What Next?

With health and social care services planning to increase the use of video conferencing and phone consultations it is clear that some of the practices used during the pandemic are set to stay. The use of artificial intelligence is increasing (Wang, 2019), and we are already beginning to see it being use within healthcare regularly, so there is no doubt the demands will grow.

With regards to the ageing population, it becomes increasingly important to consider how we can adapt existing programmes and technology to make things more easily accessible for this cohort. It is about how we design systems that these patients will be able to use and benefit from.

Addressing suicide and its prevention is everyone's issue. It is essential to continue to prioritise suicide prevention and recovery programs throughout the post COVID-19 time period to ensure that as many lives are saved as possible. It requires a collaborative whole system approach and continuous data collection to plan for future demand and allows us to adapt existing services

References available on request.

Medical student essay Prize competition entry 2

In a time with minimal therapy available, explore the principles behind societal attitudes and how they affect the experience of living with and caring for dementia.

by

Alice Bradley, 4th Year Medical Student, University of Birmingham

Dementia, often mistaken for a specific disease in itself, is a collection of progressive symptoms that affect cortical functions such as memory and problem-solving. It is most commonly caused by Alzheimer's Disease and affects one in fourteen people over the age of 65¹. Currently the only pharmacological therapy for dementia are Acetylcholinesterase (AChE) inhibitors, which are designed to manage "mild to moderate Alzheimer's disease"^{2(p.25)} under certain conditions and can sometimes be recommended for dementia with Lewy bodies². These AChE inhibitors can result in an improvement in cognitive function², or rather a maintenance or reduction in the rate of decline³, but they do not slow the progression of the disease in itself²; this progression can be characterised by a deterioration in cognitive and functional abilities, changes in behaviour and other non-cognitive symptoms such as depression and delusions². These changes are often very distressing for both the individual and their peers and can be exacerbated by a lack of sensitivity and support from the general public. Given that there is minimal drug therapy available, it can be argued that the experience of those living with dementia is defined more by how society treats them than the effects of any treatment. Therefore individual attitudes towards the condition, which are influenced by both cultural and societal norms, have a vast impact upon the day-to-day lives of people living with dementia as they dictate personal behaviour. As such, a greater awareness of society's impact on the experience of living with dementia could contribute to greater person-centred care and an overall more positive experience for those with the condition. This essay therefore aims to increase awareness of societal impact on

the lived experience of those with dementia in hope of creating a more 'dementia-friendly' community.

As with many other diseases and conditions, the word 'dementia' brings with it a negative stigma. Although this has always contributed to the experiences of those with dementia, its substantial adverse effects have only come to the limelight recently⁴. Once labelled as having dementia, this often becomes one's most defining characteristic; any other individualistic personality traits are hidden⁴. Accordingly, this stigma can be seen to cause a "spoiled identity"⁵. Other language patterns used surrounding dementia involve the concept that dementia creates a "total loss of self"^{6(p.586)} and leaves behind "shells"^{6(p.586)} of the affected persons. This use of language creates the impression that the actual person vanishes with a dementia diagnosis as they have undergone a "social death"^{6(p.586)}. Portraying someone who is still alive, not just physically but in all concepts of the word, as having undergone any sort of death provides significant risks as it undermines their human rights. Moreover these ideologies surrounding death and a lack of personality oppose the fundamental values that form empathy and compassion and therefore have widespread effects on dementia care. For example person-centred care, which encompasses "treating people as individuals"^{7(p.216)} and viewing everything "from the perspective of the person with dementia"^{7(p.216)}, relies on individual personality traits to identify the most appropriate approach to care for each person. It recognises that although the personality of the person is increasingly concealed as dementia progresses⁸, it is not lost. As person-centred care is now widely considered to be the only method of producing high-quality care and has also been found to decrease agitation and discomfort⁸, it is essential that individuals are not depersonalised and can be provided with the positive care that they deserve.

Furthermore unlike with illnesses such as cancer, where awareness spreading and charitable research promotion is based upon personal life narratives shown during primetime TV, those with dementia are seen as one unified and marginalised group. Research has shown that life-narratives and personal stories attract higher emotional involvement, empathy and increase pro-social behaviours such as donating to related charities⁹. Therefore, the identification of those with dementia as one group with limited or no personality traits may have detrimental effects on how empathetic society are towards them and the quantity of relevant charitable donations⁹. Empathy is very important as when

increased, it gives individuals more confidence to care for those with dementia^{10,11} and increases the likelihood that they will have a positive interaction^{10,11}. Alongside this, as charities fund a significant proportion of dementia research, less donations may have a profound impact on the likelihood of finding a cure. Thus it is clear that stigma and stereotypes have a significant grievous impact on the lives of those living with dementia through many different mechanisms and effects. Reducing this stigma would likely improve the quality of life of those with dementia.

However, it is not only society that have influential negative perceptions about dementia. In the early stages of dementia, individuals self-stigmatise⁴, a “process whereby stigma is absorbed by the individual”^{4(p.228)}, and feel embarrassed about their diagnosis. When combined with confusion about the nature and reality of their condition, a common early symptom of dementia, this intensifies distress and affects mental wellbeing⁴; individuals feel like they have lost autonomy and self-worth⁴. Dr Jennifer Bute¹² writes in her book, *Dementia from the Inside*, that insensitive comments and assumptions, which she internalised, lead her to question her condition and triggered an anxiety that would last much longer than the interaction itself¹². Although the initial stigma was sourced externally, she continued to feel the effects of her own distressing feelings about it for much longer¹². This self-stigmatisation therefore lead to increased anxiety as Bute was reminded that she was ‘different’¹². Although Bute uses her faith as a source of positivity¹², many other people with dementia feel hopeless about their future^{13,14}. When interviewing individuals with a dementia diagnosis about their feelings towards their life, Bradbury¹³ found that past-orientated comments similar to “I’ve had a good life”¹³ and “I’ll pop off soon I hope”¹³ were common. This despondence, which is likely worsened by both societal and self stigma, is linked here with a shifted temporal orientation to place more significance on the past; temporal orientation refers to the “relative emphasis one places on the past, present or future”^{15(p.270)}. Although older people in general are more likely to emphasise their past when speaking about their life¹⁵, the notion of wanting to die ‘soon’ is said by carers to be more common after a diagnosis of dementia. Their exact reasoning is unknown and will differ amongst individuals but pride is a recurrently mentioned theme. Many people, especially of the older generation, are very proud and have an honourable reputation which they do not wish to be ‘tarnished’ by a diagnosis of

dementia¹⁶. They share the perception and fear that a dementia diagnosis means that they will be embarrassing and they will be a burden on their families' or carers' lives¹⁶. It is clear that they self-stigmatise, causing themselves a lot of anxiety and distress, and feel total shame and embarrassment about the condition which has grievous effects on mental health and wellbeing.

Stigma is thought to be due, at least partially, to a lack of education and awareness. Therefore it is surprising that although 52% of people know someone diagnosed with dementia¹⁷, awareness of the effects and symptoms of dementia is very limited¹⁸⁻²⁰. McParland et al¹⁷, who studied the general public's knowledge and attitudes towards dementia in Northern Ireland, found that although society had an overall reasonable knowledge of dementia, there were many common misconceptions¹⁸. For example, only 29% of people were aware of the potential link between prevention, diet and exercise with the percentage even lower among younger adults¹⁸. However for other questions, younger people appeared to have significantly more knowledge than older people; when asked if dementia was a synonym for Alzheimer's Disease, only 35% of adolescents thought this statement to be true as opposed to 71-74% of those over 65¹⁸. Nonetheless in all studies, knowing someone with dementia had the most significant impact on knowledge^{18,19}. Since only limited research has been done in the English population, it is unclear if the figures found by McParland et al¹⁸ are fully generalisable but given that Northern Ireland and England are both in the UK and are countries where dementia is considered a national priority, it is likely that the figures are representative. Thus the evident lack of knowledge about dementia contributes to the maintenance of stigma and impacts upon interactions between people with and without dementia; individuals do not know what to expect when talking to someone with dementia.

Further to reporting about awareness, some studies acknowledge that younger generations, regardless of knowledge or exposure to dementia, have more positive attitudes about the condition than older generations. For example, Isaac et al¹⁹ studied adolescents', age 15-18, knowledge of dementia through a questionnaire and found that although the average participant got under half of the 15 multiple choice questions correct, they did have generally positive attitudes towards dementia¹⁹. The study reported that adolescents commonly thought that there was value in talking to someone with dementia¹⁹ and that those with dementia "should be involved in activities in the community"^{19(p.421)}.

In other studies, positive attitudes are again noted^{18,21} as less younger people agreed that "people with dementia are like children and need to be cared for as you would a child"^{18(p.1609)}, 51% of 18-24 year olds compared to 83-84% of those above 55 years¹⁸. Although these statements and papers alone cannot be used to confirm a conclusion and there is some evidence to the contrary, this may suggest that younger generations, regardless of knowledge about dementia, may foster a more dementia-friendly community. If this proves true there is hope that in the future, as younger generations form the majority of the working community, there will be more support offered to those with dementia and they will be treated more kindly. This difference may be explained by many reasons including increased education in schools and the community with notable charitable initiatives such as the Alzheimer's Society's creation of 'Dementia Friends'. However in spite of all this, there is still great scope for improvement as although positive attitudes and greater sensitivity have a powerful impact on how those with dementia feel, adequate knowledge of the condition is still required to provide the most effective care and support. If the entirety of society knew how to support those with dementia, it is likely that these individuals would not have to be institutionalised as early and they could maintain their independence for longer. Therefore, a greater societal insight into dementia could cultivate a more dementia-friendly community in which those with dementia are supported, cared for, and considered as equals.

Fear is a common theme when speaking about dementia as many members of society fear a diagnosis of dementia more than other diseases. Studies have found that the fear of getting dementia can be related to age²², being most predominant in the elderly, and personal experience²²⁻²⁵: if someone has cared for someone with dementia, they are more likely to fear it themselves²²⁻²⁵. People fear rapid deterioration, being "put away"^{16(p.180)}, and not being allowed to make decisions once the diagnosis has been made¹⁶. Shockingly in some areas including The Netherlands, it was found that an increasing number of elderly people viewed a life with dementia as such horrific suffering that they looked to avoid it by completing an advanced directive and/or requesting euthanasia if they develop symptoms of the disease^{26,27}. These sentiments, if less extreme, have also been noted by carers in UK care homes. However this fear is somewhat inevitable as firstly, dementia is increasingly visible in society and secondly, there is no therapy available that can slow down its progression so

ultimately, the disease is fatal²⁸. Nonetheless these anxieties, alongside having short-term mental health effects, have deleterious consequences on health perceptions and the marginalisation of those with dementia. To further this, worries about dementia have created a phenomenon known as 'anticipatory dementia' where individuals misdiagnose their own normal age-related memory changes as precursors of dementia²²⁻²⁴. It is most common amongst adult children of elderly people with dementia^{22,23} so often affects informal family carers and reduces their quality of life²⁴. Many studies have provided evidence for this phenomenon finding that greater concern about developing dementia personally results in a greater likelihood of a more negative assessment of personal memory functioning²²⁻²⁴. These anxieties therefore result in poorer health perceptions as people are more aware of their memory deficits and can have adverse effects on psychological wellbeing²⁸. It can also alter how affected carers interact with those with dementia.

Furthermore, fear of dementia forms the fundamentals of the Terror Management Theory (TMT) which provides an explanation for associated ageism and marginalisation²⁹. The TMT suggests that the recognition of personal mortality gives rise to anxiety and that both the protection of self-esteem and adherence to culture are common coping mechanisms²⁹. These two factors, self-esteem and culture attachment, are often provided by one's social in-group i.e. the people one chooses to spend time with^{29,30}. Therefore mortality salience, the awareness of inevitable death, is thought to increase identification with the in-group²⁹⁻³¹ as these protect self-esteem and attachment, and conversely, increase animosity towards the out-group^{29,30}. Thus it can be concluded that as a diagnosis of dementia encourages death-related thoughts^{6,29,32}, people without dementia associate much more with other 'non-sufferers' than those with the condition and therefore, those with dementia are isolated and marginalised. This marginalisation due to fear exacerbates the problem with stigma and lacking knowledge and has unfavourable mental health consequences for both those with dementia and those that care for them. It also contributes to the depersonalised 'unified group' ideology and its widespread effects mentioned earlier.

As acknowledged by the TMT, it is undeniably challenging for care for people with dementia. Caregiver burden, a common outcome measure in research, is defined as a multifaceted response to the perceived stress that arises when one

takes care of an individual with dementia^{33,34}. It has emotional, physical, psychological, and functional health consequences for the caregiver³³⁻³⁵ which also affect the quality of care received by the individual with dementia³⁵. One of the most significant predictors of caregiver burden, as found in many papers^{33,35}, is the functional decline of health in the care-recipient^{33,35}. Although this is partly due to an increased reliance on the carer and more hours required of them^{33,35}, a significant contributing factor is having to observe the decline with little power to change it. As there is no cure or therapy for dementia, many carers and families have to simply watch their relative decline in cognitive and general health without any ability to change it and whilst receiving little external support³⁴. This is widely considered to be the most agonising and torturous part of any dementia journey, not only for the sufferer but also for their loved ones. Moreover, qualitative research continues to find that the 'relief' of caregiver burden when the decision is made to admit a person with dementia into a care home is not felt for many months after the move³⁵; ex-caregivers report feelings of a loss of purpose, grief, loneliness³⁶. Generally with time, families and carers do feel relieved knowing that their relative or friend is now safe³⁶ but this process is not instantaneous. Throughout the dementia journey, people struggle to access adequate support³⁴ so often suffer these challenges alone or in small familial groups. There is hope that a more sensitive, understanding and compassionate attitude from society would make this journey more comfortable and provide the dementia community with the necessary support for better wellbeing.

To conclude, societal attitudes about dementia are influenced by many different factors such as stigma, ageism, the perception of burden, and fear. The combination of these form an overall negative view towards the condition which deeply affects individuals with dementia, their carers, and those who work in the sector. It causes great suffering, isolation and fear which severely impacts on quality of life and mental wellbeing. However despite this, there is hope that times are changing and the future of dementia care may be more positive. As we slowly approach being a fully dementia-friendly community, it is essential that we acknowledge our individual impact on the lives of those with dementia. As a carer it is frustrating that people look down on others with dementia, devaluing and dehumanising them, and treat them differently to the rest of the older generation. People with dementia, as any other, have lived fascinating lives and

when given the opportunity, can provide great company and humour. It is saddening that many people do not see this. Before this research project, I was unsure if it was just me and my associates that noticed the overwhelmingly disrespectful view that society have towards the dementia community. Although I was comforted to find that it was not only me with that perception, I felt great frustration at the findings of some research. This frustration has revived my motivation to spread awareness about individual impacts on living with dementia. By highlighting some of the principles that form the negative attitudes about dementia, I hope that readers can acknowledge and reflect on their own individual perceptions and potentially change their approach to the condition. The ultimate aim is to create a truly dementia-friendly community and although this essay only contributes minimally to that, I would like this to be the start of my personal contribution towards that goal.

References available on request.

Supreme Court rules on Mental Capacity and Sexual Consent

by

Dr Habeeba Mallu MBBS

Core Psychiatry Trainee (CT1), East London NHS Foundation Trust,

&

Dr Kapila Sachdev, MBBS, MRCPsych , Consultant Old Age Psychiatrist, East London NHS Foundation Trust, Regional Representative NCL, Old age faculty

Introduction

This article is about how the Mental Capacity Act 2005 applied to a case on capacity to consent to sexual activity. It focuses on a recent significant ruling by The Supreme Court.

A Local Authority (Respondent) v JB (Appellant) [2021]

Background

JB is a 37-year-old who has autism and impaired cognition. He lives in supported residential placement, and he is described as 'likeable'. He has had severe epilepsy since the age of 2, and in 2011 was diagnosed with Asperger's syndrome. He was deemed not to have capacity with regards to finances and accommodation.

JB wanted to have sexual relations. The local authority applied to the Court of Protection to find out if JB had capacity to consent to sexual relations.

Capacity to consent to sex

The test for capacity to consent to sex is that the person understands and can use and weigh the information relevant to consenting to or engaging in sexual activity. Depending on the individual circumstances of the person, this information can include:

- a. the sexual nature and character of the activity (including the mechanics of the sexual act);
- b. that there are health risks involved, particularly the acquisition of sexually transmitted and
- c. sexually transmissible infections;
- d. that sex between a man and a woman may result in the woman becoming pregnant;

The evidence showed that JB understands how sex works, and understands the risks of pregnancy and sexually transmitted diseases. JB also understands that he can withhold or give his own consent. However, JB had little understanding that *the other person* must be able to consent, and gives and maintains consent throughout sexual activity.

With regards to the other person withdrawing consent, JB said: *'If the person gives consent then she's already given consent and you have to go through with it to the end. Once you're half way through she can't say 'I don't give you consent' 'cos you're already doing what you need to do. She cannot change her mind if you are already doing it.'*

In September 2019, The Court of Protection ruled that JB *does* have the capacity to consent to sex. The judge concluded that *"For the purposes of determining the fundamental capacity of an individual in relation to sexual relations, the information relevant to the decision for the purposes of section 3(1) of the Mental Capacity Act 2005 does not include information that, absent consent of a sexual partner, attempting sexual relations with another person is liable to breach the criminal law"*

The local authority appealed to the Court of Appeal, and in June 2020, the lead judgement was made, *'A person who does not understand that sexual relations must only take place when, and only for as long as, the other person is*

consenting is unable to understand a fundamental part of the information relevant to the decision whether or not to engage in such relations.' Thus, it was declared that JB *lacked the capacity* to decide whether to engage in sexual relations.

JB appealed to the Supreme Court, and the appeal was dismissed. Lord Stephens summarised, '*Information relevant to that decision includes the fact that the other person must have the ability to consent to the sexual activity and must in fact consent before and throughout the sexual activity. Under section 3(1)(a) MCA JB should be able to understand that information and under section 3(1)(c) MCA JB he should be able to use or to weigh it as part of the decision-making process.'*

Capacity to consent to sexual relations

Historically, decisions with regards to capacity to consent to sex have focussed on an individual's *own capacity* to consent.

In this case, the questions the Supreme Court had to consider were:

In order to have capacity to consent to sex:

- Does a person need to understand that their sexual partner must have the capacity to consent to sex?
- Does the person also need to understand that their sexual partner must consent before the sexual activity starts and that their consent must continue throughout the sexual activity?

Decision of Supreme Court:

This new ruling from the Supreme Court concludes that for a person to have capacity to consent to sex, they need to understand that *their sexual partner* must also have the capacity to consent to sex, and they need to understand that the other person must consent throughout the sexual activity.

Following this ruling a person must be able to understand, retain and use or weigh, to have capacity to engage in sexual relations may include:

- The sexual nature and character of the act of sexual intercourse, including the mechanics of the act.
- The fact that the other person must be able to consent to the sexual activity and must in fact consent before and throughout the sexual activity.
- The fact that P can say yes or no to having sexual relations and is able to decide whether to give or withhold consent.
- That a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant.
- That there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by taking precautions such as the use of a condom.

The Reasoning of the Supreme Court

Some of the reasons the Supreme Court based its decision on are:

1. It is important that the Court of Protection is able to consider all relevant information when making decisions about capacity, if that information helps protect members of the public, as well as people who may lack capacity.
2. It is relevant to take into account the other person's capacity to consent to sex, because sexual relations must be **consensual**. Consensual sex means both people agree to have sex and continue to agree to having sex throughout.
3. There is no problem with applying a higher standard to consent in civil law as opposed to the standard of consent in certain criminal contexts if that is in the interests of protecting members of the public.
4. This decision is **compatible** with article 8 of the European Court of Human Rights, which provides for a right to respect for an individual's private and family life. Compatible means that two things are able to exist together.

Why is this ruling relevant to Old Age Psychiatrists?

Old Age Psychiatrists are often called upon to make decisions regarding capacity, including in people with impaired cognition. For example, individuals with dementia in care home settings may want to engage in sexual relations with other residents, in such a case, this ruling is of utmost importance. In addition to established practice, Old Age Psychiatrists need to consider whether an individual understands that their sexual partner must have capacity to consent to sex, and that this consent must continue throughout sexual activity. This needs to be embedded into our capacity to engage in sexual activity assessments, in order to safeguard our patients and their sexual partners.

Curriculum update

Old is new – re-writing the old age and core curricula

by

Dr Alex Bailey

Consultant older adult psychiatrist, Leeds and York Partnership NHS Foundation Trust & Chair, Specialty Advisory Committee for Old Age Psychiatry, Royal College of Psychiatrists

I've always loved education. And I've always loved a project. So you would think that I would have loved the idea of re-writing the curriculum for old age psychiatry, but the thought of it was, frankly, terrifying. But as the chair of what was the 'FECC' (Faculty Education and Curriculum Committee) and transformed in to the 'SAC' (Specialty Advisory Committee - don't ask me what it is about College acronyms...), that was what I was tasked with, along with my fellow chairs of the other specialties and interested others. Our job was of course an absolutely tiny one... translate about six gazillion learning outcomes into documents that trainees and supervisors actually *wanted* to use as well as being future proof for a new generation of training psychiatrists. Simps, no?

Over three years later and an absolutely humungous amount of toil, we are nearly (note the word nearly!) there. It has been an utter privilege to be a part of this work, led by really very dedicated College staff, an educationalist and our Associate Dean for Curriculum, John Russell, who was appointed just a short way in to the process having previously chaired the Intellectual Disability SAC. I have *never* enjoyed any meetings as much as the curriculum revision group ones, we pivot between belly-laughing out loud (usually when John mentions his 'FLIPA' – see if you can find it in the curricula) to having some of the most engaging and rewarding conversations about our profession that I can imagine. We were privileged to have the most phenomenal service user representative on our group, Veryan, who more than any one other person helped us understand what it is we actually wanted the curriculum to *do* in terms of how it helped shape training to turn out better psychiatrists. I can only hope we've managed

the task. Our trainee representatives have also been phenomenal and have had an absolutely vital role in shaping this work. Some of us even had the privilege to be asked to act as independent assessors for the curriculum submission for the College of Psychiatrists of Ireland, allowing us to see what it was like on the 'other side' of the fence.

The work was done in so many different stages, but fundamentally we worked on the core curriculum as a group and then the SAC chairs took their own curricula off and worked on them in their own committees, using a common 'framework'. I remember one of our early meetings was with some guys trying to teach us about improving our 'message' through the use of language – I suggested we had a hashtag called 'Kick-Ass Psychiatrists', but for some reason it didn't catch on...

Even though the documents look really very different to the old curricula (which we all felt they needed to be), believe it or not, *nothing* has been lost. All of our original outcomes were incorporated, jiggled, reworked and reworded, badgered, bullied and beautified so that the work that had gone before was rightly honoured and maintained. However, the curricula had become unwieldy beasts over so many years with outgrowths and add-ons that had reduced their sense of cohesive documents. This has been stripped back, made much more user-friendly (we hope) and has satisfied our GMC overlords (again, we hope!). I really believe that the new curricula really help distil what it is we already know about our profession – the importance of our medical training, our unique perspective from other specialties in understanding our patients at a really existential level, our core skills and values of communicating honestly and expertly and our ability to manage risk and complexity. It's actually made me even prouder of the job that I do.

The curriculum is not intended to radically alter how training looks, it can't nor shouldn't do that. It is there to provide a better framework for both those that train and those that train them as to how to approach training, making it more explicit and even more demonstrable. The new 'placement development plan' is possibly the biggest change in terms of process and will undoubtedly take some getting used to – it requires a significant amount of effort at the start of a placement but I still believe that done well it will really help improve how trainees and their supervisors approach each training post. More importantly, it

should make the ghastly psychiatric supervisor report much less painful when you come to the end of the job! The college is gradually increasing the number of example PDPs on the website – you should hopefully see at least three for old age.

The old age curriculum puts more emphasis on the interplay between physical and mental health, highlighting our particular skills in managing this interplay as well as our vital role in issues related to carers, safeguarding, prescribing (and *de*-prescribing), managing diagnostic uncertainty etc. It is intended to flesh out those core things that we all know we do (and love to do) but are somewhat tacit and difficult to elucidate on paper. I will let you be the judge of whether you think we have managed that or not! We have also renamed special interest sessions as ‘professional development sessions’ – no real change, but sadly I couldn’t get us back to the good old days, when I were a lad, and we had *two* days a week!!

The work has not been without its frustrations. The GMC don’t always get what our professions ‘do’ and how they differ and a lot of work went in to helping them get to grips with our training pathways, as well as safeguarding our individual subspecialties. At times the work went incredibly slowly and felt stuck, only for a simple idea to radically open up new possibilities and rejuvenate the process.

I didn’t want to write this as an exhaustive explanation of the new structure, the College are putting in a huge amount of resource (both in terms of drop-in sessions and online documentation) to do this way better than I could. We are now in a pilot phase, with all new CT1s and ST4s in February 2022 on the new curriculum, with full roll out starting in August of this year. Scary. But exciting. What I’d hoped to do is give some context to the work and *really* encourage you to head to the College curriculum [microsite](#) and have a look at the documents and sign up for a drop-in session on Thursday mornings. This work has relied on feedback at all stages, and it is still being constantly tweaked and improved. Any suggestions, I’d love to hear from you, on alex.bailey@nhs.net. And as much as I’ve loved this whole thing, I may never want to tackle another curriculum again as long as I live ☺.

Acknowledgements: I would like to thank the whole of the SAC for all their hard work with this mammoth project, and in particular Dr Sharon Nightingale and Dr Orima Kamalu for their amazing work on developing example PDPs.

Cochrane Corner

by

Dr Jenny McCleery

Consultant Psychiatrist, Oxford Health NHS Foundation Trust

Joint Coordinating Editor, Cochrane Dementia and Cognitive Improvement Group

Featured review: Palliative care interventions in advanced dementia

The palliative care approach has transformed the care of people with advanced cancer over the last 50 years, but it has often seemed that those with other diseases have been left behind in both research and services for the late stages of illness. In 2014, mounting calls for a palliative care approach to be applied to advanced dementia led to the European Association for Palliative Care (EAPC) running an international Delphi exercise and publishing the first description of optimal palliative care for dementia (1). EAPC has defined palliative care as "the active, total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and social, psychological and spiritual problems is paramount. Palliative care is interdisciplinary in its approach and encompasses the patient, the family and the community in its scope. In a sense, palliative care encapsulates the most basic concept of care - that of providing for the patient's needs wherever he or she is cared for, either at home or in the hospital. Palliative care affirms life and regards dying as a normal process; it neither hastens nor postpones death. It sets out to preserve the best possible quality of life until death" (2).

The authors of the updated Cochrane review on *Palliative care interventions in advanced dementia* (<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011513.pub3/full>) (3) identify some of the particular difficulties in providing palliative care to patients with dementia. These include the variable trajectory of the illness, the difficulty of assessing pain in advanced dementia, and the early loss of patient decision-making capacity. Researching palliative care interventions in dementia also raises additional challenges related to consent and identification of appropriate outcome measures. Despite these hurdles, the updated review now

includes nine controlled trials of interventions intended to support the implementation of palliative care for patients with advanced dementia. This compares to only two trials in the original review in 2016. All of the included trials were conducted in high income countries (Europe, North America and Australia).

The authors divided the interventions into two categories. The first category (6 trials) was described as interventions focusing on changes to the organisation and delivery of care, although there was considerable diversity of approach within this category: facilitation of family case conferences; methods to obtain structured feedback from families; introduction of dedicated hospital palliative care teams; and complex, multidimensional interventions in nursing homes. The second category of interventions, described as advance care planning (ACP) included three trials of the use of decision aids or videos about ACP with surrogates of people with advanced dementia in nursing homes in the USA.

Identifying the key outcomes for the review was a challenge. The seven authors independently ranked outcomes for priority and settled on the following seven for their evidence summaries: patient comfort in dying; symptom management; pain; palliative care plan in place; quality of life; occurrence of discussion on advance care plan; care consistent with goals. It is not clear how closely these would align with patient and carer priorities and the authors rightly identify the need for a PPI-informed core outcome set for this area of research.

The authors did attempt some synthesis of results, but, perhaps not surprisingly when the research was so diverse and the trials small, they could not reach robust conclusions from meta-analyses. Nevertheless, this review is a very valuable resource for anyone interested in the scope and quality of trials which have been conducted on this topic. When considering the development of palliative care services, some interventions might seem to be common-sense good practice, but all service developments require the weighing of priorities for the allocation of resources and so methodologically sound comparisons with usual care are important. However, this is perhaps one of the areas where there is particular value in assessing new interventions in a local context, against usual care in a particular care system.

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Research update

by

Dr Catrin Thomas,

Trainee Editor, RCPsych Old Age Faculty Newsletter,

ST5 in Old Age Psychiatry, Betsi Cadwaladr University Health Board.

Hamilton *et al.* Assessment of autonomic symptoms may assist with early identification of mild cognitive impairment with Lewy bodies.¹

This longitudinal study aimed to assess whether people with mild cognitive impairment with Lewy bodies (MCI-LB) report more autonomic symptoms than cognitively healthy older adults or those with mild cognitive impairment due to Alzheimer's disease (MCI-AD). They also assessed the usefulness of the Composite Autonomic Symptoms Score 31-item scale (COMPASS-31) in differentiating MCI-LB from MCI-AD.

The study included 93 individuals over the age of 60 with MCI and 33 healthy controls. After adjusting for age, the severity of overall autonomic symptoms was greater in MCI-LB. Compared to controls, people with MCI-LB were found to have higher orthostatic intolerance, higher urinary symptoms severity, greater risk of gastrointestinal symptoms, and greater risk of secretomotor symptoms. People with MCI-AD did not have statistically significant higher overall autonomic symptom severity scores compared to controls. The study found that a cut-off of >4.5 on the COMPASS was highly sensitive but not specific to MCI-LB.

The study undertook a sensitivity analysis controlling for the use of acetylcholinesterase inhibitors and found that the use of acetylcholinesterase inhibitors was associated with significantly lower total COMPASS-31 and secretomotor symptom severities.

Evidence has already shown that the synucleinopathies are commonly associated with autonomic dysfunction. Although not specific, this study has shown that people with MCI-LB have greater autonomic symptom severity compared to people with MCI-AD and normal ageing. This study has highlighted that there

may be a role for using autonomic symptoms severity scores, such as COMPASS-31, when screening patients with suspected MCI-LB seen in memory clinics.

Van de Veen *et al.* Provisional consensus on the nomenclature and operational definition of dementia at a young age, a Delphi study.²

The aim of this study was to reach a consensus on the terminology and operational definition of dementia at a young age. Achieving this consensus is important because dementia at a young age is different to dementia in old age in many ways including disease characteristics, mechanism, course, and care needs.

The authors used the classical Delphi technique to transform opinions of international experts into a group consensus by using an online survey. The survey included 35 statements covering: the terminology used (5); age related criteria (8); and aetiologies that can be considered as causes of dementia at a young age (22). The experts were asked to rank each statement on a 5-point Likert scale that ranged from 'strongly disagree' to 'strongly agree', as well as having space to comment on their opinions and explaining their answers.

Forty-four international experts completed the survey. Consensus was reached on 22 out of the 35 statements. The term 'young-onset dementia' was preferred. A provisional consensus was reached for the use of 65 years of age as a cut off for young-onset dementia.

The majority of the experts stated they would like to use the age of symptom onset as a cut-off age criterion to distinguish from late-onset dementia, as opposed to date of diagnosis, due to the existing prolonged time to diagnosis in younger individuals. Some experts suggested the need for a different term for people living with dementia aged below 45 years and those between 45 and 65 years.

Consensus regarding the aetiological causes of dementia at a young age was reached for Alzheimer's disease, frontotemporal dementia, dementia with Lewy bodies, Parkinson's disease dementia, progressive supranuclear palsy,

corticobasal degeneration, and Huntington's disease. Consensus was not agreed for multiple system atrophy, Down's syndrome and depression.

The hope is that this study will aid to improve the current variations in both diagnostic and post-diagnostic care and support for young people living with dementia and their carers. It has also given food for thought about the use of date of symptom onset rather than date of diagnosis as the cut-off age criterion as clinically, locally at least, there are different levels of support available to those with young-onset dementia and dementia in old age.

Neelamegam *et al.* The effect of opioids on the cognitive function of older adults: results from the Personality and Total Health through life study.³

Unfortunately, chronic pain is common in the older adult population and I certainly find that patients referred to the memory clinic will frequently have some form of opioid-based medication among their list of regularly prescribed medications. This prospective, longitudinal cohort study aimed to examine the association between prescription opioid use and changes in cognitive function in older adults over a 4 year period.

The study participants were taken from the Personality and Total Health Through Life Study based in Australia and included 2,222 individuals aged 65-69 years at baseline.

The authors calculated opioid exposure over the 4 years of study for each individual as total morphine equivalent dose (MED). They used the Mini Mental State Examination (MMSE) to assess global cognition. They used other more focused tests to assess more specific cognitive functions e.g. Trail Making Test to assess processing speed and executive function.

The study found that there was decline in the global cognitive function of participants over the 4 years. In particular, the participants with a cumulative opioid exposure exceeding total MED of 2,940 (the highest exposure group) were significantly associated with poorer performance and more decline in the MMSE when compared to those not on opioids, indicating a decline in global cognitive function. The severity of decline in the Trail Making B test seemed to

be linked to the increasing total MED opioid exposure. Performance in other cognitive assessments were not associated with opioid use.

Although it has its limitations, this study indicated that prolonged, high dose, opioid use in older adults may accelerate a decline in their cognitive function and therefore highlights the need to rationalise and optimise pain management medications in the first instance as well as encouraging alternative pain management strategies in older adults.

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Book Review

by

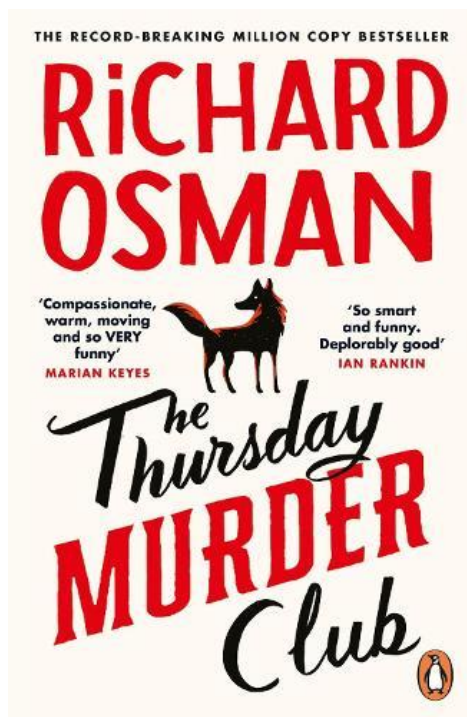
Dr Charlotte Bendall

Foundation Year 2, Queen Elizabeth Hospital, Gateshead

The Thursday Murder Club

Author: Richard Osman

ISBN: 0241425441



The fastest selling adult crime novel since records began and the first debut novel to ever make Christmas number one, written by 'Pointless' co-host and creator Richard Osman (the tall chap in glasses who mans the laptop). Given the 'celebrity' author, I was a tad dubious. I was completely wrong, and I adored it.

The Thursday Murder Club is set in Coopers Chase, a luxury retirement village nestled in the Kentish countryside. It follows 4 main characters, Elizabeth, Ibrahim, Joyce and Ron, all in their seventies, who meet every Thursday to

explore old unsolved murder cases in their retirement village 'jigsaw room'. When a local builder is found dead in very suspicious circumstances, the Thursday Murder Club swings into action and starts to investigate.

What follows is a romp of a 'whodunnit' with plentiful twists and turns, some feeling far less plausible than others, and leaving the reader, or certainly me, with no idea as to the culprit/s until the very end. However, this wasn't why I loved this book. I loved this book for its original setting inside a retirement village, the quiet Britishness that is interwoven through its pages and the positivity with which its older protagonists are written. The retirement village sounds like nothing I have ever stepped inside, and certainly never read a book set in one, and to be honest, I'd be keen to sign up now; Coopers Chase; 'You can't move here until you're over sixty-five and the Waitrose delivery vans clink with wine and repeat prescriptions every time they pass over the cattle grid.' Sounds fabulous.

Despite being a murder mystery, this book made me smile and laugh throughout, and offered more than a few poignant moments that were gently touched upon and stayed with me. Given the protagonists are septuagenarians, The Thursday Murder Club touches on many aspects of ageing; illness, change of purpose, love, loss and loneliness amongst many others. No spoilers here, but reading with a 'doctor's hat' on, will make some of the storylines of the book feel distinctly uncomfortable (let alone illegal and unethical), such as one character's attempt to hide and manage a loved one's undiagnosed dementia by crushing temazepam into their tea. However, these themes run quietly in the background of the book, and offer much food for thought, but do not overshadow the wit, joy and pure escapism that comes from following the adventures of the Thursday Murder Club.

I really enjoyed the positive way in which older people were portrayed and particularly loved how the protagonists would often play on the stereotypes of older people and use these, joyfully, to manipulate younger characters. Of the main characters, Elizabeth is particularly brilliant in undermining the stereotype of the 'old woman'! This made for great reading and gave much to reflect on, and certainly reminded me of a few patients I have worked with since qualifying.

The portrayal of relationships between the Murder Club 4 and their grown-up children is another element that I felt was well-written and allowed the reader to

view a variety of different family dynamics from the viewpoint of our older leads. I felt many of these were incredibly accurate and reflected family relationships I have observed during my short stint working in old age psychiatry. An early comment from one character encapsulates this and rather sets the tone for the novel; "after a certain age, you can pretty much do whatever takes your fancy. No one tells you off, except for your doctors and your children."

In an interview following the release of *The Thursday Murder Club*, author Richard Osman said he felt that older people were being 'erased' from modern culture and simply not seen in television, film or books, where society tended to focus on the opinion and storylines of the young. His inspiration for this book came from wanting to write a novel inspired by the retirement community his own mother and her friends lived in, and the stories they would share. I certainly feel that Osman has managed this in spades and created an uplifting, funny and warm reflection on life as we grow older.

Following the success of *The Thursday Murder Club*, there are plans for a further 3 books, and Spielberg has the film rights... stay tuned!

Film Review

by

Dr Anita Howard

Consultant Psychiatrist, Bensham Hospital, Gateshead

The Father



Director: Florian Zeller

Released: 2020

Currently streaming on Amazon Prime

The Father is a moving depiction of a man's progression through dementia and its impact on the daughter who loves him. Anthony Hopkins rightly won an Oscar for his role as The Father, and you can see why this film was nominated for so many Oscars and Bafta's.

The basic plot can be summarised as a man struggling to manage the progression of his dementia but that would be downplaying the complexity of the film.

The daughter, Anne, as the illness progresses, goes through the range of emotions from love to frustration to guilt to acceptance. The film also highlights the impact caring for a parent with dementia can have on a child life, work, and

relationships. The part where The Father refuses to have carers to help and accuses his daughter of trying to cheat him could have been a day in my outpatient.

We experience the Father's confusion as situations change around him and he mixes up places and people but everything makes sense at the end when we realise that we are living a day in the mind of person with dementia. The final scene when the Father breaks down and is comforted by his carer is heartbreakingly real.

As usual, the portrayal of the Psychiatrist managing the Father's dementia is unrealistic- she hands Anne a card and informs she can call the Doctor at any time (and Anne does literally pick up the phone and is able to speak with the Doctor).

I would recommend this film to anyone who works with people with dementia as this possibly the closest to experiencing the sense of disorientation our patients can feel.

Film Review

by

Dr Alex Skulnick, Specialty Doctor

Bensham Hospital, Gateshead

Petite Maman (2021)

Director: Céline Sciamma



The next chapter in Céline Sciamma's unique storybook, fresh from the extolled *Portrait of a Lady on Fire*, is the short (72 minutes), sweet and boldly reflective *Petite Maman*. This amiable, and U-certificate, ethereal parable uses restrained whispers to explore mortality, grief and acquiescence.

The film shadows eight-year-old Nelly, whose grandmother has just passed away. Accompanying her parents, she goes to her grandmother's house (and her mother's childhood home) to organise the possessions and memories left behind. She discovers the adjacent woods and comes across a girl her age, building a fort. She shows Nelly to her home, a mirror image of Nelly's grandmother's house. Inside Nelly encounters a woman; a middle-aged vision of her late grandmother. Nelly soon realises she's somehow transcended time and befriended her eight-year-old mother.

Petite Maman stays buoyant and naive, rather than becoming a spooky or fantastical affair, even as Nelly begins to piece the resemblances together. The central conceit is cleverly upheld by the casting of twins Joséphine and Gabrielle

Sanz, and the camera is kept at their eye-level throughout, allowing the viewer to discover the intrinsic bond between the girls, without parental interference.

Grief permeates all of our lives, and is seen across mental health service users. The way we perceive and process death varies depending our stage in life, and sorrow in children can be remarkably challenging to comprehend. This movie goes some way to convey how children make sense of such difficult subjects. The loss of Nelly's grandparent will alter her world forever, and she is seen saying goodbye to childhood innocence, whilst sharing this moment with someone she is intimately related to.

Death is a dominant theme in *Petite Maman*, and the void left by the grandmother's demise is displayed through an empty house, missing the life that was once within its walls. Mourning becomes too much for Nelly's mother to handle, leading to her departure during the film, and abandonment of her daughter at the most crucial time, only for this vacuum to be satiated by the mysterious friend. In reality, we do not have such magic to guide us through heartache, and the cavity cannot be filled with a dream, but rather placated by items incomparable to what was lost.

A child's parents mould the adult they evolve into. Our perspectives of our parents can be negative, especially after the humdrum nature of adulthood takes its toll. Perhaps if we could revisit their early lives, and see the world through their fledgling eyes, we would better be able to understand them, and the intergenerational challenges that can precede mental health issues in children would be less prevalent.

Seeing a U-rated feature in the cinema carries with it a certain expectation. However, with *Petite Maman* I was greeted by smiles, looks of wonder, and an adult audience undoubtedly learning a little more about themselves and the curiosities of childhood.