

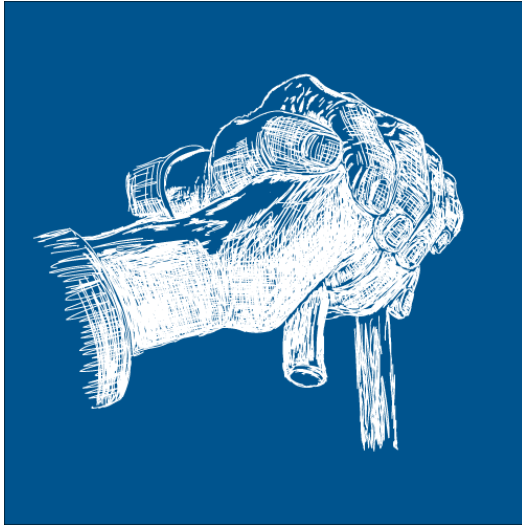


# The Old Age Psychiatrist

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Issue 84, September 2022

Old Age Psychiatry Faculty  
Newsletter



# The Old Age Psychiatrist

Issue 84, September  
2022

## In this issue

### Editorials

[2. Update from Editorial Team, Sharmi Bhattacharyya](#)

[3. View from Chair, Mani Krishnan](#)

[6. Update, A Burns & A Thompsell](#)

### Tribute

[11. Tribute to Dr K Mukhopadhyaya, N Mukhopadhyaya & A Mukhopadhyaya](#)

### Features

[14. Behind closed Doors, J Jones & M Curtice](#)

[19. No place Like Home, J Hill-Holmes & M Curtice](#)

[23. Management for Trainees, Jian Loo](#)

[27. Reflections on Remote working, P de Silva](#)

[31. Reflections of PD specialist, C Denman](#)

### Case Study

[35. Chronic Traumatic Encephalopathy, G Goss & A Varanasi](#)

[40. Improving communication with families, S Yeoh, L John & A Fadipe](#)

### Research

[45. Research Update, C Thomas](#)

### Review

[48. Book review, A Howard](#)

# Update from the Editorial Team

by

Sharmi Bhattacharyya

Editor, The Old Age Psychiatrist, Royal College of Psychiatrists

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Hello again from the Editorial Team. Hope you are all keeping safe and well. How time flies... and our September 2022 Newsletter is out for reading.

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 as always provides an interesting and informative update.

If you are interested in legal aspects, there are 2 informative articles by Dr Curtice and his medical students, which help us understand making Best Interests decision with limited information and around residence and care arrangements.

This edition also contains our usual research update. If Higher Trainees are interested in Management and Leadership options to explore please read the article by Dr Loo. Our book review by Dr Howard as always provide food for thought.

We have appointed our new trainee Editor Dr Anne M. Bonnici Mallia from September 2022. Dr Thomas has been an excellent trainee editor and she will be a hard act to follow. Thank you Catrin.

The next newsletter is January 2022 so the last date for submission of articles is 30<sup>th</sup> November 2022. As always let us know what you think of the newsletter, and feel free to email me on [drsharmib@gmail.com](mailto:drsharmib@gmail.com) with ideas, suggestions and of course articles for the future newsletter.

# View from the Chair

by

Dr M S Krishnan (Krish)

Chair of the Faculty of Old Age Psychiatry

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Dear colleague

Hope you had managed to get some time off this summer and were able to rest, relax and recharge.

Thank you to Sharmi and our editorial team for putting together another excellent edition during these busy times this summer. I am saddened to hear the news of Dr Kaushik Mukhopadhaya, a compassionate leader and a kind soul a real loss to our faculty. On behalf of all of you I am sending our condolences to his family. I met him pre COVID and we connected instantly.

We are clinically gradually catching up with backlogs and I am sure everyone is feeling the work pressure. Thank you for all your leadership to deliver care to our older adults in your areas.

We had our recent faculty executive committee meeting in July. Please join me in welcoming our newly elected Executive committee members. Dr Mohan Bhatt our finance officer and Dr Chineze Ivenso our academic secretary are busy planning for our next annual conference in March 2023.

The current idea is to run it as Hybrid event. After 2+ years it would be great to meet our faculty members F2F but also those who are not able to join can benefit from the online streaming. Chineze is working with our CALC team with plans and will keep you updated with exact date and venue.

Josie has been working closely with our Liaison faculty and had successfully facilitated two webinars for Old Age Liaison network group (an informal group) which was attended by over 200 colleagues. You can watch the recording

through the links First webinar <https://youtu.be/r-sIpi536cw> and Second webinar <https://youtu.be/-rqzwR4unEo>

Following this successful webinar, we are hoping to run a joint faculty event (Old Age & Liaison) specifically focusing on Old Age Liaison topics this winter. As a preparation for next year's Hybrid annual conference, we are planning to do this as Hybrid as well. Please save the date 9 December 2022. Details will follow once we get the logistics all sorted.

We are supporting the [PsychStar](#) project of the college and we have awarded one position to a medical student who will start one year of their role from 1 September 2022.

The picture on this page is from the Congress at Edinburgh. Josie and I attended the congress. We had excellent opportunity to network with colleagues after 2 years.

I have attended a meeting with Tim Kendall, Adrian James our president, and colleagues from MOJ regarding our ongoing issues with Section 49. We are getting more traction and support to move this forward. There are further meetings planned with NHSE (Amanda will be attending) hopefully we will move in the right direction to improve the situation.

You might have seen some of the work done on complex and emotional needs on NHS Futures Webpage. Thanks to Amanda, Suhana and colleagues the recording and slides from the webinar have been uploaded into two places:

1. [Complex Emotional Needs in Older Adults - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform](#)
2. [Complex Emotional Needs - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform](#)

We have been collaborating with Alzheimer's society and our faculty chairs from devolved nation to look at UK wide survey on issues regarding memory services to support and give further information complementing the national dementia audit. I should be grateful if you could help us to collate the information across the country. Please prompt your NHS trust to help you to

provide data that can be feedback into the survey. Our colleagues in Scotland are also doing similar exercise and we are hoping to compile the findings towards the end of the year.

Here is the link for the Survey

<https://www.smartsurvey.co.uk/s/8G3T87/>

I am delighted to be delivering the keynote speech at Alzheimer's Research UK's [Clinical Conference](#) on October 14th. This year the event is taking place online and in person at the Royal College of Physicians and will explore the theme of 'Innovations in Dementia Research: What the Future Holds for Dementia Clinical Practice.' Hope I might see some of you after a long time. Details of the conference

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

Hope you enjoyed the recent warm (Hot) weather and ready to see some Autumn colours. We have our first face to face executive committee meeting in November and will keep you posted with further updates. Look forward to seeing some of you on December 9<sup>th</sup> at the college or online.

# Update for the newsletter

by

Professor Alistair Burns, [alistair.burns@manchester.ac.uk](mailto:alistair.burns@manchester.ac.uk)

&

Dr Amanda Thompsell, [Amanda.thompsell@nhs.net](mailto:Amanda.thompsell@nhs.net)

## **Dementia**

A lot of current interest around dementia focuses on the Secretary of State's (SoS) announcement of a new 10-year plan. There had been talk of a 5-year plan in terms of dementia which was to focus on prevention, diagnosis and post-diagnostic support and research. The potential for a 10-year plan opens up real opportunities for us to be more ambitious and allows the potential to consider carefully what future care for people with dementia should look like. At the time of writing, there has just been a change in the person who holds the position of SoS and we await to hear the views of the new incumbent.

There are a few initiatives that we have made some progress on recently which are important in terms of dementia.

The dementia diagnosis rate still is lagging, understandably because of the effects of the pandemic. The DiaDEM tool (<https://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Dementia%20Diagnosis/2016/DiADeM/DiADeM%20Tool%20Final%2002092016.pdf>) has been supported by NHS England and will be rolled out in a number of areas in a pilot study. It gives the opportunity to diagnose dementia in care home and presents a way that general practitioners and other staff can be made aware of the potential symptoms of dementia that would culminate in a diagnosis. Important in this obviously is the need to make sure that the resident and their families are fully aware of the situation.

I know we have all discussed and described over the years the benefits of a diagnosis of dementia in someone in a care home – it is *not* so they can be taken off to have a brain scan at a local hospital but it is in terms of understanding behaviours and making a personal care plan available for the

individual. It is the issue of “*Do you need a brain scan to diagnosis dementia?*” comes to the fore and the NICE guidelines are very clear that in people with established disease, if it is not deemed clinically appropriate, then it is not necessary.

We are all used to doing at least some work remotely now and it may be that many of us would use this way of working at least in a blended approach in the future. Leeds Beckett University have done a piece of work on behalf of NHS England (<https://www.leedsbeckett.ac.uk/-/media/files/research/dementia/taking-memory-assessment-services-into-future-web.pdf>) which aims to understand different models of delivery in memory assessment services across England and Wales and has identified areas of good practice.

As waiting lists continue to be an issue, many people have introduced the idea of “*peri-diagnostic*” support. This is based on the proposition that even before the full assessment has been completed at a memory clinic, there are things that one can do to support people next steps (<https://www.nextsteps.org.uk/about/>) is an innovative way of looking at this and could provide a very helpful resource for patients waiting on assessment, their families and carers.

Each region will have its own way of trying to recover the dementia diagnosis rate and this has been helped by the additional funding which has gone in to support areas. For example, London has developed a decision support tool, the North-West has specific initiatives for people with young onset dementia, the South-West has community development coordinators (who raise awareness around dementia), the North-East and Yorkshire has pilots of specialist community nurses, the Midlands are looking at a boundaryless memory assessment service and the East of England have a specific initiative upscaling community care workers. One of the things that I think is important is the issue of recognising the range of facilities there are and the range of innovations which take place.

The impact of Covid on dementia is still being seen and Public Health England (now the Office for Health Improve and Disparities), has a number of initiatives and lots of factsheets that are available giving a summary of dementia surveillance <https://fingertips.phe.org.uk/profile/dementia/supporting-information/data-products>.



The news that the licence for Aducanumab is not being pursued will probably come as little surprise to many people. It is important to keep up interest in the potential for new agents in the future and to prepare NHS services for their introduction.

Finally, as an example of something which can bring to life an issue, have a look at the dental dementia friendly guide. This is a booklet for dental practices to make them become more dementia friendly and it may be that something for general practice might work well.

[https://www.plymouth.ac.uk/uploads/production/document/path/20/20743/Dental\\_Dementia\\_Friendly\\_Guide.pdf](https://www.plymouth.ac.uk/uploads/production/document/path/20/20743/Dental_Dementia_Friendly_Guide.pdf)

There are also significant developments in older people's mental health.

### **Community Mental Health**

The National Community Mental Health Team has decided to focus this year particularly on older adults. As part of the statistics for judging the success of the current Community Mental Health Transformation (CMHT) initiative, the Team plans to collect data on how many of the patients seen are over 65. This should generate some interesting numbers that may be helpful to old age psychiatrists to monitor whether the increased resources are benefitting our patient group.

The National Community Mental Health Team is keen to learn which representatives it should be liaising with locally at the level of an Integrated Care System (ICS) on issues relating to older people's mental health in the community. If you do not know who to contact locally and are interested in getting more engaged through your local Integrated Care Board (ICB) in relation to the CMHT, please let Kitti know and we will pass the information on to the National Team for onward transmission to your ICB. Currently we have colleagues who have put their names forward in well over half the total number of ICSs.

The frequently asked questions guide for the CMHT outcome measures is being worked on as I write this (in August 2022) and should be available soon. This will be followed by the implementation guidance. The chosen measures are ReQoI 10, GBO and DIALOG (the National Team is continuing to discuss with the developers how DIALOG could work best for older adults).

These outcome measures are not going away so we will all need to learn how to implement them into routine use.

### **Complex emotional needs**

You can now find on the Futures webpage ([Older Adult Complex Emotional Needs: Standards for Services - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform](#)) recommendations on making your local complex emotional needs pathway fit for older people. You will also find there a webinar [Complex Emotional Needs in Older Adults - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform](#) where you can hear about the issues and some examples of good practice.

### **Eating disorders**

A similar set of recommendations has been completed in relation to older adults accessing the new eating disorders pathway and will be going on the Futures webpage. There will be a National webinar in October focusing on eating disorders in older adults which you will be able to sign up for,

### **Older adult inpatients**

NHSE&I has a renewed focus on the therapeutic environment for older adult inpatients. The National Team is producing guidance on therapeutic inpatient care. Whilst more money has been allocated for this area (this year £46 million) there was a poor take-up of the money that was available last year. To avoid missing the opportunity for your inpatients this year, make sure that you make a bid for your allocation. Here is a link to the LTP Analytical Tool which can help ICSs identify how much funding they should expect to receive to address therapeutic acute care, this can be found at: <https://future.nhs.uk/MHLTPat/view?objectId=122625509>

### **End of Life**

The National End of Life audit of mental health inpatients is now out: [PowerPoint Presentation](#). This both highlights good practice and identifies some areas of improvement (such as being able to access palliative care support). It offers

some interesting insights that you may be able to apply to your own inpatient ward.

For those of you keen on digital the "Priorities for Digital Mental Health" has been published and can be found on the FutureNHS Collaboration platform. [NHSE&I Priorities for Digital Mental Health \(May 2022\) - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform](#) .

As the CMHT is now starting to deliver it really does seem as if there is renewed interest in older adults with and without dementia and the ambitions of the CMHT are supported by some extra resources. It is essential (although in no way easy) that in spite of our busy workloads that we try and make the most of these various potential opportunities.

As always, we would be happy to hear your views and thoughts on national developments.

# Tribute to Dr Kaushik Mukhopadhaya (1965 -2022)

by

Dr Neela Mukhopadhaya (wife)

&

Akash Mukerji (son)

Kaushik was born in Ranchi, the capital of the Jharkhand state of India. He got his primary education in Victoria Boys School in Darjeeling and went on to get his medical degree from North Bengal Medical College in 1989. He moved to the UK with his family in 1998.

He started his career in psychiatry in 1999 and moved into a registrar post in Hertfordshire in 2002. He was appointed as a substantive consultant in old age psychiatry in the Hertfordshire Partnership Trust in 2005, a Clinical Lead in 2009 and then a Medical Director of the Trust in 2015. He served in this post until 2018, subsequently serving as an advisor to the Trust's senior medical management team. He was based at Seward Lodge in Hertford which caters to old age psychiatry, and he worked relentlessly through the pandemic to ensure that all his patients were safe and that his colleagues were supported.

Kaushik excelled in his career. He was spotted early in his career as a rising star and became a Joint Head of Service (Clinical Director at the time) after only a year as a consultant in 2009. As a Joint Head of Service, Kaushik ran the acute services for the whole trust and pioneered the concept of medical managers working outside their clinical specialty. In 2015, Kaushik was appointed as Director of Quality and Medical Leadership of HPFT; he held this post until 2018. He led on innovative projects in delivering old age care in psychiatry and was an advisor to the CCG and local strategic boards. He was the Chair of the Medical Staff Committee. Kaushik attended and contributed to a vital Royal College meeting exploring collaborations between The Faculty of Old Age Psychiatry, British Geriatric Society and Indian Psychiatric society. He was also a

member of National Clinical Advisory Group and had various other advisory roles, regional and national. He did an impressive presentation of leadership and management at the Joint Masterclass organised by European association of Geriatric Psychiatry and Faculty of Old Age Psychiatry, RCPsych at Institute of Mental health, University of Nottingham.

Even as he did that, he gave a lot of time to his family who remained his touchstone throughout his life. He was married to Neelanjana (a doctor by profession) for 33 years and they have two sons Akash and Abhilash. He loved cars and he knew every detail about every car. Often you would find him engrossed in the car magazines in the aisles of supermarkets or glued to the automotive shows on the Discovery Channel. One of his retirement plans was to do voluntary work in a friend's mechanic garage. He loved sport in all its forms and never missed the big football, cricket or other game of the season. He had many interests: he kept up to date on politics and enjoyed staying up late in the nights watching the debates and news. He had vast knowledge of things outside of medicine and he could talk to anyone about anything – many of the messages we have received describe his wonderful public speaking style and conversational grace. Beyond medicine and his worldly interests, everything always came back to what was most important to him – his family.

This is evident in the cards and tributes received from his friends and co-workers; they all say that he always spoke about his family, how proud he was of his wife and his two sons, and how much he loved them. He was a true family man. He was always there for his family, and further, the many more who considered him family.

Kaushik had an extraordinary ability to connect with people, including his patients. He became popular among both medical and nonmedical colleagues because of his kind, compassionate and problem-solving attitude. He had exceptional leadership qualities and focused on improving clinical care, reducing referrals between teams within the various services and releasing professional time for direct patient care. He was an excellent teacher and trainer and travelled up to Nepal to run dementia training workshops for Nepalese doctors just before the Covid-19 pandemic in 2020.

Kaushik had an uncanny quality of inspiring people around him. He developed and harnessed the skills of embedding dedication, tenacity and the aspiration to progress and excel. There are many examples of colleagues, junior doctors and healthcare workers who he has inspired to progress into much more fulfilling and important roles. He always believed "in not giving up" and he would often speak to acquaintances over the phone counselling, inspiring, motivating and encouraging them. Within his social circles, he was one of the advisors; when someone had a problem, Kaushik always had the solution.

Friends and acquaintances have always found a listening ear about anything. Juniors looked upon him for career guidance and sound advice. For his friends his loss is irreplaceable. His smiling face will forever be etched in their memory.

Kaushik left us for his heavenly abode on 5<sup>th</sup> March 2022 following post operative complications of cardiovascular surgery.



# Behind closed doors – deciding best interests with limited information

by

Julia Jones, Warwick Medical Student, University of Warwick

&

Dr Martin Curtice, Consultant in old age psychiatry, Coventry and Warwickshire Partnership NHS Trust

## **Introduction**

Deciding the best interests for a person who lacks capacity under the MCA can at times be a complex decision mired with a myriad of unknown factors. In November 2021, the Court of Protection (meeting twice in five days) oversaw such a case<sup>1</sup> in deciding the residence of an older woman but with a confounding element – her carer was refusing to let anyone properly assess her care needs.

## **Background**

Mrs A was a 76-year-old woman with vascular dementia, complicated by agitation and psychosis. It was agreed she lacked capacity to make decisions about her residence and care. In March 2021 the local authority applied to the Court of Protection for a best interests residence decision to be made. During this, one of her sons, B, proposed to be her primary carer at home assuring he would seek professional support as needed. This was approved, and care was put in three times a day together with additional day centre attendance.

However, in August 2021 there was a change in B's behaviour towards carers and the court. Potentially as a response to the court's consideration of vaccinating Mrs A from Covid-19, B immediately cancelled all care, stopped Mrs A from visiting the day centre and other family were not able to visit. B became increasingly hostile to professionals, becoming verbally abusive when social care workers visited, accusing them of stealing money and threatening to call the police. When the case again came to court in November 2021, no professional had been allowed to enter the house for a month.

Further consternation by professionals arose regarding the way Mrs A was being treated as evidence of B's character and previous behaviours emerged:

- In 2018 and 2019 B was living with someone next door to Mrs A when allegations were made to the police that B had made threats to harm and kill Mrs A, including threats to burn down her house.
- In May 2021, B contacted the police stating that Mrs A was being abusive towards him.
- In July 2021, a former care provider documented they had discovered a bruise on Mrs A's arm – both Mrs A and B agreed that B had caused it, but B maintained it was an accident.

In September 2021, during a capacity assessment by a consultant psychiatrist, the doctor reported that B had suffered childhood physical abuse from his late father and had 'disappeared' for five years from the age of 15. Now in his mid-fifties, B has several criminal convictions including a ten-year imprisonment for GBH with intent. During his adult life he became a 'born again Christian' regarding himself as 'a Messianic Jew and I follow no man made laws' and had worked as a missionary in Africa. It was also noted B had only re-appeared in Mrs A's life 'relatively recently'.

Apart from the bruising incident above, all accounts reported that Mrs A seemed healthy and clean. Mrs A usually expressed her wish to remain living at her home. However, there was one second hand piece of evidence, from a brief conversation in the front doorway, that Mrs A whispered she did not like 'him' and she may have indicated she did not want to live with B.

### **The options**

The court considered there were only two realistic options:

1. Watchful waiting under the care of B in Mrs A's home, under the condition that a health and welfare check was allowed to be conducted without B present in the same room, or,
2. To organise a residential care home for Mrs A (for an interim period to enable further assessment).



The judge was reticent about the latter as it would likely be a traumatic experience for Mrs A, not only because she wouldn't know the environment in the new residential care home, but B's behaviour implied that he would do whatever possible to obstruct Mrs A being transferred into a residential care home. This could lead to a real risk of injury for people involved and may result in physical restraint being used, all of which could be very distressing for Mrs A. Furthermore, there was no concrete evidence of harm coming to Mrs A from B's care. Because of this, the judge initially chose watchful waiting, with the health and welfare check to be organised and reported back to the court as soon as possible – another key element being that B was given the opportunity to demonstrate he would co-operate.

### **The degradation of trust**

When the health and welfare check was attempted, Mrs A tried to allow the social workers entry before being stopped by B, who again threatened to call the police. They were able to post him information about the next court hearing which was taking place remotely, which he joined.

At the hearing, the day following the failed health and welfare check, B stated Mrs A was well, takes her medication and that she was less paranoid. He expressed the view that he didn't want any visitors as they might spread Covid-19 to him and Mrs A and that it was no one else's business how they lived. When challenged (by suggesting allowing only visitors who have had negative covid tests and wearing appropriate PPE), B became more agitated and stopped answering the questions referring to 'things I have seen' before ultimately leaving the meeting and refusing to re-join. Interestingly, he stated that he would be happy for someone independent to visit, which put into question whether Covid-19 fears were his actual reason for not allowing people into the house.

### **The best interests assessment**

The salient issues considered in the best interests assessment were:

- The judge, in acknowledging it was a difficult decision, balanced all competing factors and weighed all the circumstances of the case around

the 'substantive' question of whether it was necessary to remove Mrs A from B's care and into a care home.

- It was a 'precarious' situation with 'every option laden with risk'.
- Mrs A's wishes and feelings were considered, as best as could be determined given the limited access to speak to her and the overly controlling behavior of B.
- Given B's history and his recent behaviour, there were 'deep concerns that A may be suffering and/or is at risk of suffering significant harm whilst she is under his sole care' hence potential risks leaving Mrs A at home.
- The court could not know, because B 'stubbornly refused' opportunities to meaningfully engage, if B was actually keeping Mrs A safe and well or whether his relationship was harmful towards her.
- There were potentially harmful risks to Mrs A in removing her from her home to a care home.

### **The court conclusion**

The judge concluded it was not in Mrs A's best interests to continue to be looked after by her son at home given his obstructive and hostile behaviour, his 'current state of mind', his past forensic history and his 'intransigent determination to isolate' Mrs A. There was no adequate way to check on her health and welfare due to this. Hence the only 'viable option' was to remove Mrs A to a residential care home for an interim period during which time it may be easier to ascertain her wishes.

The judge, using MCA powers, made orders in Mrs A's best interests allowing:

- Mrs A to be removed from her home to a nominated care home (including the use of restraint to ensure she was conveyed safely).
- B to be prevented from obstructing social workers entering Mrs A's home and removing her.
- Mrs A to have safe contact with B and other family members at the care home.

Mrs A was successfully moved the day after the second court hearing without the need for physical intervention or restraint.

## Reference

1. *Hull City Council v A & Ors* [2021] EWCOP 60 (12 November 2021)

\*The full judgement for the above case can be accessed for free via [www.bailii.org](http://www.bailii.org).

# No place like home?

by

Joshuah Hill-Holmes, Warwick Medical Student, University of Warwick

&

Dr Martin Curtice, Consultant in old age psychiatry, Coventry and Warwickshire Partnership NHS Trust

## Introduction

This article reviews a decision from the Court of Protection (COP) in 2021<sup>1</sup> regarding the relocation of a patient with dementia from Lebanon to the UK.

## Background

XS was a 76-year-old Lebanese born woman who moved to the UK in 1971. In 2013, she was diagnosed with Alzheimer's dementia and later suffered a fall, leading to an admission to hospital. During this admission she was found to lack MCA capacity to decide her residence and was discharged to a care home under a best interests decision. Whilst at the care home, XS was noted as saying that she would like to move back to Lebanon to 'trial' living there but had not committed to a permanent move. At this point, in 2014, a capacity assessment was completed allowing XS to enter into a Lasting Power of Attorney, with the patient being found to have capacity by both her solicitor and an independent psychiatrist. Whilst the court found this LPA to be registered and valid, interestingly it did not specifically state who the attorneys were or if the LPA was involved in the move to Lebanon below and it was unclear 'as to how much of this plan was XS's idea and how much that of her family'.

Soon after completing the LPA in 2014, XS completed the move to Lebanon, living in a flat near her brother who unfortunately died two years later. Following his death XS was moved into a care home in Beirut where she had lived since (a nephew was involved in this decision). The evidence at this time suggested XS's mental state had deteriorated and there was a 'strong implication' that she lacked capacity around welfare decisions such as where and in what country she lived.

The COP case was brought by AB, the patient's cousin, who resides in London. AB hadn't seen XS since 2015 due to ill health. AB wanted to relocate XS back to the UK as she believed this was what she would have wanted. AB had worries regarding the care of XS in Lebanon citing well-known economic struggles including medical supply shortages as primary concerns as medications have had to be obtained on the black market, a situation AB argued was not sustainable. The court found the care XS received in Lebanon was good and that she was well looked after.

In 2018 and 2019 AB applied for a court order in Lebanon to bring XS back to the UK. As part of these legal proceedings an independent guardian was appointed who agreed that XS could move back and a Lebanese court order was made to this effect. However, this effort was curtailed by two of XS's nephews, who obtained a travel ban from the Lebanese courts. AB believed the nephews had financial motivation to keep XS in Lebanon, however, this was not based on evidence. At the time of the COP hearing in the UK in 2021, this travel ban was awaiting a hearing to be appealed. AB had organised a medical charter flight to London with arrangements for a care home bed in London should the court order be given to bring XS back to the UK.

### **XS's health**

Two medical reports were provided for the COP being made by separate doctors – both concluded that XS had advanced dementia. At the time of assessment she was 'non verbal' and her mobility had deteriorated to the point of being wheelchair bound. One doctor reported how XS currently had very good medical care and that her nursing needs were being met, whilst the second doctor stated that there was a risk of an interruption to her medical care due to the situation in Lebanon. However, both agreed that a long-haul flight would likely negatively impact on her confusion due to the change in time zones, noise and fatigue that it would cause.

### **The issues in the case**

The court ascertained three key points to consider in order to decide whether they could intervene to bring XS back to the UK:

1. Was XS habitually resident in England and therefore, does the COP retain jurisdiction?
2. Could the court make an order for XS to return to the UK under the inherent jurisdiction?
3. Was coming back to the UK in the best interests of XS?

### **Habitual residence**

The court found that XS was habitually resident in Lebanon and *not* the UK. This was because she had integrated into Lebanese society and into her care home and with the staff, and having lived there for over 7 years. The judgment noted it was impossible to know whether or not she would have decided to stay in Beirut had she capacity to do so, but, because she was habitually resident in Lebanon, the court had no powers under the Mental Capacity Act 2005 to make a return order.

### **Inherent jurisdiction**

Inherent jurisdiction is the power of a court to make orders to protect adults who have mental capacity to decide but are vulnerable. This power has been used previously to bring British citizens back to the UK but previous case law had ruled such a power cannot be used without limits. The judgment in this case argued that using inherent jurisdiction in this scenario would be circumventing the MCA as this was the statute that XS would fall under should she be habitually resident in the UK. Therefore, making an order on this basis would be a misuse of the power to avoid limitations set by parliament in the MCA.

### **Best interests of XS**

The court found evidence that XS had been well looked after for over five years in Lebanon and that she was very frail with one old age psychiatrist reporting that she could die at any time (given her frailty even with the best care, she was likely to find any travel and flight physically and possibly emotionally exhausting). The court noted she was familiar with her environment and her carers, and because of her stage of dementia, she would most likely be unaware of her move to England and the people she knows here. This was enough to conclude there was 'therefore little tangible emotional benefit to her being in

England'. The court understood there was a possibility she may in future not be able to receive her medication in Lebanon and that this might lead to palliative care. However, the court, in balancing this issue with the more obvious potential detriment to her physical health by travelling to the UK, concluded the benefit of being brought to the UK for a more certain supply of medication was a 'relatively minor factor'. The court found it hard to ascertain what weight to give to the notion that XS would have wanted to spend her last days in England. However, the court gave evidence for this from the applicant 'little weight in the best interests balance' given XS would be 'wholly unaware of the matter' and that she was well cared for and apparently content in Lebanon.

In taking all these factors together, the court concluded that 'XS's best interests were served by her remaining in Lebanon and spending her days there'.

### **Conclusion**

This article highlights a complex case that details the intricacies at play in English law when considering the best interests of patients who are not habitually resident in the country. It also illuminates the complexity of best interest decisions that are entangled with the wishes of family members, especially in those patients in the latter stages of dementia.

### **Reference**

1. *AB v XS* [2021] EWCOP 57 (29 October 2021)

\*the full judgment for the above case can be accessed for free via: [www.bailii.org](http://www.bailii.org).

# Learning to Manage and Lead: Opportunities are everywhere for Psychiatrist Trainees.

by

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*"Management is doing things right; leadership is doing the right things."*

-Peter Drucker-

One of the important competencies highlighted across all psychiatric curricula for specialist trainees (STs) is management and leadership skills. Its importance has long been recognised by the General Medical Council (GMC), which has stated:

*"Being a good doctor means more than simply being a good clinician. In their day-to-day role doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. However, unless doctors are willing to contribute to improving the quality of services and to speak up when things are wrong, patient care is likely to suffer."*  
(GMC, 2012)

One of the common questions encountered during the induction for new STs is: where can I learn or access training in management and leadership? This article is written with the aim to share my personal experience and also the opportunities that I am aware of for STs who are new to management and leadership roles.

## **What are the options?**

Opportunities to learn the skill of management and leadership are plenty in the National Health System (NHS). Based on my personal (and limited) experience, I have loosely categorised them into three broad groups, i.e. the ultra-short-term, short-term, and long-term options.



### **Ultra-short-term Options**

There are plenty of short courses that require only several hours and typically homework is not needed (I know most of us do not like homework!). These ultra-short-term options are mostly lectures or webinars that provide knowledge and information on the topic of management and leadership. There are resources that offer insight into how the NHS management system works, e.g. modules created by the NHS Project and Change Academy in partnership with Health Education England (e-learning for healthcare, 2022). The topics include:

1. Getting Started: Projects and Change
2. Key Ingredients for Project Success
3. Project Leadership: The Role of the Senior Responsible Owner
4. Introduction to Benefits Management
5. Introduction to Change Management

I find their explanation easy to understand. Nevertheless, the ultra-short-term options do not necessarily improve the skill as it is knowledge-based.

### **Short Term Courses**

Short-term programmes require slightly more time commitment, i.e. from days to weeks. Most of the NHS Trusts or Health Boards have their own training programmes in management and leadership. For example, Betsi Cadwaladr University Health Board (BCUHB) Medical Education Department organises regular half-day and full-day introductory management and leadership courses. STs can find out from their respective medical education department.

At the national level, the Faculty of Medical Leadership and Management (FMLM) has a dedicated page for the trainees (FMLM, 2022).

There are also international leadership courses organised by different international psychiatric organisations. Prof Dr Norman Sartorius has been conducting different leadership and professional skills training workshops for early career psychiatrists in different countries. The coming course is held in Vilnius in September 2022 (Rūmai, 2022).

### **Long Term Programme**

A long-term programme requires significant commitment and it involves completing assignments and providing evidence to demonstrate competency in

management and leadership. I have the opportunity of joining the Course of Introduction to Healthcare Leadership organised by the Health Education and Improvement Wales (HEIW, 2022). A participant has the option of choosing either the certification pathway or the qualification pathway. The certification pathway involves attending five full days of workshops and completing the workbook. The option of qualification pathway is a one-year learner-centred experiential learning which will end with an Agored Cymru level 4 qualification once a candidate has provided adequate evidence of competencies in different domains defined by the learning outcomes of the course.

Another option for STs is the Royal College of Psychiatrists (RCPsych) Fellowship Scheme in Leadership and Management (RCPsych, 2022). The participating ST will work with the sponsoring employing NHS body to conduct a management project throughout a 12-month period.

In addition, academically orientated ST can pursue a postgraduate degree in management or leadership from a university or college. For instance, the University of South Wales provides a part-time course in Leadership in Healthcare at the level of a postgraduate diploma (one year) or a master (two years). Partnering with Learna, the courses are conducted fully online (Learna, 2022).

### **How to get started?**

The special interest SPA slot of the ST training is a good place to start. We can also optimally use our study leave to attend courses. Furthermore, there is also the option of Out of Programme placement. Of course, management and leadership experience do not happen only during courses or workshops. Whenever we are working collaboratively with our junior colleagues, there are chances for us to apply our management and leadership skills. For example, initiating a clinical audit or quality improvement project and delegating part of the roles to junior colleagues while upskilling them creates a win-win situation for both parties.

There are also management projects at the departmental or hospital level that STs can find out from their line manager or directors, who are usually an email away. Other examples include attending the clinical governance meetings, e.g. risk management and operational meeting.

## Conclusion

The information above is not meant to be exhaustive. Opportunities are everywhere if we look hard enough.

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# Reflections on Full Remote Working into Care Homes

by

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## Background

During (and now following) the Covid pandemic, there has been increasing use of remote working by old age psychiatrists, typically discussing diagnosis and treatment options over the phone and taking part in multi-disciplinary team (MDT) discussions over Microsoft Teams (MST). On occasion video consultations with patients and carers take place, despite limitations of digital competency amongst our patient and carer group.

As part of a pre-retirement 9-month secondment to North Cumbria from my established post in Sunderland, I negotiated a job plan involving working from home providing a liaison service to 72 care homes, as part of the established CHESS (Care Home Education and Support) Team. I also proposed seeing patients and care home staff using 'assisted consultations' (ACs) on MST with a CHESS staff member present at the care home with her laptop. I was interested in remote working partly as I was writing up a 'bite sized' e module on remote working during and after the Covid lockdown (now available on the RCPsych eCPD platform).

## Activity

My main activity was to review psychotropics in residents with challenging behaviour unresponsive to non-pharmacological interventions. Prior to my posting, CHESS staff utilised 'duty consultants' available Monday to Friday. The problem with this system was lack of continuity with new medications being added to the current list, with no facility to review at 6 weeks. Consequently, I found the extent of psychotropic polypharmacy to be around 60% being referred to me, causing problems in terms of reducing medications before attempting

alternative trials of treatment. The other practical issue was the absence of blood and ECG screening, as most of the referrals to CHES were from Care Home staff directly, without the GP being involved.

From a remote consultation viewpoint, as suggested above, CHES staff were stretched, mainly responding to crises in care homes, and not always able to take part in ACs. CHES also had a waiting time for new referrals of around 8 weeks in some areas of North Cumbria. Consequently, there was limited opportunity to carry out early interventions as part of a true liaison service model. However, on the practicalities of remote working, I found that the option of ACs were seen positively by CHES staff, as this offered rapid co-production, as care home staff and family could be involved in treatment planning. I also found ACs adequate for observing patient behaviour, content of speech and the degree of frailty (sarcopenia). It seemed to help patients if I placed my face close to the camera, so they could judge my affect. Furthermore, I was able to assess body type and frailty before deciding on the dose / frequency of psychotropics. When a person's main family carer was present during an AC, a best interest discussion on benefits and harms could be accomplished (see Montgomery judgement and GMC guidance). Carers (both formal and family) were surprised that the risks of psychotropic medication had not been discussed previously.

### **Outcome analysis**

As part of a Service Evaluation for the Trust (recommended by the Trustwide Medicines Optimisation Committee), I carried out an analysis of 45 consecutive referrals for medication review over 3 months. On subject characteristics, 28 were aged 85 or over, with 33 female, 12 male. Most had moderate to severe dementia with 2 people with chronic psychoses. Outcome was assessed after 1 month of recommending a plan. Of the 15 patients where I declined medication changes, none got worse, 11 became better (without pre-existing evidence of delirium), and 4 were unchanged.

Of the 30 people I did carry out interventions (typically adding or swapping to Memantine, stopping AChI's or swapping to Amisulpiride, around 50% 16/30 improved, 11 were unchanged and 3 got worse. The 3 people who got worse, they were on 3 or more psychotropic medications (Quetiapine, Risperidone, Pregabalin, SSRI's, Mirtazapine, Z drugs and Benzodiazepines, alongside opiates

and anti-histaminergics). I was struck by worsening symptoms of distress when reduction of 2 psychotropics simultaneously in situations of imminent and credible risk (falls / aspiration). Multiple psychotropic drug reduction is best done in in-patient settings, but no in-patient beds were available during most of the 3 months (November – February).

### **My reflections**

1. Overall, full time, home based, remote working is realistic for day-to-day clinical work although consistent human resources are needed to carry out assisted consultations (AC's). Ideally, this should be via a non-medical prescriber embedded in the MDT, who can also arrange pre / post physical health monitoring (for example by using the Lester tool) and able to prescribe on site. CNTW trust is trialing the post of Medical Assistant for each consultant, who can help with arranging consultations and MDT's; in effect able to modulate demand.
2. Remote, home-based working is less effective in-service improvement, for example limiting polypharmacy and optimising physical health monitoring. This is partly because face to face meetings are much more liable to rapidly build up a co-working culture. Furthermore, in a crisis focussed service, these longer-term objectives are difficult to achieve, as key stakeholders (mainly middle to senior managers) are already engaged in 'wall to wall' meetings on MST.
3. I would concur therefore with the opinion held by my old age colleagues that remote working should be part of a blended working pattern involving face to face and telephone consultations and time protected strategy meetings for service improvement. However, in well organised services with clear pathways, 'cold work' for MDT feedback and diagnostic formulations could work in managing waiting lists

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# Joining Old Age Psychiatry late in life, reflections of a personality disorder specialist on becoming an old age psychiatrist.

by

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It's a bit of a cheek writing for the Old Age Psychiatrist since I have been one for just under a year. However joining has been such a great experience for me I felt I wanted to share it and to talk about some ideas for a service innovation I have been trying to get off the ground.

When I retired from my full time role at my trust the Old Age Psychiatrists reached out and asked me if I'd like to join them part time. It was flattering and also enticing. I had missed out on a lot of old age psychiatry in my life as a psychotherapist and adult psychiatrist and, of course, I was getting older myself and had some lived experience from my parents' old age.

However what then transpired was so welcoming and so fascinating that I now feel rather cross I haven't been one all along! My new colleagues were warm, intelligent and had a working life that had a fantastic and fascinating mix of medicine and psychology. The multidisciplinary teams seemed to me to be more compassionate and more able to be creative than I had found before and the integration of psychiatry and social care was closer, sharper and smarter than in adult psychiatry. I was impressed and enthralled.

## **Personality disorders in later life**

One thing was the same though and that was the problems that the teams had with people suffering with personality disorders. Further, it was clear that there wasn't a great deal of research that was old age specific. Fortunately there is growing interest in the topic and work is underway to characterise the



epidemiology of personality disorder in later life and to apply treatments developed for working age adults to an older group of patients.

Nevertheless this leaves some gaps. The phenomenology of personality disorder in later life is poorly characterised as is any theory of routes to a personality disorder presentation in later life. If we do not understand why in a condition that remits with age some people remain ill and others present apparently with a personality disorder that was not evident before we risk our interventions being ill aimed.

Another worry is that many patients with personality disordered features in old age end up on multiple psychotropic medications to add to the multiple physical health medications that they may take. The reasons to worry about this are legion. For a start NICE guidance says medications should not be prescribed long term for patients with personality disorder.

Next we know the risk of adverse effects rises dramatically as the number of medications prescribed rises. But for older patients it is also reasonable to worry that the aging brain will be more vulnerable to taking harm from medications – something we know for sure with antipsychotics. For these patients reviewing medication and reducing it – if it could be achieved – might actually improve wellbeing and prolong healthy lifespan. It's hardly a new idea but applying it to patients with personality disorders will take a particular skill set and this is where prescribing links to the issue of phenomenology.

### **The phenomenology of psychotropic medication prescribing in personality disorder**

I want to share my working hypothesis: Whatever their aetiology one common feature of the cluster B (impulsive unstable) and C (anxious avoidant) personality disorders is unpleasant internal states of disgust or disquiet. These cause arousal and activation but there is no obvious target for action and this produces anxiety.

The anxiety of personality disorder combines with social causes of anxiety in old age (such as changes in setting or circumstance), with new psychological anxieties (fear of loss, pain, illness and death) and even with new organic causes of anxiety (secondary to a dementing process).

It should therefore come as no surprise that almost all the medications used in patients with personality disorder are essentially prescribed with anxiolytic intent (antipsychotics and hypnotics) or at least appreciated for anxiolytic impact. A case in point are antidepressants which generally, in patients with personality disorder are reported to be effective more rapidly than would be expected from their antidepressant properties but then have waning benefits as tolerance to their anxiolytic effect develops.

However, for people with a personality disorder prescribing is a relational and psychological intervention at least as much as it is a pharmacological one. Suggesting reducing medications may be experienced as abandonment or even condemnation and the naked exercise of power! Worse, if the patient agrees to reduce medication initial rebound effects feel little different from an intensification of the internal miseries already imposed by having a personality disorder.

### **Not as easy as crossing drugs off the chart**

The upshot is that the task of rationalising medication and the task of helping patients to manage their internal emotional states better and more kindly towards themselves (which lies at the heart of all psychological treatments for personality disorder ) turn out to be largely the same task.

While that the task might not be easy I can see room for a therapeutic approach that tries to take advantage of the aim of rationalising medication. First, most effective therapeutic approaches involve some psychoeducation. This builds an alliance in which patient and therapist collaborate to educate each other about the patient's situation. Discussing the impact, meaning and risk/ benefit balance of medications fits well into the psychoeducation component of therapy. My hope is that many patients in later life will quickly see the value of reducing medication burden.

Second, reducing medications can act as a proxy for progress in distress tolerance. If patient and therapist agree that ability to reduce medication burden is both an aim and a marker of emotional progress this, may encourage patients to tolerate more distress and build more resilience than they would otherwise.

Last, an overall approach founded on sympathy for the vicious pain of anxiety, hope that some level of relief and self management is possible, and the use of psychoeducation and a biopsychosocial formulation and intervention is exactly what multidisciplinary teams already do and lies at the foundation of managing all chronic conditions.

### **What about therapy?**

I think that it is possible to overstate the role of “formal” therapies in delivering what is needed. A great part of the value of a formal therapy is that it is set aside time with someone who is willing to build a relationship and has skills in doing so but therapy has disadvantages. It can have side effects and it is difficult to organise and deliver consistently with acceptable waiting lists. Our IAPT programs have not tended to treat patients with personality disorder. Finally in later life the pattern of an older person being given therapy by someone who is often very much younger produces a cultural dissonance that can be hard to overcome. Think of the representation of therapy in movies and name any where the therapist is younger than the patient.

However my experience of old age teams is that they are easily capable of implementing intervention that extends their existing skills in managing chronic conditions, building relationships with people who are distracted or cognitively impaired and coping with physical frailty to skills in managing personality disorder where the task is to make an alliance in difficult circumstances, manage a chronic condition by minimising harm and building resilience (personal, environmental and social).

Returning then to my impressions of old age psychiatry as a newcomer. It seems to me that the clinical strengths and emotional intelligence of old age services puts them in an ideal position to offer practical intelligent and compassionate care for patients with personality disorders using an approach of the sort I have described. Who knows, if we get it right then the adult psychiatrists and the psychotherapists may come knocking.

# Chronic Traumatic Encephalopathy and psychiatric comorbidities

by

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&

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## **The Case**

Mr C is a 57year old Male who was referred to our local memory team in 2017, following a private consultation with a Neurologist due to concerns over his memory.

CT Head was reported in 2017 as 'normal appearance- incidental normal variant Cavum Septum Pellucidum'.

The Neurologist referred him to the local memory services and he was reviewed by the local Psychiatrist in December 2017. Mr C reported a noted memory decline over the previous few years. He reported he was forgetful over dates and appointments for example. Mr C also voiced concerns over previous repeated head injuries whilst boxing regularly in the army.

Mr C was living independently with no noted impact on his activities of daily living. They also discussed Mr C's mood which was noted to be low over the past few months. There was also a poor sleep pattern reported. Mr C had a background of chronic back pain which was noted to be a contributing factor. Mr C also described ongoing suicidal thoughts which were intermittent and intrusive. There was no reported plan in place and protective factors were noted including his family.

Mr C had no previous Psychiatric history. He had previous medical problems including Dilated Cardiomyopathy and Chronic Lower back pain including five previous spinal fusion surgeries. There was no noted significant Family History.

Mr C grew up locally and described his childhood as 'happy' He left school at age 16 and initially worked as a miner for 3 years before joining the armed forces for 18 years. Mr C had various roles in the army including; PT Instructor, Boxing, driving army vehicles and overseeing men. Mr C was medically discharged due to his back pain. Currently, Mr C is in a relationship following two marriages. He has 3 children. No noted excess alcohol with approx. 8-10 units per week.

Initial diagnosis was felt to be a Depressive Disorder with a potential background of Cognitive impairment. A plan was made to treat Depression initially and monitor cognition for an improvement. A trial of Duloxetine was initiated.

Following this review Mr C had another consultation in 2020 with a General Adult Psychiatrist as part of a Veterans clinic. At this stage there were ongoing concerns regarding his mood with persistent intermittent suicidal thoughts. It was noted that he had been 'forgetful for years' and concentration and memory remained poor. Duloxetine was changed to Sertraline for a 'Moderate Depressive Episode'.

Mr C had ongoing concerns regarding his memory and therefore re-presented to the Neurologist privately in 2021. At this stage an MRI Head was requested which showed 'Bifrontal brain volume loss. Several hyperintensities in periventricular and deep white matter. Cavum Septum Pellucidum and Cavum Vergae was noted. No Microhaemorrhages' The Neurologist referred back into memory services due to concerns regarding a memory disorder and a likely diagnosis of Chronic Traumatic Encephalopathy (CTE).

Mr C was reviewed in memory clinic in June 2021. His history was re reviewed and it was summarised that he noted memory difficulties since 2016. He had difficulties learning new information and had noted an impairment in his spatial awareness. Furthermore, his mood remained low with ongoing intermittent suicidal thoughts. His background of recurrent head injuries was also noted due to his history of boxing,

ACE III- 75/100 (June 2021) Attention 16/18, Memory 15/26, Fluency 6/14, Language 23/26 and Visuospatial 15/16.

Mr C was diagnosed with Chronic Traumatic Encephalopathy (CTE).

Mr C has ongoing close monitoring by the community nursing team due to ongoing suicidal thoughts and had psychology input. During a routine follow up with the local Psychiatrist he complained of experiencing vivid dreams and occasional visual hallucinations whereby he would see his deceased father. A DAT scan was requested which was positive for Lewy Body Dementia (LBD). He is currently on dual anti-depressants Venlafaxine and Mirtazapine for low mood and on dual antimentia medication- Donepezil and Memantine. He has become more dependent on his family with his son now living with him and assisting him with activities of daily living.

## **Discussion**

Chronic Traumatic Encephalopathy is a progressive brain condition that is thought to be caused by repeated head injuries.

The force of the blows is felt to cause damage to the neurones which cause Tau protein deposits and Neurofibrillary tangles develop as the brain repairs (1).

There is no current diagnostic test for CTE, and it remains a pathological change that is confirmed post-mortem.

Clinical manifestations are often grouped into 4 categories.

1. Cognitive Impairments in memory, executive function and processing speed.
2. Behaviour abnormalities such as aggression, paranoia and impulsivity.
3. Mood disorders such as depression, anxiety and suicidality.
4. Motor dysfunction such as dysarthria, bradykinesia, rigidity or gait disturbances (2).

The below table summarises the differences in presentation between different memory disorders:

<b>Table 1</b>				
<i>Chronic Neurodegenerative disorders that are classified as Tauopathies</i>				
<b>Disease</b>	<b>Cognitive Impairment</b>	<b>Behaviour changes</b>	<b>Mood changes</b>	<b>Motor dysfunction</b>
Alzheimer Disease	<ul style="list-style-type: none"> <li>• Memory</li> <li>• Executive Function</li> </ul>	<ul style="list-style-type: none"> <li>• Apathy</li> </ul>	<ul style="list-style-type: none"> <li>• Anxious</li> </ul>	<ul style="list-style-type: none"> <li>• Apraxia</li> </ul>
CTE	<ul style="list-style-type: none"> <li>• Memory</li> <li>• Executive Function</li> </ul>	<ul style="list-style-type: none"> <li>• Aggression</li> <li>• Paranoia</li> <li>• Impulsivity</li> </ul>	<ul style="list-style-type: none"> <li>• Depression</li> <li>• Anxiety</li> <li>• Suicidality</li> </ul>	<ul style="list-style-type: none"> <li>• Rigidity</li> <li>• Bradykinesia</li> <li>• Dysarthria</li> </ul>
Corticobasal Degeneration	<ul style="list-style-type: none"> <li>• Memory</li> </ul>	<ul style="list-style-type: none"> <li>• Irritability</li> </ul>	<ul style="list-style-type: none"> <li>• Depression</li> <li>• Anxiety</li> </ul>	<ul style="list-style-type: none"> <li>• Rigidity</li> <li>• Bradykinesia</li> <li>• Aphasia</li> </ul>
Frontotemporal Lobar Degeneration	<ul style="list-style-type: none"> <li>• Memory</li> <li>• Executive Function</li> </ul>	<ul style="list-style-type: none"> <li>• Loss of social awareness</li> <li>• Compulsive disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Depression</li> <li>• Anxiety</li> </ul>	<ul style="list-style-type: none"> <li>• Aphasia</li> </ul>
Progressive Supranuclear Palsy	<ul style="list-style-type: none"> <li>• Memory</li> </ul>	<ul style="list-style-type: none"> <li>• Poor impulse control</li> </ul>	<ul style="list-style-type: none"> <li>• Depression</li> </ul>	<ul style="list-style-type: none"> <li>• Ophthalmoplegia</li> <li>• Ataxia</li> <li>• Tremor</li> <li>• Rigidity</li> </ul>

Figure 1: Taken from McCambridge and Stinson (2).

A study done in 2018 in Boston suggested that contact sports put people at increased risk of Lewy Body Dementia in addition of Chronic Traumatic Encephalopathy.

They found that those with CTE and Lewy Body Dementia had a younger mean age of death compared to Lewy Body Dementia alone. They also found it was the number of years of contact sports not concussion history that would best predict the stage of CTE (3).

### **Learning Points:**

- Carry out cognitive testing on presentation to service and monitor throughout.
- Although Cavum Septum Pellucidum is a normal variant it can be indicative of CTE. Therefore, if it is noted explore history of Traumatic Brain Injuries.
- Review Diagnosis and follow up- although reasonable to treat a mood disorder initially Mr C had ongoing concerns regarding his memory which could have been addressed at follow up.
- Association between CTE and aberrant extrapyramidal motor function may be due to co-morbid LBD pathology (3).

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# Improving communication between the medical team and families on Holbrook dementia intensive care ward, Woodlands Unit, Sidcup

by

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## **Background**

We have undertaken a service development project on improving communication between the medical team and patients' families on Holbrook ward, Woodlands Unit, Sidcup. Holbrook ward is a 23-bed mixed-sex dementia intensive care unit within a mental health hospital setting, for patients with challenging behaviour in the context of their dementia.

Prior to the pandemic, the doctors spoke to patients' families as needed on the ward and families were also invited to attend ward rounds. The idea behind this project came about from the first wave of the pandemic, when there was a high mortality rate amongst our elderly patients from Covid-19 and families were no longer allowed to visit the ward. Doctors had less face-to-face contact with families and fewer opportunities to provide them with updates. As restrictions eased throughout 2021, the ward did not quite return to pre-Covid status, as families were not attending ward rounds in person because of repeated Covid outbreaks on the ward.

Feedback from carers' surveys from this time showed that families felt they would have liked to speak to the doctors more frequently, particularly as they were not seeing their relatives as often due to visiting restrictions. Families felt that they were not adequately informed about their relatives' treatment plan, medications and the discharge planning process.

In light of this feedback, from February – July 2022 we have trialled an intervention to ensure that doctors on Holbrook ward communicate more frequently and consistently with patients' families.

## **Aims**

1. We aimed to speak to each patient's family within the first 2 weeks of admission, gain their perspective and collateral history, and establish a point of contact.
2. We aimed to invite families to a multi-disciplinary Welcome to the Ward meeting in person within the first month of admission, attended by doctors and the therapy team.
3. We aimed to update families on at least a monthly basis: in person on the ward, over the phone, or through Teams meetings. We aimed to invite families to ward rounds on a regular basis over Teams with the care co-ordinator, to ensure good links with the community team.
4. During our conversations with families, we aimed to discuss the patient's diagnosis, medications, treatment plan including psychological approaches and legal status (DOLs or Mental Health Act) in a way that was clear and accessible to understand, and to provide them with opportunities to ask questions. We sought to discuss discharge planning with families; explaining the process, ensuring that their views were heard and that they felt involved.
5. We also aimed to inform families promptly in the event of a significant change in their relative's mental or physical health.

We asked permission from patients to share information with their families, in cases where they had capacity to make this decision. For patients who did not have capacity, we shared information with family members under the patient's best interests.

## **Methods**

We collected feedback from questionnaires circulated to patients' families. These were completed in person or over the phone.

## Results

Out of the respondents (n = 8), 100% said that the doctors contacted them within the first 2 weeks of their relative's admission and 75% were invited to a multi-disciplinary Welcome to the ward meeting within the first month. 88% spoke to doctors at least monthly and 12% (1 respondent) every 2-3 months. 100% felt that they were informed in a timely manner in the event of a significant change in their relative's condition, and 100% were happy with the opportunities to ask questions and have them answered by the doctors. 88% said that the doctors discussed diagnosis, medications, treatment plan and legal status with them. 38% felt that discharge planning was not discussed, however this was mainly due to their relative not yet approaching discharge. Overall, 75% of respondents were very happy with the doctors' communication with their family, and the remaining 25% were satisfied.

Responses about what was good about the communication from the doctors:

- *'The doctors communicated with me on a regular basis, and they were kind to my loved one'.*
- *'The doctors were very responsive when I asked to speak to them, and they provided good explanations of what was going on and answered my questions'.*
- *'I felt that my concerns were listened to and acted upon'.*
- *'We have been extremely happy with the communication received and are always updated when we visit. We would like to thank you for the care you have given our relative, we appreciate it so much'.*

Suggestions for improvement:

- *'I would prefer to speak to the doctors more in person, and to be invited into ward rounds as I have a sensory impairment and find it easier to communicate with them face-to-face'.*
- *'It would be better to be able to attend ward round in person, as I find Teams meetings quite difficult'.*
- *'I sometimes found it hard to understand what the doctors were trying to explain to me – it would be helpful to have clearer explanations.'*

## **Discussion**

Studies have shown that good communication between the medical team and families has many benefits and enhances the standard of patient care. A qualitative study looking at communication with families towards the end of life showed that families felt empowered when a mutual understanding of their relative's condition was achieved with healthcare professionals, helping them make informed decisions with the patient, and overall led to higher rates of satisfaction with patient care [1]. A study evaluating families' perceptions of care on a specialised a medical and mental health unit compared to those on standard acute medical wards found that an integrated approach to physical and mental health resulted in families feeling more informed [2]. On our dementia psychiatric ward there is a significant interface between physical and mental health, and this has been a key element in our conversations with families.

Feedback from families has generally been positive, with relatives appreciating regular progress updates and the opportunity to have their questions and concerns addressed by the doctors. Suggestions for improvement were mainly around having more face-to-face contact with doctors in ward rounds, and since July 2022 we have started inviting patients' families to ward round in person to revert to our pre-Covid practices. We have also made efforts to ensure that explanations provided to families are clear and easy to understand.

As clinicians, it has been a valuable experience to form therapeutic alliances with families, particularly when it is challenging to communicate verbally with our patient group who have advanced dementia. Families have provided a window into the patient as a person and helped us get to know them; their premorbid personality, interests, and their life before they had dementia. At times, it has been quite moving to speak to them about this.

Going forwards, we will continue to maintain these standards in our communication with patients' families on Holbrook ward as it has clear benefits for patients, their families and the medical team.

## **Contributors:**

Dr Merline Muthukumar (FY2 doctor on Holbrook ward)

Dr Neha Hodrali (FY2 doctor on Holbrook ward)

Dr Garima Jain (Consultant psychiatrist on Holbrook ward)

**References:**

1) *Communication between family carers and health professionals about end-of-life care for older people in the acute hospital setting: a qualitative study*

Glenys Caswell 1, Kristian Pollock 2, Rowan Harwood 3, Davina Porock 4  
 BMC Palliative Care 2015 Aug 1;14:35. doi: 10.1186/s12904-015-0032-0

2) *Delivering dementia care differently—evaluating the differences and similarities between a specialist medical and mental health unit and standard acute care wards: a qualitative study of family carers’ perceptions of quality of care*

Spencer K, Foster P, Whittamore KH, et al

BMJ Open 2013;3:e004198. doi: 10.1136/bmjopen-2013-004198

Feedback questionnaire for Families on Holbrook ward



Did the ward doctors get in touch with you within the first 2 weeks of your relative's admission?

Yes	No
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Were you invited to a Welcome to the Ward meeting within the first month?

Yes	No
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How often did you speak to doctors (either on the ward, over the phone, or in ward round)?

At least monthly	Every 2-3 months	Infrequently, less than every 3 months	Never spoke to doctors
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Did the doctors inform you in a timely manner if there were major developments or changes in your relative's condition?

Yes	No (please provide further details)
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Tick if the doctors discussed the following topics with you:

Diagnosis	
Medication, including covert medications and side effects	
Treatment plans	
Legal status on the ward (DOLs / Mental Health Act)	
Discharge plans	

Did you have the opportunity to ask questions, and have them answered by the medical team?

Yes	No (please provide further details)
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Overall, how satisfied are you with the medical team's communication with your family?

Very happy	Satisfied	Neutral	Unhappy	Very unhappy
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What was good about the way the medical team communicated with your family?

Do you have any suggestions on improving doctors' communication with families?

Thank you very much!



The Holbrook ward team

- Dr Su Ying Yeoh
- Dr Latha John
- Dr Merline Muthukumar
- Dr Neha Hodrali
- Dr Garima Jain
- Dr Abimbola Fadipe

# Research Update

by

Dr Catrin Thomas, Trainee Editor, RCPsych Old Age Faculty Newsletter,  
ST6 in Old Age Psychiatry, Betsi Cadwaladr University Health Board.

## **Leighton *et al.* Delirium and the risk of developing dementia: a cohort study of 12 949 patients.<sup>1</sup>**

This large retrospective cohort study aimed to estimate the cumulative incidence of dementia in those who develop delirium and to model the cause-specific hazard of dementia. The study included all patients over the age of 65 who were diagnosed with delirium and who did not have a diagnosis of dementia at the onset of the delirium. The study was conducted between 1996 and 2020 across the Greater Glasgow and Clyde NHS services. The study only included patients diagnosed within secondary care services or at death if treated in primary care, therefore there was a selection bias towards more severe cases of delirium.

12,949 patients were included in the study with a mean follow up time of 741 days (minimum = 0.5, maximum = 8,855 days). The study found that the estimated cumulative incidence of dementia (i.e. the risk of developing dementia following a first episode of delirium in those aged over 65) was 9% by 6 months, 13.6% by 1 year, and 31% by 5 years. As this study was not a case-control design, they were not able to determine the net effect of delirium itself on dementia diagnosis.

This study supports the concept of delirium as a possible precipitating and accelerating factor of cognitive decline. It remains unclear whether delirium is a marker of someone's predisposition to developing dementia; whether it accelerates unrecognised dementia; or if delirium has direct neurotoxic effects that are causal in the pathogenesis of dementia. However, given that delirium is preventable in 30-40% of cases, it is an important modifiable risk factor for dementia and this study highlights the importance of early recognition, management and prevention of delirium.

**Damsgaard et al. Hospital-diagnosed sleep disorders and incident dementia: a nationwide observational cohort study.<sup>2</sup>**

The aim of this nationwide cohort study was to explore the possible association between sleep disorders and late-onset dementia. The study cohort consisted of 1,491,276 people from the Danish national patient registries over a 40-year period.

They found that people with any form of sleep disorder had an adjusted 17% increased risk of dementia compared to people without a sleep disorder. The risk of dementia was significantly increased between 0-5 years after being diagnosed with a sleep disorder but it was not significantly increased after 5 years or more. Of the specific sleep disorders, sleep apnoea had the highest increased risk of late-onset dementia, with a 13% overall adjusted risk increase.

This study's findings raises the question of whether sleep disorders are a risk factor for dementia, an early symptom of dementia, or an accelerating factor in the development of dementia. Further studies are required to distinguish between the three, however, this study has highlighted the role of sleep disorders as a potential target for early prevention of dementia and reminds us of the importance of taking a detailed sleep history from our patients and refer onwards if necessary.

**Kouloutbani et al. The effectiveness of physical exercise interventions in the management of neuropsychiatric symptoms in dementia patients: a systematic review.<sup>3</sup>**

This systematic review aimed to compare the effect of different types of physical exercise on the neuropsychological symptoms (NPS) of dementia. They included randomised controlled trials that applied interventional physical activity programs (with specific characteristics - type, frequency, intensity, and duration) in patients with dementia or mild cognitive impairment and studied the effect of the exercise on their NPS comparing them to control groups. A total of 13 studies were included with 1,925 participants.

The results were categorised and analysed by the type of exercise: aerobic exercise, multidimensional interventions, and muscular strength training

programs. The results showed that aerobic exercise repeated three to five times a week had a positive effect on NPS of dementia. Multidimensional interventions combining different types of exercise did not appear to be as effective. Strength training programs were found to significantly reduce depressive symptoms and behavioural problems patients with dementia and mobility problems.

Due to the high heterogeneity between the included studies, we cannot draw a conclusion about what the most effective exercise intervention program for relieving NPS is. However, this review does show that there is evidence for the use of aerobic exercises in the management of NPS and we should consider designing exercise programs for use in community groups, residential homes, and inpatient services as a non-pharmacological approach to managing NPS of dementia.

### **References:**

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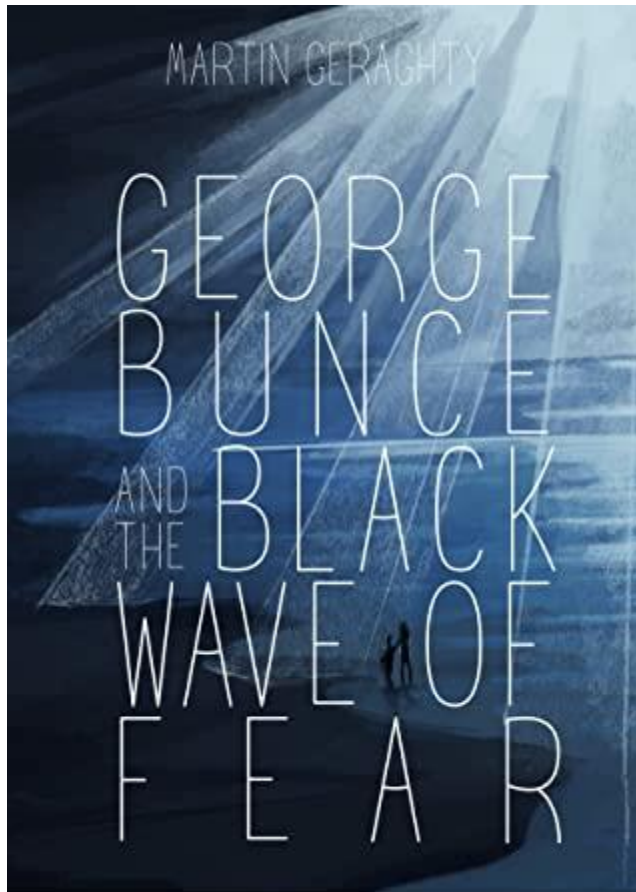


# Book Review

by

Dr Anita Howard

Consultant Psychiatrist, Bensham Hospital, Gateshead



## **George Bunce and the Black Wave of Fear**

by Martin Geraghty

Publisher: Spellbound Publishers

Publication Date: April 18<sup>th</sup> 2022

Image from Goodreads

George Bunce is a 70-year-old man who is placed in the four-season care home against his wishes after he accidentally burns down his flat. He is befriended by an OT (against his will again) who gradually brings down his barriers and helps him regain his joy for life as she helps regain his independence.

I confess, I didn't warm to George as a character- he is grumpy, abrupt and slightly prejudiced (which I think is supposed to portray humour), I empathised with the Doctor who has to assess George and with Claire the OT who has to

work with George to get him home- George's rather non PC comments do seem to hinder his relationships then help. But this is fiction, so Claire pulls out all the stops and goes beyond the expected to engage with George to eventually form a friendship with him (which again in real life might have led to a safeguarding alert).

In my view, the book accurately captures George's frustration and despair at being caught up in an unsympathetic system- a system that places him in a care home that is clearly unsuitable for his needs. George's difficulty in his interactions with people with dementia and his own wave of despair in realising that he may be stuck there was beautifully described. It did make me think about our patients who are not cognitively impaired who need help for a short period of time but are now placed in care homes as local authorities close places that used to provide this support.

The book also touches upon PTSD and how we rarely assume men are also victims of domestic abuse and the impact this may have.

So I would recommend this book to anyone looking for a feel good story with a positive and optimistic ending.