



HELLO

Welcome to Issue 96, September 2026, of the
RCPsych Old Age Faculty Newsletter

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'Walking Through the Seasons'

Dr Bipin Ravindran

Consultant Old Age Psychiatrist, Nottinghamshire Healthcare NHS Foundation Trust

"My painting reflects the journey through later life, companionship, the passage of time, memories gathered along the way, and the changes that come with ageing."

Instagram: [bipins.arts](https://www.instagram.com/bipins.arts)

Disclaimer:

Please note that 'The Old Age Psychiatrist' newsletter is intended for the RCPsych Old Age Faculty membership. The content is provided by contributors and does not necessarily reflect the views, position, or policy of the College. The Royal College of Psychiatrists does not provide any endorsements or assume any responsibility for the accuracy, completeness, or suitability of the content provided. This is not a formal peer reviewed publication and clarifications should be sought from individual authors.

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UPDATE FROM THE EDITORIAL TEAM



Dear colleagues,

Welcome to the September issue of The Old Age Psychiatrist from all of us on the editorial team. A sweltering Summer has given way to what has so far been a crisp and cosy Autumn; perfect conditions to curl up with the latest updates in old age psychiatry. We have a packed newsletter for you and I really hope you enjoy the interesting variety of articles we have included.

You will already have noticed the striking cover art for this edition, which was painted by Bipin Ravindran. We are enormously grateful to Bipin for creating this work for the newsletter. Further demonstrating the creative ability of our colleagues, TCD Lewis has shared his poem, 'Untitled' with us in The Creative Corner section. If you are on the look-out for a spooky Hallowe'en film which could add to your continuing professional development, then have a peek at Thomas Rose's review of 'Relic'.

The RCPsych Old Age Faculty is preparing a position statement on health care inequalities in memory services. Hari Subramaniam brings us through the feedback received from members of the faculty and MSNAP partners which will feed into this work, which reinforces clinicians' concerns that ethnic elders are underserved by existing services.

The value old age psychiatrists can add to delirium research is highlighted by Yehudit Bauernfreund, who contends that generalist reporting trends in delirium research are a barrier to person centred care at the clinical coalface.

We all encounter complex scenarios in our work which require layers of unpicking. Alexander Sunderland has shared an interesting case of two brothers with frontotemporal dementia alongside a masterclass in the associated genetics. Meanwhile, Shalina Ramsewak details a case where an initial probable diagnosis of delirium in an older adult evolved into a bipolar diagnosis. Martin Curtice reviews two Court of Protection cases which involve hoarding.

Dansheela Makan shares her reflections on developing as a medical educator and makes a great case for why old age psychiatrists should get more involved in medical education. Indira S Vinjamuri and Rachel Gorny describe the practical application of psychological formulation in training; this is important as it reflects the changes ahead in psychiatry training.

This newsletter could not have come together without the meticulous planning, creativity and effort afforded by our three resident doctor editors- Rachel Gorny, Dansheela Makan and Galina D'Souza. Behind the scenes, Kittie Kottasz, is always fantastic and we are lucky to have her as our head of faculty. I am delighted to have taken the baton from Shaheen Shora to become the lead editor of the newsletter, having greatly enjoyed being part of the editorial team as a trainee.

We look forward to hearing what you think of the newsletter, and we welcome ideas, suggestions and of course articles for our next edition. Keep your eyes peeled for the announcement of our creative writing competition later in the year. Please get in touch with us via oldage@rcpsych.ac.uk.

We hope you enjoy reading this edition.



Best wishes

Dr Jennifer Parker

Lead Editor

Consultant Old Age Psychiatrist,
Avon & Wiltshire Mental Health
Partnership NHS Trust

VIEW FROM THE (VICE) CHAIR

Dr Ben Underwood

Vice Chair, Faculty of Old Age Psychiatry
Royal College of Psychiatrists



Dear colleagues,

I write at a very exciting time for old age psychiatry. Blood tests to help diagnose dementia are well and truly out of the bag – it is already possible to order a test online. The ADAPT and READ OUT studies are well under way. These studies will tell us about the performance and value of these tests in real clinical settings. In the faculty we are keen to stay abreast of these developments and distil the latest evidence for our members. We have worked with the Association of British Neurologists to write the first UK clinical guidelines for these tests and the guidelines have been submitted for publication.

Similarly, monoclonal antibodies for Alzheimer's disease are in use around the world and are still being reviewed by NICE, which could lead to them being available on the NHS. Other drugs have submitted evidence to the MHRA and are at late stages of the approval process. The world's first adaptive platform trial in Alzheimer's disease (AD-SMART) has opened in the UK. These sorts of trials, which test many drugs at once against placebo, have made a profound difference in cancer and infectious disease. There is no real reason to believe they cannot have the same impact in neurodegeneration.

It has been a time of change at the College – not least the election of a new President. As a faculty we thank Lade for her outstanding leadership and extend a warm welcome to Subodh. We will of course support him in any

way we can. We have also seen significant change within the faculty. I cannot say how excellent Chineze Ivenso has been as academic secretary – anyone who has been to one of our conferences over the last three years has Chineze and her team to thank for having such a good experience. We welcome Rashi Arya and Judy Rubinsztein – if anyone can follow Chineze's tough act it is them! Our annual conference will be 11/12 March next year in Edinburgh so save the date. We thank all outgoing executive members and welcome our new colleagues.

Mohan continues to address our workforce issues and the work of last year's faculty fellows which describes this will soon be published. We will build on this to fill our higher training places and campaign for more training places. Our other two new projects this year are led by Charlotte Deasy who will be looking at a public health approach to decreasing risk factors for dementia and I will be looking to optimise throughput through memory clinics. We welcome Alex Smith, Cheryl Leung, Jonathan Philips, Chinenye Omesili and Kathryn Mitchell, our new faculty scholars for this year.

When I meet the talented and energetic trainees and see the science making real change to clinical practice, there has ever been a more exciting time to be an old age psychiatrist. We are truly lucky to have chosen this profession for our working lives.

Ben Underwood
Vice Chair



Opportunity for Consultants, SAS Doctors, Resident Doctors, Medical Students & Allied Health Professionals

The Old Age Psychiatrist, the official newsletter of RCPsych's Old Age Faculty

CALL FOR SUBMISSIONS JANUARY 2027

An excellent opportunity to have your work published

- We invite you to contribute to the growth and enrichment of the Old Age Psychiatry faculty by submitting your work for publication.
- We welcome a broad range of articles, including (but not limited to) descriptions of innovative services, literature reviews on topics of interest, case reports, opinion and reflective pieces, QIP/audit reports, creative writing and artwork and reviews of books, films or other cultural highlights
- To discuss or submit your work, email oldage@rcpsych.ac.uk.
- The ideal word count is between 800–1500

DEADLINE 1 DECEMBER 2026

A SNAPSHOT OF PSYCHIATRY IN 2026

Be part of the College's history! Another chance to help us build a snapshot of psychiatry in 2026 by capturing your day...



As part of the College's celebration of 100 years since receiving its Royal Charter, we are recording a snapshot of what psychiatry is like in 2026 at four points throughout the year. To do this, we need your help.

Society generally excels at recording the decisions of institutions and the lives of famous people. It is less successful at conveying what ordinary people, thought, felt and experienced. We know our members do amazing work, often in difficult circumstances, and we want future generations to know that too.

The College is creating an archive of the experiences of its members, and the third snapshot window is taking place between 14 - 18 September. We know it can be difficult to set aside time, so please feel free to write about, or otherwise record, any day that week. Journal entries, selfies, vlogs and other submissions are all welcome!

Find out more, and submit your entry:
[Help us create a picture of psychiatry in 2026](#)



GRN-MUTATION ASSOCIATED FRONTOTEMPORAL DEMENTIA IN TWO BROTHERS: A CASE REPORT

Dr Alexander Sunderland, ST5 Older Adults Psychiatry, Gloucestershire Health and Care NHS Foundation Trust

Introduction

Frontotemporal dementia (FTD) is a clinically and pathologically heterogeneous group of neurodegenerative disorders characterised by progressive degeneration of the frontal and temporal lobes. It accounts for approximately 10–20% of all dementia cases and is a leading cause of early-onset dementia (1,2). Among its clinical subtypes, the behavioural variant (bvFTD) is the most common, comprising approximately 50% of cases, and typically presents with early changes in personality, behaviour, and executive function (3). Unlike Alzheimer's disease, memory impairment is often not the predominant early feature, contributing to diagnostic difficulty (4).

A key characteristic of FTD is its strong genetic basis. Pathogenic variants are most commonly identified in three genes: microtubule-associated protein tau (MAPT), progranulin (GRN), and chromosome 9 open reading frame 72 (C9orf72) (5,6). These mutations are generally inherited in an autosomal dominant fashion, conferring a 50% risk to first-degree relatives (7). However, incomplete penetrance and variable clinical expression mean that family history may be absent or unclear, even in genetically mediated cases (8).

This case report describes two brothers with GRN-associated FTD who initially presented without a convincing family history. Their clinical trajectories highlight the diagnostic challenges of bvFTD, particularly in psychiatric settings, and underscore the crucial role of genetic testing in diagnosis, management, and family risk assessment.



Brother 1

A 62-year-old man presented in 2022 with suicidal ideation and progressive cognitive decline. On assessment, he scored 56/100 on the Addenbrooke's Cognitive Examination (ACE-III), reflecting significant impairment. Structural neuroimaging with computed tomography (CT) demonstrated generalised cerebral atrophy, more pronounced in the right hemisphere.

Over the subsequent year, he developed hallmark features of bvFTD, including marked apathy, loss of motivation, impaired judgement, and reduced self-care. Neuropsychiatric symptoms became increasingly prominent, including paranoid ideation and fixed delusional beliefs, such as being pursued or at risk of imprisonment. Behavioural dysregulation manifested as agitation, verbal aggression, and unsafe behaviours.

Fluorodeoxyglucose positron emission tomography (FDG-PET) revealed hypometabolism in the right frontotemporal region, consistent with FTD (9), see Figure 1. Amyloid PET imaging showed no evidence of amyloid deposition, making Alzheimer's pathology unlikely. Whole genome sequencing subsequently identified a heterozygous pathogenic GRN mutation, confirming the diagnosis of GRN-associated FTD.

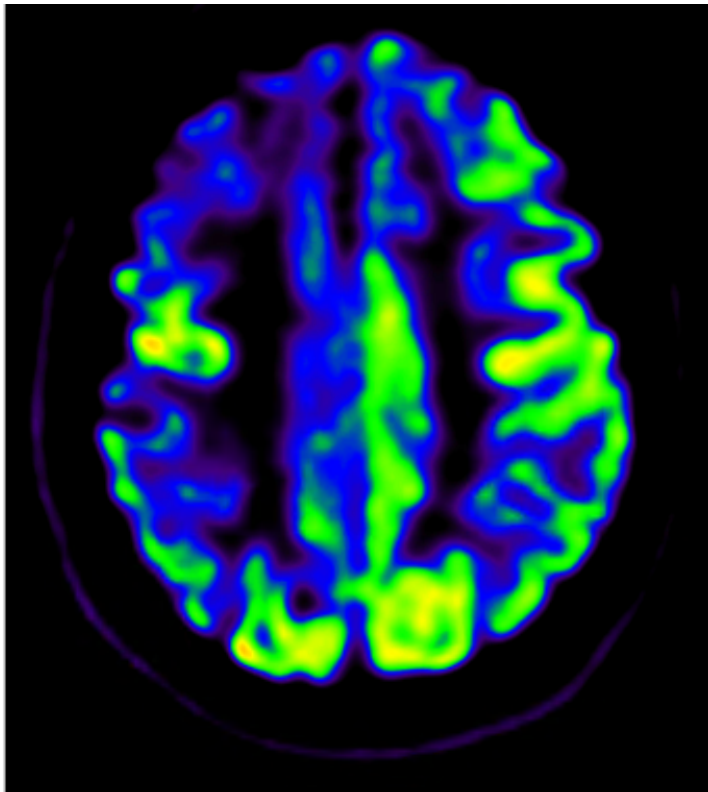


Figure 1. FDG-Pet imaging showing marked reduction of cortical uptake in the frontal lobes (right more than left) and moderate reduction of cortical uptake in both parietal lobes (more prominent on the right with involvement of the precuneus).

Brother 2

The patient's 64-year-old brother initially presented with emotional distress related to psychosocial stressors. However, over time, he developed progressive cognitive decline, apathy, irritability, and impaired executive function. His ACE-III score was 24/100, indicating severe cognitive impairment.

Neuroimaging revealed significant frontal and temporal lobe atrophy on CT, with FDG-PET demonstrating widespread hypometabolism across the frontal, temporal, and parietal regions, see Figure 2.

Genetic testing was subsequently undertaken and identified the GRN mutation with the same heterozygous variant. Despite both brothers carrying the same pathogenic mutation, there was no clear family history of FTD, see Figure 3. These genetic findings, together with the characteristic frontotemporal hypometabolism observed on FDG-PET, provided sufficient diagnostic confidence in FTD and hence his planned amyloid PET imaging was cancelled.

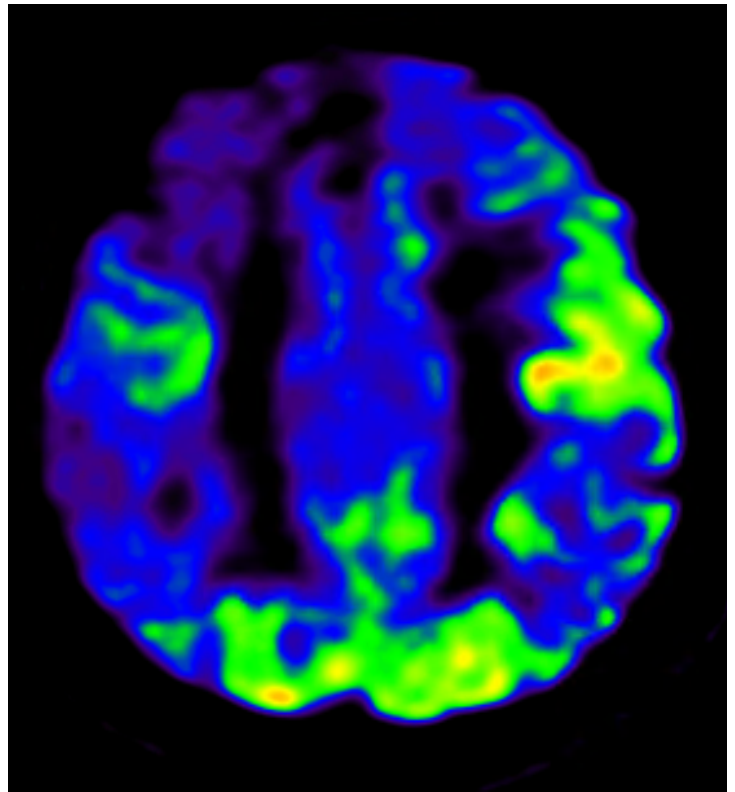


Figure 2. FDG-PET imaging showing severe reduction of cortical uptake in the frontal lobes (right more than left) and marked reduction of cortical uptake in both parietal lobes (right more than left).

He subsequently experienced rapid functional and behavioural decline, including aggression and disinhibition, necessitating inpatient psychiatric admission.

Discussion

Diagnostic Challenges in BvFTD

BvFTD frequently presents with behavioural and psychiatric symptoms, including apathy, disinhibition, mood disturbance, and psychosis, which can lead to misdiagnosis as primary psychiatric disorders (4,10). Both patients in this case initially presented with psychiatric features, delaying recognition of an underlying neurodegenerative disorder.

Neuroimaging plays an essential role in distinguishing FTD from other conditions. FDG-PET is particularly sensitive, often demonstrating characteristic frontotemporal hypometabolism before structural changes become evident (9).

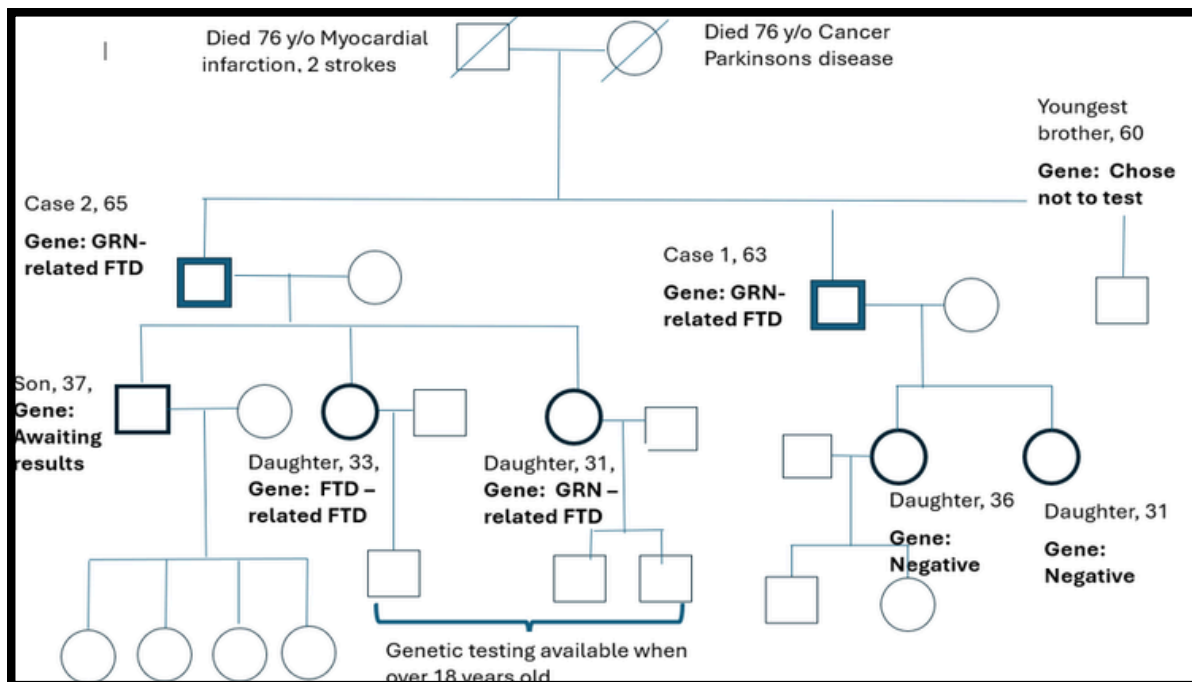


Figure 3. Family tree showing the genetic testing offered to family members, and the genes identified. Genetic testing was declined by their youngest brother. Predictive genetic testing was also offered to relatives, and of four offspring tested, two were found to carry the mutation. Genetic testing will also be offered to the to relatives, and of four offspring tested, two were found to carry the mutation. Genetic testing will also be offered to the children of the daughters who carry the mutation when they are over 18 years old.

The absence of amyloid on PET imaging further supports a non-Alzheimer's pathology, consistent with FTD, which is typically associated with tau or TDP-43 protein deposition rather than amyloid plaques (11).

Crucially, a lack of known family history should not preclude a diagnosis of FTD, nor a genetic cause. Approximately 7% of FTD cases with no reported family history are found to carry a pathogenic genetic variant (16). This may occur due to small family sizes, early deaths of relatives, or reduced penetrance, where some carriers live into their 80s or 90s without ever developing symptoms.

Role of GRN Mutations

Mutations in the GRN gene account for approximately 5–10% of all FTD cases and a significant proportion of familial disease (6,12). GRN encodes progranulin, a protein involved in neuronal repair, inflammation regulation, and lysosomal function. Haploinsufficiency due to GRN mutations leads to TDP-43 proteinopathy and neurodegeneration (13).

GRN-associated FTD exhibits autosomal dominant inheritance with age-dependent penetrance, meaning some mutation carriers may remain asymptomatic into later life (7,13). This variability can obscure family history and complicate diagnosis, as seen in this case.

Importance of genetic testing

Genetic testing is increasingly central to the diagnosis and management of FTD, offering benefits that extend beyond diagnostic confirmation.

While clinical features and imaging can strongly suggest FTD, genetic testing provides definitive diagnosis. This is particularly important in cases with atypical or psychiatric presentations, where misdiagnosis is common. In this case, whole genome sequencing enabled confirmation of GRN-associated FTD in both brothers and avoided further diagnostic uncertainty.

This case also reinforces that the absence of family history does not exclude a genetic cause. Studies suggest that a significant proportion (up to 10–15%) of apparently sporadic FTD cases harbour pathogenic mutations (8).

Reasons include reduced penetrance, early death of relatives, or misdiagnosis in previous generations.

Genetic testing also allows for early and accurate classification of disease subtype, which is important given FTD is a heterogeneous condition with differing underlying pathologies.

Genetic testing allows precise molecular classification, distinguishing between tauopathies and TDP-43 proteinopathies. This, therefore, has implications for prognosis, clinical monitoring, and future therapeutic strategies (5).

Genetic testing is increasingly important for eligibility for clinical trials targeting specific molecular pathways. In GRN-associated FTD, therapies aimed at increasing progranulin levels—such as gene replacement or monoclonal antibody approaches—are currently under investigation. For example, the ASPIRE-FTD study evaluates the safety and efficacy of AVB-101, a gene therapy specifically designed for patients with a confirmed GRN mutation (14). Early identification of mutation carriers will be critical for accessing these therapies at a stage when intervention is most likely to be effective. In addition, mutation carriers may benefit from participation in longitudinal monitoring programmes and clinical research studies. Early identification also allows enrolment in presymptomatic trials, which are increasingly important as disease-modifying therapies are developed.

Genetic testing enables predictive testing for at-risk relatives. Given the autosomal dominant inheritance pattern, first-degree relatives have a 50% risk of carrying the mutation (7). Identifying carriers allows individuals to make informed decisions regarding family planning. Those at risk may choose assisted reproductive technologies, such as in vitro fertilisation with pre-implantation genetic diagnosis, to avoid passing the mutation to future generations.

In addition, genetic testing can support informed decisions about the future, enabling individuals to consider decisions about their finances, career and future care in light of their potential risk of developing the condition. Additionally, knowledge of genetic risk can facilitate psychological preparation and engagement with support services.

Conclusion

This case report of two brothers with GRN-associated frontotemporal dementia highlights the diagnostic complexity of bvFTD and the central role of genetic testing in modern clinical practice.

This case emphasises the need for clinicians to maintain a high index of suspicion for FTD in patients with late-onset psychiatric symptoms, and to use functional imaging early where diagnosis is uncertain.

Despite no clear family history, both patients were found to carry a pathogenic GRN mutation, demonstrating that genetic causes should also be considered in all cases of FTD. Genetic testing provided diagnostic clarity, guided clinical management, and enabled identification of at-risk relatives.

Furthermore, as advances in neurogenetics and targeted therapies continue, early and routine genetic testing will become increasingly important in improving outcomes for patients and families affected by FTD.

References are available on request

HEALTH CARE INEQUALITIES (HCI) WITHIN MEMORY SERVICE PATHWAYS - RCPSYCH OLD AGE FACULTY SURVEY RESULTS: A STORY IN 10 FIGURES



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Introduction

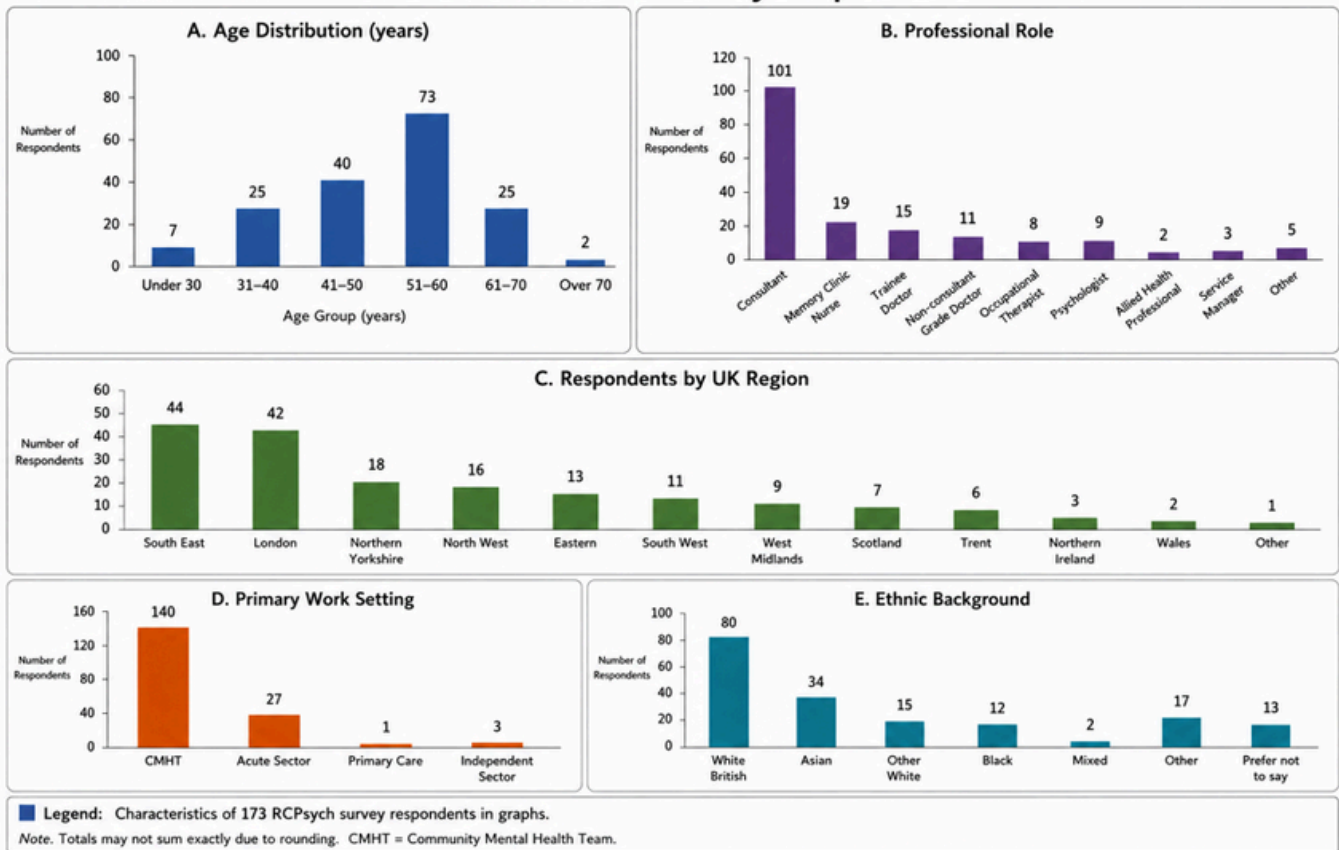
Health Care Inequalities (HCI) are avoidable and systematic differences in health experienced by different population groups. Within dementia care, people from ethnic minority (EM) backgrounds experience substantial inequalities in access to diagnosis, assessment, treatment, and post-diagnostic support (1). These disparities are associated with language barriers, culturally inappropriate assessment tools (2), stigma surrounding dementia (3), lower health literacy, and unequal access to specialist services.

Together, these factors contribute to delayed diagnosis, underdiagnosis, and poorer outcomes (4). Reduced access (5) and variations in access to dementia services by EM elders (6) reflects inequalities that operates across the entire care pathway including access to treatments and care (7, 8, 9).

Faculty Survey

Although these inequalities are well documented, relatively little is known about how clinicians working within memory services perceive their impacts in everyday practice. To address this gap, the Old Age (OA) Faculty of the Royal College of Psychiatrists (RCPsych) conducted a UK-wide survey of clinicians involved in dementia assessment and care that has led to the production of OA faculty position statement. The UK-wide online survey during May–June 2025 to members of the OA Faculty and the Memory Services National Accreditation Programme (MSNAP), received 173 responses with over 200 qualitative free text responses. Invitations for participation were distributed online, and participation was voluntary and confidential.

Characteristics of Survey Respondents



The anonymous nature of the survey meant that detailed respondent characteristics of those taking part was not recorded and hence unavailable. The particulars of 101 men and 68 women are given in the chart above.

The survey explored variability, accessibility, and availability of services, staff experiences and how professional backgrounds and personal histories shape understanding of the health inequalities.

Here, we present the summary in a range of graphs and figures, the full details are being published in academic journals this year, so keep a look out for them and the soon due OA Faculty position statement!

Collected survey responses were grouped and analysed using Likert analysis and data presented in tables 2-4. Qualitative perceptions were transformed into measurable data allowing for statistical analysis helping quantify subjective opinions and attitudes, this helped track patterns and differences.

Chi square goodness of fit test was used to compare differences between groups where appropriate. The key descriptive values are presented as percentages. The main findings are presented as tables 2-4.

Likert scale analysis demonstrated that respondents perceived EM elders as significantly underrepresented in services both relative to local population mix and in comparison to White British groups. Chi square goodness of fit test confirms statistically significant deviations from equal response distributions ($p < 0.001$). Training related to culturally tailored assessment practices appeared limited with no statistically significant variation across training categories.

Respondents reported moderate to high use of cognitive assessment tools in practice. Many clinicians considered available tools were therapeutically useful for clinical decision making. Despite this, substantial concerns remained regarding the cultural adequacy and validity of current cognitive assessment tools for ethnic minority elders.

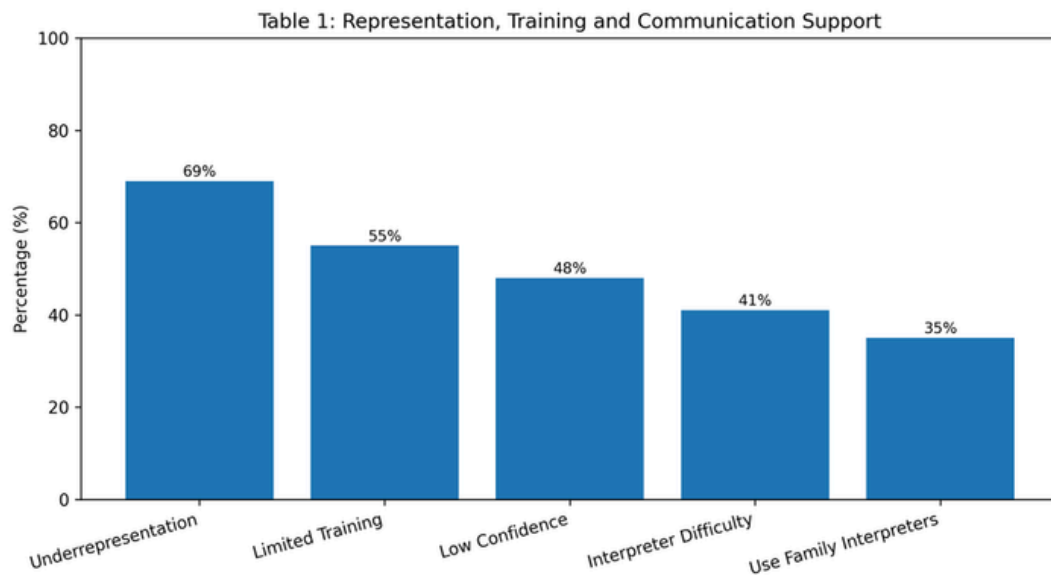


Figure 1: Representation, Training and Communication Support

Findings suggest a potential mismatch between practical reliance on existing tools and confidence in their cultural appropriateness. ACE was the commonest cognitive tool being used (132 respondents) followed by MOCA (83 respondents) then RUDAS (64 respondents) and MMSE (61 respondents). 47 respondents used a validated translated version of an established Western tool. Overwhelmingly they agreed that there was a role of language proficiency on accuracy, fairness and interpretation of the results. Language barriers affected diagnostic confidence, and few had access to post diagnostic culturally appropriate care.

Chi-square goodness of fit analysis demonstrated statistically significant response distributions across all domains ($p < 0.01$), suggesting significant perceptions of increased mental health burden amongst ethnic minority older populations. Likert scale analysis demonstrated mixed perceptions regarding cognitive assessment tools used with EM older adults.

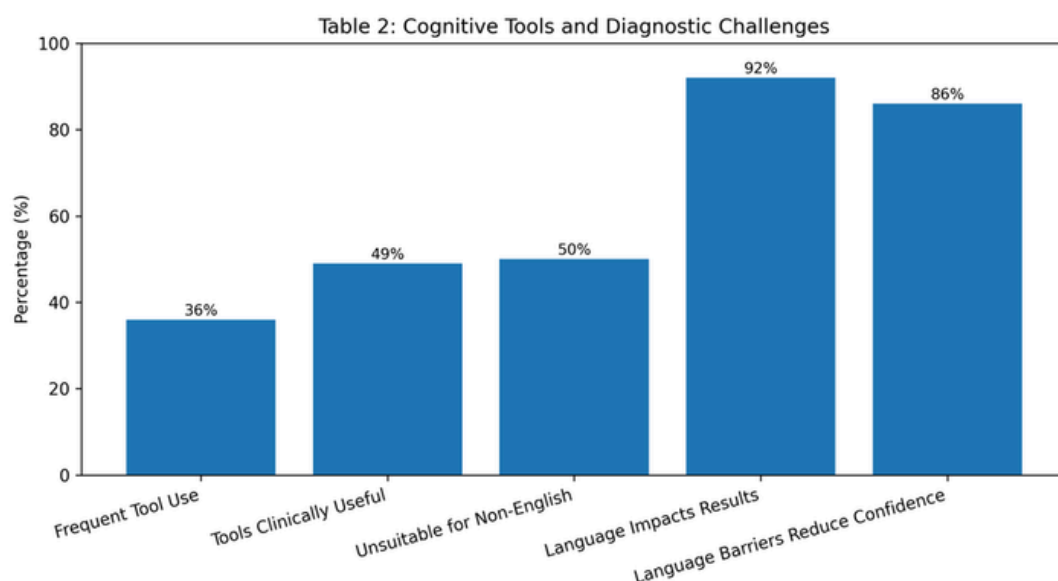


Figure 2: Cognitive Tools and Diagnostic Challenges

Likert scale analysis demonstrated mixed perceptions regarding cognitive assessment tools used with EM older adults. While respondents generally reported moderate to high usage and acknowledged therapeutic value in clinical decision making, significant concerns were expressed regarding the adequacy of current tools for assessing cognitive abilities across diverse ethnic groups. Chi square analysis indicated statistically significant concern regarding assessment adequacy ($p=0.007$) and significant support for the perceived therapeutic utility of available tools ($p<0.001$).

Respondents generally perceived mental health conditions, anxiety symptoms and affective symptoms to occur at similar or higher rates amongst minority ethnic older adults. Perceptions of increased prevalence were strongest for affective symptoms. Likert scale analysis indicated that respondents perceived mental health conditions, anxiety symptoms and affective symptoms amongst ethnic minority older adults occurring at similar or higher rates compared with White Caucasian older adults.

Chi-square goodness of fit analysis demonstrated statistically significant response distributions across all domains ($p<0.01$), suggesting significant perceptions of increased mental health burden amongst ethnic minority older populations.

Respondents perceived substantial deficiencies in dementia support pathways for ethnic minority older adults and culturally appropriate training provision within services. Perceptions of inadequate cultural competency training were particularly strong. There was widespread concern regarding the adequacy of local health and social care services for ethnic minority older adults.

Respondents perceived dementia support pathways and culturally appropriate work force training as significantly insufficient. Chi-square goodness of fit analysis demonstrated highly significant response distributions across both domains ($p<0.001$), indicating strong professional consensus regarding gaps in culturally responsive service provision.

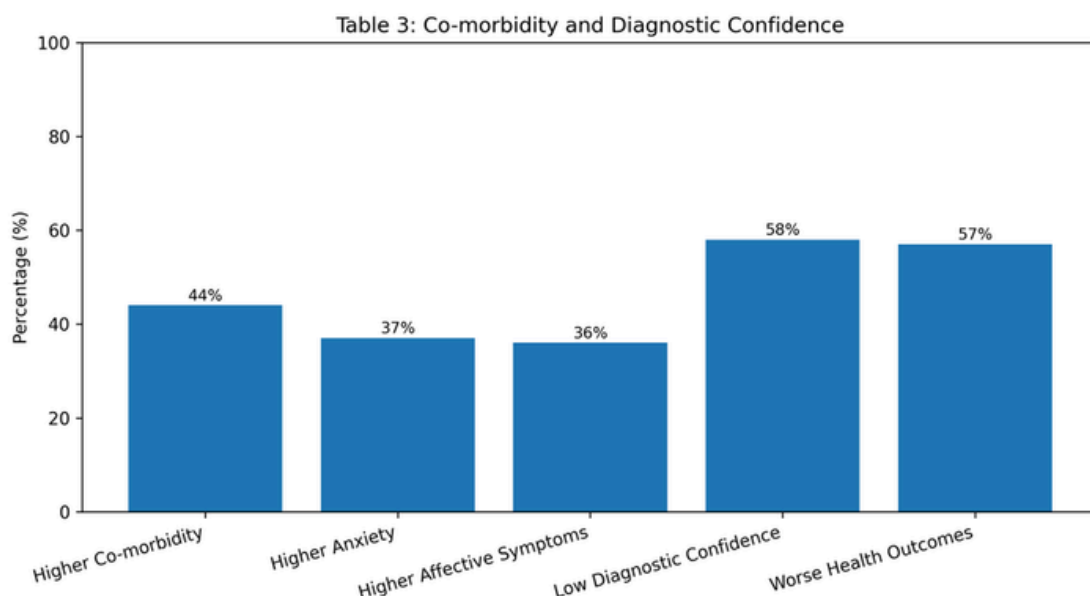


Figure 3: Co-morbidity and Diagnostic Confidence

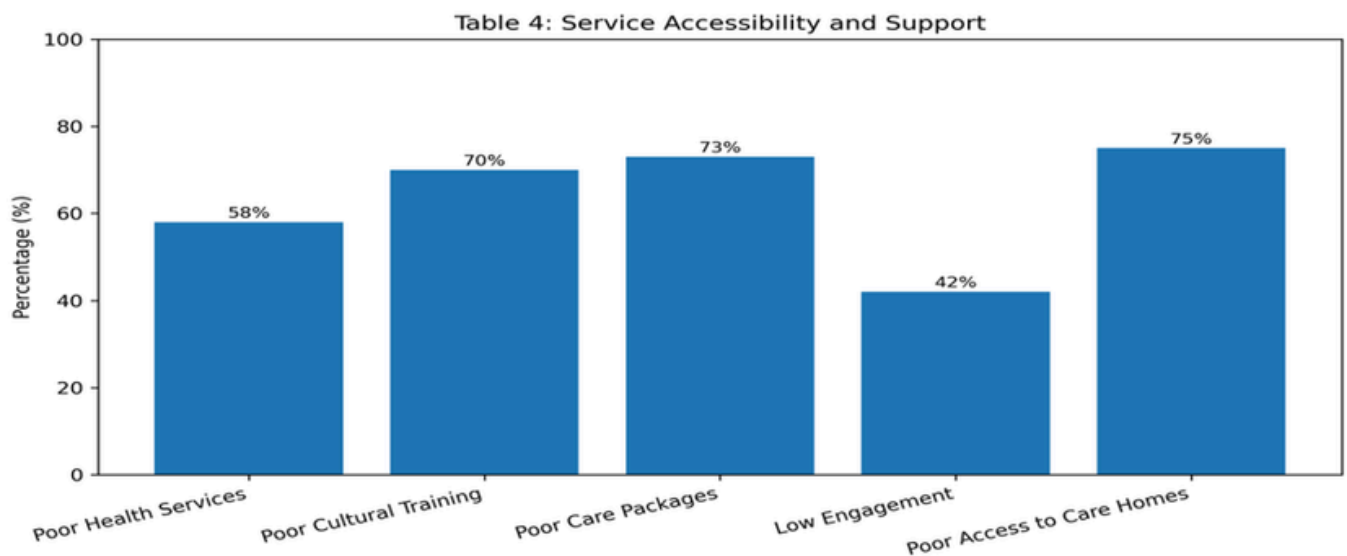


Figure 4 Service Accessibility and Support

The qualitative experiences of health care professionals within the RCPsych membership and the MSNAP memory clinic services were captured through their free text responses. Free text responses to open-ended survey question such as “Describe your experience of ethnic elders presenting to your memory clinic services” were analysed using Braun and Clarke’s six-step model. We conducted a thematic analysis using Nvivo (version 13) of the qualitative responses obtained exploring healthcare use by ethnic elders within mental health service and memory clinics. Data were coded inductively, generating themes grounded in participant insights. Initial codes were grouped into larger themes corresponding to the six main questions eliciting free text responses, the coding frame was then developed iteratively during coding. Themes, descriptions and representative comments are provided on the following page *themes emerging from free text responses*.

Conclusions

Reduced health care access within dementia services by ethnic groups in the UK and elsewhere is well recognized and this survey adds the perceptions of clinicians working within memory services. Our survey re-enforces clinicians’ perceptions that are in keeping with those described in literature. Ethnic elders face multiple, interconnected barriers to accessing timely and equitable dementia care in memory clinics. Addressing these challenges requires systemic changes spanning clinical practice, service delivery, and community engagement. This thematic analysis provides valuable insights to inform targeted strategies that improve diagnosis, support, and outcomes for ethnic minority older adults with dementia. Providers of memory services assessing people from multicultural populations may wish to consider these above findings to develop a best practice guidance with the aim of improving current memory clinic assessment standards. Modern memory services need to meet the requirements of today’s multi-ethnic urban memory clinics to improve assessment and support standards for cognitive problems irrespective of patient backgrounds.

Themes emerging from free text responses

Themes	Descriptions	Representative comments
Under representation	Ethnic elders are under-referred compared to local population demographics	"Very low numbers despite local demographics" "Lower than that of the community"
Late presentation and presentation in crises	Often present at advanced stages or during crises, delaying diagnosis and support	"Usually present when in crisis" "Late or not at all"
Language & Communication Barriers	Assessment and follow-up are hindered by limited interpreter availability and linguistic mismatches	"Language barriers are an issue" "Interpreters vary in quality"
Cultural Beliefs & Stigma	Dementia may be normalized or stigmatized; reluctance to seek help due to mental health taboos	"Memory decline seen as part of ageing" "Don't want to be seen with mental health issues"
Systemic Disadvantages and differences in management approaches	Services lack cultural competence; staff are not always trained to meet the needs of ethnic groups	"Services not well equipped" "Staff unaware of cultural needs"
Clinical Complexity	Patients often present with multiple comorbidities and complex psychosocial issues.	"More complex problems" "Advanced form of impairment"
Family Dynamics	Families can delay or enable access; often manage symptoms until unmanageable.	"Family take over tasks" "Need to convince the carer more than the patient"
Service Development Efforts	Some clinics run outreach or culturally adapted services, but these are not widespread	"We run a transcultural memory clinic" "Worked with Hopscotch to increase referrals"

Key themes and the subthemes to each of the questions are summarised in the following visual mind maps. The analysis identifies key themes reflecting barriers, facilitators, and challenges in service engagement, diagnosis, and care for ethnic minority older adults with dementia.



Figure 5: Experiences of ethnic elders presenting to memory services



Figure 6: Perceptions on the use of family members in clinical assessments

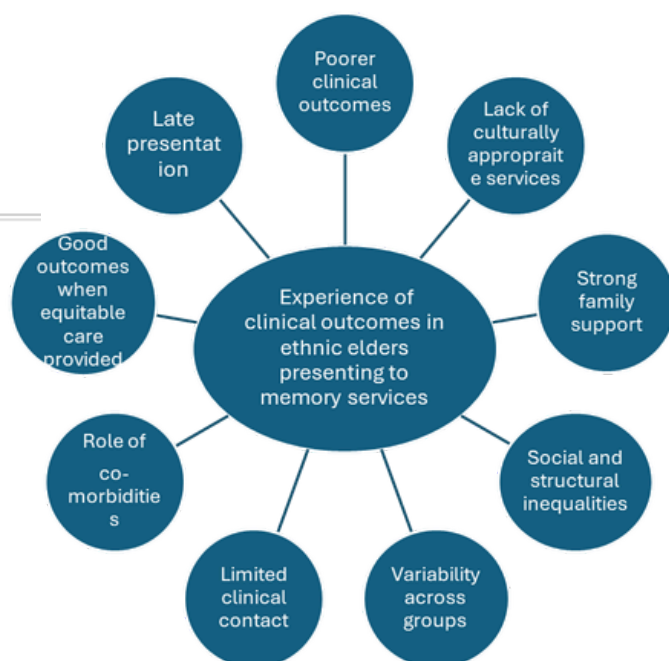


Figure 7: Experiences of clinical outcomes in ethnic elders presenting to memory services



Figure 8: Describe experiences of culturally appropriate services in your area

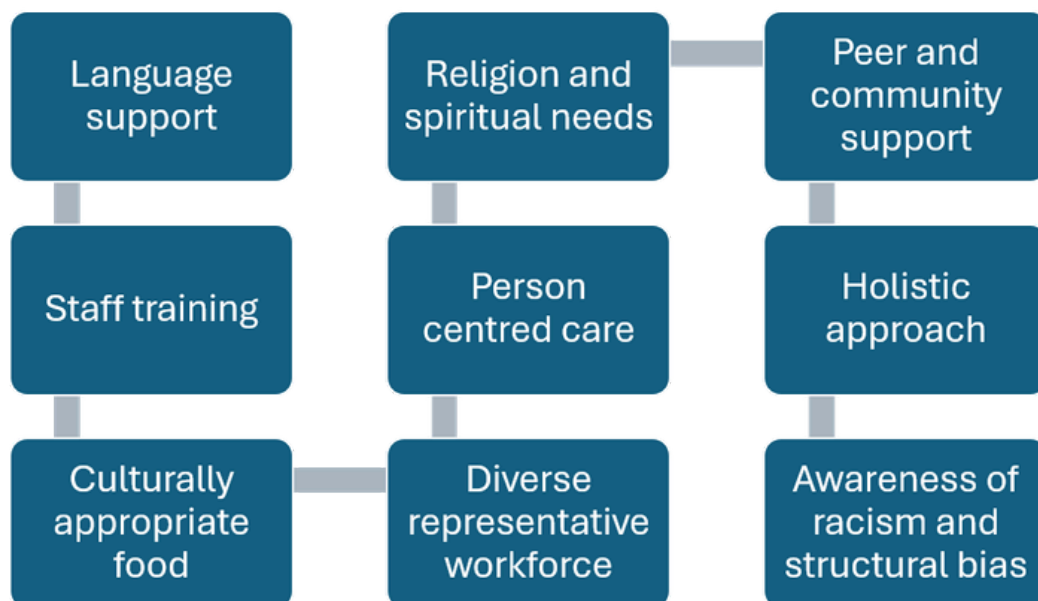


Figure 9: Improving care in care home for ethnic elders

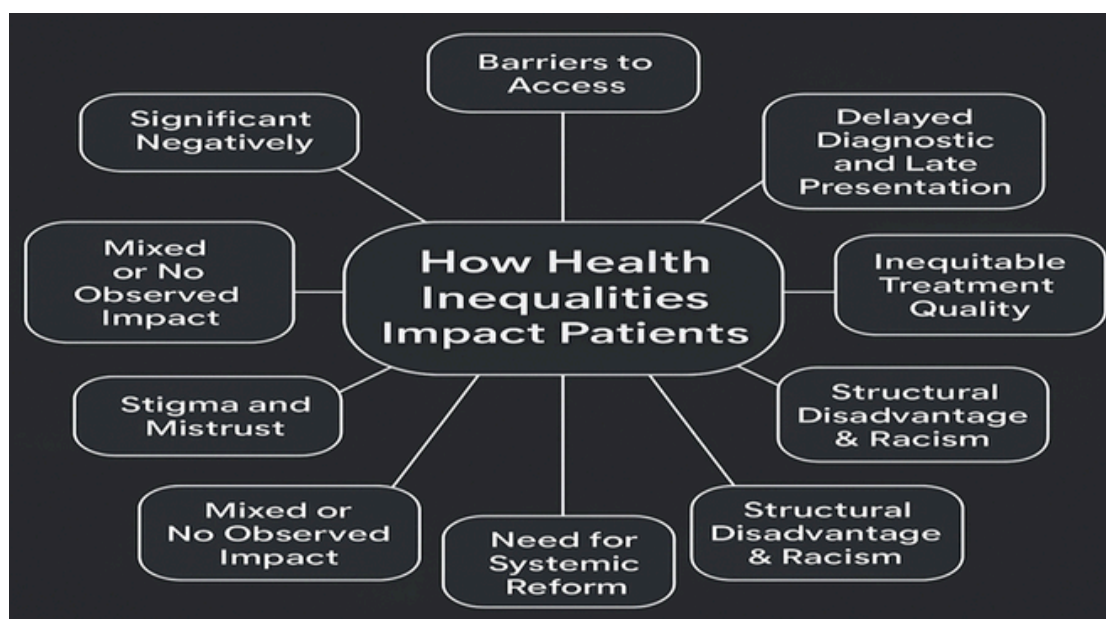


Figure 10: Respondents' experiences of how health inequalities affect patients

Next Steps

The OA faculty is presently bringing out a position statement to address these health inequalities within memory service pathways, so keep a look out for this College position statement!

References are available on request

PSYCHOLOGICAL FORMULATION IN CASE PRESENTATIONS



Dr Indira S Vinjamuri, Associate Dean, Royal College of Psychiatrists, Director of Medical Education, Mersey Care NHS Foundation Trust and **Dr Rachel Gorny**, ST5 Older Adult Psychiatry, Derbyshire Healthcare NHS Foundation Trust

One of the major updates to formative assessments for psychiatry trainees launching in August 2026 is 'embedding formulation skills throughout training'. In this article we will give an overview and rationale for psychological formulation in psychiatry training as well as wider clinical practice. We will then discuss the practicalities and considerations of psychological formulation in older adult patients.

Why Use Formulation?

Psychological formulation is a core clinical skill that goes beyond diagnosis to provide a meaningful understanding of an individual's difficulties. Whereas a diagnosis categorises symptoms, formulation seeks to explain why this person is experiencing these difficulties at this time integrating biological, psychological and social factors into a coherent narrative. It helps clinicians move from describing problems to understanding the mechanisms that underpin them.

Formulation is particularly valuable in psychiatry because many clinical presentations are multifactorial and do not fit neatly within diagnostic boundaries. A well-constructed formulation helps clinicians generate and test hypotheses, identify risk and protective factors, understand engagement and anticipate potential challenges in care. It also guides intervention by highlighting therapeutic targets and informing multidisciplinary management plans.

In case presentations and discussions, formulation enables trainees and multidisciplinary teams to organise complex information into an explanatory framework. This can be through any modality of formulation and different modalities may be appropriate in different situations¹. A robust formulation will link the presenting symptoms with relevant developmental experiences, vulnerabilities, strengths, precipitating events and maintaining factors, creating a shared understanding of the patient's difficulties. This approach promotes person-centred care by ensuring the patient's unique experiences and values are considered alongside diagnostic considerations.

From a training and assessment perspective, formulation demonstrates higher-order clinical reasoning. It allows assessors to evaluate a trainee's ability to synthesise information, apply psychiatric and psychological theory, consider alternative explanations, and develop an individualised treatment plan. The process reflects critical thinking rather than simple factual recall. Embedding formulation within case discussions therefore enhances learning, encourages reflective practice, and supports the development of holistic clinical judgement.



Practicalities of a Formulation Approach in Older Adults

Applying psychological formulation in the older adult population requires adaptation to the unique complexities of later life. The life course will inevitably be punctuated by events such as medical diagnoses, hospital admission, bereavement, retirement, marriage, divorce or relocation. Conditions such as neurodegenerative illness and frailty can fragment the patient narrative, disrupting the individual's ability to provide a coherent history, reflect on emotions, or engage in traditional formulation discussions. The narrative may be then reimagined and rerecorded by family, health and social care professionals and the risk is the loss of the patient's own voice. It is our job as psychiatrists to advocate for our patients and enable their voice to be heard. We can do this through the process of formulation which can be defined as 'an attempt to explain how a situation is developed, maintained or resolved, or an attempt to make sense of what has happened'¹.

Psychiatrists of all grades and particularly those in training may find it helpful to have in mind an objective for the formulation or question that needs to be answered. Formulation in itself cannot answer a question but can help to highlight the pertinent areas for the patient. In other words "what has happened, what matters, and what might help"?

The process of formulation in older adults must integrate cognitive, physical, psychological and social factors, while remaining person-centred and collaborative. We can think of the clinical narrative as a collection of pieces of evidence and sequences of events collected and distilled from notes, letters, meetings and handovers as well as the constructed stories and shared understanding of families and social networks.

Developing a formulation with the patient narrative in mind can provide greater support and inform a wider treatment plan, particularly in cases of patients where there is an impairment in their ability to make capacitous decisions. The links between a patient's symptoms and their life history can be crucial here particularly if we wish to support patients in formal Best Interests processes such as in decisions relating to future care and residency. We can use formulation to ensure treatment and support plans are congruent and consistent with the patient's premorbid views.

When it is clear views are not consistent with the patients' historical preferences, we can then examine whether this represents a shift in perspective or can be attributed to the disease process.

Formulation in old age psychiatry should routinely consider:

Physical health and frailty	chronic illness, pain, sensory impairment, sleep disturbance and medication effects
Cognitive factors	dementia subtype, executive dysfunction, memory impairment and capacity issues
Psychological factors	personality traits, coping styles, attachment patterns, past trauma and previous psychiatric illness
Social factors	loneliness, social isolation, safeguarding concerns, caregiving burdens, family dynamics and financial stressors
Life-stage factors	bereavement, retirement, loss of role, reduced independence and transitions into supported accommodation or care homes
Strengths and protective factors	including family support, established coping strategies, cultural beliefs, personal values and preserved abilities. These are often overlooked but are crucial for recovery-oriented care

A practical and focused formulation should remain concise and clinically useful. Rather than attempting to explain every aspect of a person's history, it should focus on factors that are most relevant to the current issues.

In multidisciplinary settings, formulation can provide a shared language that helps teams understand patients who, for example, have cognitive impairment with behavioural and psychological symptoms of dementia. Such patients may be experiencing behaviours that may otherwise be viewed solely as "challenging" or "difficult." For example, agitation in dementia may be formulated as a response to pain, environmental overstimulation, unmet emotional needs or communication difficulties.

Formulation when used in this way is not only a tool used to demonstrate understanding in accordance with the updated college curriculum, rather it is fundamentally working towards a deeper understanding of our patients and how we can support them to live a life in line with their values, wishes and beliefs.

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DELIRIUM RESEARCH NEEDS GREATER EQUITY: HOW OLD AGE PSYCHIATRY CAN HELP



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Delirium, an acute and fluctuating disturbance in mental state, affects one in four general hospital patients across the acute hospital care pathway, and one in five care home residents (1). Reflecting its broad clinical impact, delirium research has developed as a multidisciplinary field, drawing on perspectives from acute medicine, geriatrics, general practice, surgery, neurology, intensive care and psychiatry. Yet conditions that are everyone's responsibility can easily become no one's priority, hence delirium earning its reputation as the "Cinderella of medicine" (2), demonstrated through its persistent under-recognition in clinical practice (3), and relative paucity of research and evidence-based interventions.

Our understanding of delirium has evolved considerably. Once thought of as a transient mental disturbance that resolved with treatment of the underlying physical cause, delirium is now recognised as a marker of chronic vulnerability, with devastating consequences and vast healthcare system costs(4). This has driven national and international efforts to improve delirium awareness, detection and management.

Despite this progress, significant gaps remain in delirium research and care. Whilst there has been substantial study of biological delirium risk factors and development of detection tools, much less attention has been paid to questions of equity and inclusion of under-served populations. This has been highlighted in recent NICE guidance (5).



While delirium research has rightly drawn on expertise from a range of medical disciplines, we suggest that its existing gaps would benefit from greater representation of an Old Age Psychiatry perspective. Old Age Psychiatry has long grappled with the realities that define delirium: diagnostic uncertainty, overlapping syndromes, and the influence of social and personal context. As the delirium field develops to address questions of equity, this perspective should move from the margin to the centre of delirium research.

The unique approach of Old Age Psychiatry

Whilst person-centred care is a core value across medicine, Old Age Psychiatry is distinctive in the extent to which it routinely works with complexity, multimorbidity, and diagnostic overlap. Training promotes the development of advanced understanding of the interplay between physical and mental health disorders, alongside skills in psychiatric formulation; appreciating the impact of early relationships and life experiences on presentations in older age. Taking an inclusive approach and considering cognitive, sensory and neurodevelopmental needs, as well as patients' ethnic, linguistic and cultural contexts, is explicitly required ([9-old-age-psychiatry-curriculum.pdf](#)). These priorities mirror the realities of clinical practice, where we are familiar with disparities in healthcare use and outcomes for people from under-represented and socio-economically deprived groups, and those living with multimorbidity or severe mental illness.

The paradox of exclusion in delirium research

Delirium remains a challenging diagnosis. Its fluctuating nature, overlapping symptomatology with other cognitive and psychiatric disorders, and the limited knowledge clinicians often have of a patient's baseline presentation in the acute setting, all contribute to diagnostic uncertainty. As a result, many delirium studies exclude groups perceived to introduce complexity to the delirium assessment, including patients with language barriers, sensory impairments, advanced dementia, and psychiatric conditions, particularly those with severe mental illness (6). There is a striking paradox in this approach; many of these characteristics are established risk factors for delirium (7).

This disconnect is particularly apparent in Old Age Psychiatry, where clinicians routinely care for people with dementia and severe mental illness;

groups at heightened risk of delirium, and are accustomed to advocating for their needs when they present with acute changes from baseline. By excluding patients most vulnerable to developing delirium from research, we risk generating an evidence base that is not applicable to our patients in practice. Adults with intellectual disabilities provide an important example; there is a marked absence of literature on delirium, and as a result, we know very little about detecting or treating delirium in this group particularly vulnerable to diagnostic overshadowing.

Under-representation and under-reporting

Further limitations in our ability to understand delirium presentation and management in different groups include poor demographic representation and reporting. Brain health research has been criticised for this previously, with systematic reviews highlighting issues around lack of non-Caucasian participation in dementia trials (8).

This gap is now beginning to be addressed in the dementia field, with interventions adapted to target under-served populations worldwide (9). Clearer socio-demographic reporting of patient characteristics in other psychiatric conditions has supported the development of clinical care pathways that utilise a more equitable evidence base (10).

However, delirium research is still in its infancy, and we are yet to see clear reporting of occurrence across different socio-demographic groups, let alone consideration for health inequalities in intervention design. Considering the bio-psycho-social approach, delirium research in its current state appears largely focussed on the biological aspects, overlooking patients' psychological and social contexts. We aim to address this in upcoming research: PROSPERO, PROSPERO

Conclusions

Delirium will, and must, remain a multidisciplinary responsibility, but its next phase in research should be shaped by perspectives intrinsically comfortable with complexity and multimorbidity. Rather than excluding groups for whom diagnosis is challenging, or who increase heterogeneity in studies, our research should embrace those who are most likely to experience it, ensuring an evidence-base reflective of those seen in everyday practice. These populations should not be treated as methodological inconveniences, but as central to the future of delirium research. The relative early stage of delirium research provides an opportunity to consider this from the outset of intervention development.

As Old Age Psychiatry promotes; assessment and treatment cannot be 'one size fits all', and generalist reporting trends in delirium research may be barring the development of truly person-centred care for those affected. By steering research and practice with an Old Age Psychiatry perspective, we can build a more inclusive, equitable, and clinically relevant understanding of delirium from the ground up.

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HOARDING AND THE MENTAL CAPACITY ACT

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This article reviews two Court of Protection cases that involved hoarding which will no doubt resonate with many older adult clinicians. A key learning point came from the application of a checklist of information developed relevant to making decisions in respect of one's items and belongings which was used in MCA assessments of capacity and best interests of people with hoarding.

AC and GC (Capacity: Hoarding: Best Interests) [2022]

AC was a 92-year-old woman with Alzheimer's dementia and alcohol-related brain damage. She lived for over four decades in her home prior to moving to a care facility. In 2018 she appointed her son, GC, as sole attorney for both property/affairs and health/welfare. Both AC and GC had longstanding hoarding disorder. Their shared home environment became increasingly hazardous, with significant clutter, poor sanitary conditions and risks identified by multiple professionals, including fire services and electricians. Following an emergency hospital admission AC was discharged to a nursing home under an urgent DOLS order. This was challenged under s.21A MCA, prompted by her persistent wish to return home.

The court concluded that, despite significant hoarding-related risks, AC should be given a 10-week trial return home with an intensive care package and strict environmental safeguards. Her consistent wish to return home, emotional attachment to place and close relationship with her son were given substantial weight. With a deputy appointed to manage belongings and risks deemed manageable, a home trial was judged to be in her best interests, recognising her limited life expectancy and the importance of autonomy and familiarity.



A Local Authority v X [2023]

This case involved X, a single woman with severe OCD and Hoarding Disorder. She had lived in a one-bedroom maisonette for over 27 years. It was assessed as having a hoarding level of 8/9 (the highest severity). Her living conditions posed significant risks including fire hazards, restricted mobility and difficulty accessing emergency services. Despite extensive efforts by the local authority, mental health professionals and specialist agencies over several years, she consistently resisted interventions to declutter her home citing extreme anxiety and distress.

The court determined she lacked capacity to make decisions regarding her residence, care, belongings and financial affairs due to her mental disorders. It approved the local authority's contingency plan to temporarily relocate her to supported living accommodation whilst her flat was decluttered. The plan included a multidisciplinary approach with mental health oversight, aiming to minimize distress and ensure her safety. The court acknowledged the significant risks of distress and potential suicide (she had made repeated threats if she was removed from her home) but concluded that the risks of leaving her in her current living conditions outweighed these concerns.

Assessing hoarding under the MCA

Information relevant to making decisions in respect of one's items and belongings was developed in the case of AC and GC [2022] and subsequently applied in A Local Authority v X [2023]:

(1) Volume of belongings and impact on use of rooms:

the relative volume of belongings in relation to the degree to which they impair the usual function of the important rooms in the property (and other residents in the property) e.g. whether the bedroom is available for sleeping, the kitchen for the preparation of food etc. Rooms used for storage (box rooms) would not be relevant, although may be relevant to issues of (3) and (4).

(2) Safe access and use: the extent to which the person (and other residents in the property) are able or not to safely access and use the living areas.

(3) Creation of hazards: the extent to which the accumulated belongings create actual or potential hazards in terms of the health and safety of those resident in the property. This would include the impact of the accumulated belongings on the functioning, maintenance and safety of utilities (heating, lighting, water, washing facilities for both residents and clothing). In terms of direct hazards this would include key areas of hygiene (toilets, food storage and preparation), the potential for or actual vermin infestation and risk of fire to the extent that the accumulated possessions would provide fuel for an outbreak of fire, and that escape and rescue routes were inaccessible or hazardous through accumulated clutter.

(4) Safety of building: the extent to which accumulated clutter and inaccessibility could compromise the structural integrity and therefore safety of the building.

(5) Removal/disposal of hazardous levels of belongings: that safe and effective removal and/or disposal of hazardous levels of accumulated possessions is possible and desirable on the basis of a "normal" evaluation of utility.

These elements were used within MCA capacity assessments and as a practical framework for best interest assessments (s.4 MCA). They can also be helpful as a framework and starting point to use in assessing cases of hoarding.

Clinical risk-management recommendations in hoarding disorder

Drawing on the Court of Protection's reasoning in AC and GC and A Local Authority v X, the following clinical risk-management principles can be inferred for multidisciplinary work with severe hoarding disorder.

(1) Differentiate capacity domains clearly

Hoarding disorder frequently coexists with uneven decisional capacity. Teams should separate:

- capacity to manage possessions and environment
- capacity for residence and care
- capacity for finances
- capacity for relationships and personal decisions

Avoid assuming global incapacity based on environmental risk alone. Documentation should specify how pathological anxiety, cognitive impairment or executive dysfunction interfere with the ability to use or weigh information in hoarding-related decisions.

(2) Adopt a risk-tolerance framework, not risk elimination

Total risk elimination is rarely achievable and often counter-therapeutic. Instead:

- Identify non-negotiable risks e.g. fire load, blocked exits, electrical hazards.
- Distinguish these from tolerable risks that preserve autonomy.
- Record the rationale for tolerated risk in care plans to protect staff and services from drift back into crisis-led responses.

This aligns with MCA principles and reduces cycles of eviction, hospitalisation and re-accumulation.

(3) Use environmental risk controls as first-line interventions

Before compulsory clearance or relocation:

- Install smoke detectors, fire-retardant bedding, and heater restrictions.
- Maintain clear 'golden pathways' for access and egress.
- Restrict high-risk appliances rather than possessions per se.

These measures may reduce imminent danger sufficiently to avoid escalation to court proceedings.

(4) Expect distress – plan for it

Psychological distress during decluttering or restriction is predictable, not evidence that intervention is wrong. Teams should:

- Pre-emptively plan for anxiety spikes, grief reactions and anger.
- Provide consistent explanations and timelines.
- Avoid repeated starts and stops, which worsen avoidance and mistrust.

Where clearance is unavoidable, framing it as risk-containment rather than 'tidying' can reduce perceived threat.

(5) Prioritise continuity and relationship-based working

Repeated changes in professionals significantly worsen outcomes in hoarding disorder. Best practice includes:

- A named clinician coordinating risk decisions.
- Stable care agencies trained in hoarding-specific responses.
- Avoiding punitive or shaming language.

Therapeutic alliance is often the single most protective factor against disengagement.

(6) Use legal tools strategically, not reflexively
Deputyship, injunctions or best-interests decisions should be:

- Time-limited.
- Clearly linked to specific risks.
- Reviewed regularly.

The court's reasoning reinforces that over-extension of control risks unlawful paternalism, especially when capacity is decision specific.

(7) Plan for long-term management, not 'resolution'

In older adults, severe hoarding is usually chronic. Success should be measured by:

- Reduced crisis frequency.
- Sustained habitability.
- Preserved autonomy.
- Emotional containment.

A realistic, harm-reduction model is clinically and ethically preferable to repeated emergency interventions.

Cases

1. AC and GC (Capacity: Hoarding: Best Interests) [2022] EWCOP 39 (15 August 2022)

2. A Local Authority v X [2023] EWCOP 64 (16 August 2023)

*The judgements for both cases can be freely accessed in full at: www.bailii.org



WHEN DELIRIUM IS NOT DELIRIUM: A CASE OF LATE-LIFE MANIA INITIALLY ATTRIBUTED TO MEDICATION EFFECTS

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Mrs X is a 67-year-old woman who was assessed and managed by the Psychiatric Liaison Service during a prolonged admission to an acute medical ward in a general hospital. She had a longstanding psychiatric history of recurrent depressive disorder, obsessive-compulsive disorder, and anxiety, as well as a brief private psychiatric admission several years earlier for psychotic symptoms. Her current medical history was notable for chronic musculoskeletal pain, peripheral nerve disease, hypothyroidism, hypertension, asthma, and irritable bowel syndrome. Premorbidly, Mrs X was described as sociable, warm, and nurturing, with strong community ties through her church and a particular enjoyment of baking and caring for others. She lived with her spouse and shared responsibility for raising their adopted adolescent grandson.

In the months preceding admission, Mrs X's chronic pain medications had been subject to repeated changes in primary care. She was sequentially trialled on amitriptyline, pregabalin, co-codamol, and finally tramadol. Within days of starting tramadol, she developed an acute change in her mental state characterised by severe insomnia, confusion, behavioural disorganisation, pressured speech, and perceptual disturbances. At home, she became increasingly difficult to manage; she stopped taking her regular medications, sent incoherent messages to her friends, slept very little, and behaved markedly out of character. Her spouse who was concerned about her safety and ability to function, brought her to hospital.

On initial assessment, Mrs X presented with a strikingly disturbed mental state. She was markedly sleep-deprived, distractible, and exhibited pressured speech, flight of ideas and psychomotor agitation. Her behaviour was disinhibited, and she displayed paranoid ideas and ideas of reference that fluctuated in intensity. Although she denied suicidal or homicidal ideation, she had limited insight into her condition and her capacity to consent to care and treatment was inconsistent. On the ward, she was frequently invading other patients' personal space and attempting to "help" staff, requiring frequent redirection. There was clear evidence of carer strain, and safeguarding concerns were raised given her responsibilities towards a dependent adolescent.

Given the acute onset of symptoms, their close temporal relationship with recent analgesic changes, and the presence of sleep deprivation with apparent cognitive disturbance, the initial working diagnosis was delirium secondary to medication, with hypomanic features. Tramadol was considered the most likely precipitant, particularly in the context of recent exposure to multiple centrally acting agents and her vulnerability as an older adult. Tramadol's combined opioid and serotonergic properties are well recognised to increase the risk of neuropsychiatric adverse effects, including delirium, psychosis, and mood elevation, especially in older adults and those with psychiatric comorbidity (Reeves and Burke, 2008; Senay et al., 2003; Marcum et al., 2015).

Mrs X was initially managed as an informal inpatient. However, her ongoing lack of insight, increasing objection to treatment, behavioural disinhibition, and risk of self-neglect necessitated detention under Section 2 of the Mental Health Act. By this point, her medical condition had stabilised, and her presentation was no longer fluctuating in a manner consistent with delirium, suggesting that a primary mental disorder had become the predominant driver of her symptoms and that management under mental health legislation was appropriate. The distinction between delirium and primary psychiatric illness is clinically significant, as delirium is characterised by fluctuating attention and cognition, whereas affective disorders demonstrate more sustained symptomatology (American Psychiatric Association, 2022).

The management focused on withdrawal of tramadol, which was then added as a medication sensitivity and recorded in her records as an allergic drug. Other analgesics with central nervous system effects were discontinued, and her antidepressant escitalopram was withheld due to her hypomanic presentation. She was commenced on olanzapine, alongside regular clonazepam and hypnotic medication, with lorazepam prescribed on an as and when needed basis for agitation and severe insomnia. Antipsychotic medication is commonly used in the management of psychosis and severe behavioural disturbance in both delirium and acute mania, although ongoing diagnostic clarification remains essential (NICE, 2019). Input from medical teams and the pain service was sought to optimise her physical health and pain control. In view of a significant unintentional weight loss of 26 kgs over the past 1 year, she underwent extensive investigations, all of which came back to be negative.

As her admission progressed, some features initially attributed to delirium, such as confusion and disorientation, improved following tramadol and escitalopram withdrawal and restoration of sleep. However, Mrs X continued to display sustained mood elevation, reduced need for sleep, increased goal-directed activity, pressured speech, and intrusive behaviour. These symptoms became consistent rather than fluctuating, and her attention and cognition were otherwise intact. This evolution prompted diagnostic reassessment. Collateral history later revealed a possible family history of bipolar affective disorder in her mother. Late-life mania is relatively uncommon and is frequently secondary to medications, neurological illness, or medical comorbidity, but it may also represent the first presentation of bipolar disorder, particularly in individuals with prior depressive episodes or genetic vulnerability (Young and Klerman, 1992; Almeida and Fenner, 2002; Depp and Jeste, 2004).

This diagnostic shift highlights the importance of longitudinal assessment in older adults presenting with acute behavioural disturbance. Delirium and mania may overlap early in presentation, particularly when precipitated by medications and sleep deprivation. While fluctuating cognition and impaired attention favour delirium, sustained mood elevation, reduced need for sleep, increased goal-directed activity, and preserved cognition are more consistent with mania (Meagher, 2001; American Psychiatric Association, 2022). Failure to reassess diagnosis over time risks diagnostic anchoring and inappropriate management.

With continued treatment, Mrs X's mental state gradually improved over several weeks. Her sleep-wake cycle normalised, psychomotor agitation reduced, and her speech became less pressured and more coherent. Psychotic symptoms resolved completely, and her behaviour on the ward became settled and appropriate.

She became increasingly reflective about her illness and was able to acknowledge that her experiences represented a departure from her usual functioning. Her relationship with her spouse improved as her mental state stabilised, and carer strain reduced significantly.

1 month later, Mrs X's mental state had returned to baseline. She was euthymic, with appropriate and reactive affect, and there was no evidence of formal thought disorder or psychotic phenomena. She denied any thoughts of harm to herself or others and demonstrated good insight into her illness. Importantly, she was able to understand, retain, weigh, and communicate information regarding her treatment and expressed willingness to continue medication and engage with community follow-up. She was therefore assessed as having regained full decision-making capacity, and her Section 2 detention was appropriately rescinded. She remained briefly as an informal inpatient to facilitate safe discharge planning.

This case underscores the complexity of diagnosing acute mental state changes in later life. While the initial presentation strongly suggested medication-induced delirium with manic features, the subsequent evolution into a sustained manic episode illustrates how medications and sleep disruption may act as precipitants rather than sole causes of illness. Diagnostic flexibility, multidisciplinary collaboration, and proportionate use of legal frameworks were central to achieving recovery. Through careful reassessment and intervention, Mrs X regained insight, capacity, and functional stability, enabling a safe return to the community.

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COLLABORATIVE WORKING BETWEEN A DEMENTIA & DELIRIUM OUTREACH TEAM AND A MENTAL HEALTH LIAISON TEAM: IMPACT ON OUTCOMES IN ACUTE CARE

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Background

People with undiagnosed dementia are three times more likely to visit A&E than those without[1]. Admissions are often prolonged due to uncertainty around diagnosis, leading to delays in discharge planning and of sourcing appropriate placements. Extended hospitalisation in older people can lead to poorer health outcomes and additional costs to the NHS, with estimates that “the gross annual cost to the NHS of treating older patients in hospital who no longer need to receive acute clinical care is in the region of £820 million”[2].

Objective

This project aims to evaluate whether collaborative working between an acute hospital-based Dementia and Delirium Outreach Team (DDOT) and a Mental Health Liaison Team (MHLT) supports diagnostic clarification and improves discharge outcomes for older adults admitted with suspected dementia.

Methodology

An initial service evaluation of DDOT activity reviewed 183 patients supported over a 6-month period in 2025. Alongside this data, we also considered 17 patients discussed in a joint weekly in-person MDT between the DDOT and the MHLT.



This included input from a Consultant Geriatrician, Dementia Nurse Consultant, Psychologist and Consultant Old Age Liaison Psychiatrist.

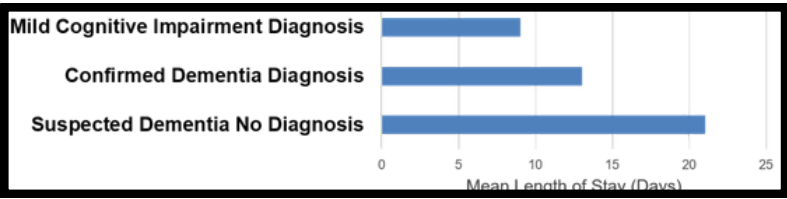
Outcomes reviewed included length of stay (LoS), cognitive impairment status, intervention type and discharge outcome. The relationship between LoS and cognitive impairment status (e.g. suspected dementia no diagnosis) was also examined. This data was considered alongside selected anonymised case examples intended to illustrate the joint working between these services in patients with complex presentations.

Results

When considering the reason for referral for the total DDOT cohort, discharge support had the highest mean LoS (36 days), followed by diagnostic assessment (28 days). Patients recorded as suspected dementia no diagnosis had the longest mean LoS (21 days) in comparison to other types of cognitive impairment status such as mild cognitive impairment (9 days) and confirmed dementia diagnosis (13 days), as demonstrated in the attached table. Across the cohort, DDOT input achieved a 20% reduction in average LoS and a 10% reduction in discharge to new long-term care; their primary forms of intervention were non-pharmacological in origin (for 78% of patients). 68% of patients within the entire cohort returned to their usual place of residence.

For the 17 patients we identified from the joint MDT, it was noted that 23.5% of these patients had already had an acute hospital admission in the 30 days prior to the current admission. The same percentage were being nursed on 1:1 care. 35% of these patients were classed as suspected dementia no diagnosis. Interventions that were actioned from the joint MDT varied, including discussion and advice, MHLT Old Age Psychiatry review or a joint DDOT and MHLT assessment. 23.5% of the total MDT cohort were ultimately given a diagnosis of dementia as an inpatient. 12% of patients were given a primary psychiatric diagnosis. 70.5% of patients had non-pharmacological ward care advice provided, and 53% of patients had specialist medication advice. Nearly 25% required a new long-term care placement.

Mean Length of Hospital stay by Diagnosis of Cognitive Decline



Case Studies

Case Study 1 - A Swift Diagnosis

An older adult patient was admitted to the acute hospital from a care home due to episodes of distress. An initial assessment gave an impression of increased behaviours of unmet need on a background of a suspected dementia. Following MDT discussion with input from the MHLT Consultant Old Age Liaison Psychiatrist, a diagnosis of dementia was given. Post-diagnostic counselling was organised and the patient was able to be discharged with additional community support put in place.

Case Study 2 – A Holistic Approach

An older adult patient was admitted to the acute hospital with an increase in agitation at home. They had a known diagnosis of dementia. Joint MDT working allowed implementation of non-pharmacological interventions alongside commencement of psychotropic medication. An appropriate care home was identified as a discharge location.

Case Study 3 - Clarifying Complexity

An older adult patient was admitted to the acute hospital with episodes of distress. Joint MDT working and specialist assessment allowed amendment of their diagnosis to one of a Mixed Dementia. Psychotropic medication changes were recommended in accordance with this diagnosis and they were able to be discharged to a care home to meet their increasing care needs.

Conclusion

Collaborative working between the DDOT and MHLT enabled specialist support through multidisciplinary decision making, including diagnostic formulation and discharge focused care. The case studies highlight the merits of joint working between specialist services; all of whom had a LoS lower than the cohort average and none were readmitted within 30 days. We believe that this model is feasible in acute hospitals collaborating with mental health liaison services, and merits further evaluation to explore longer-term outcomes and replicability across other healthcare settings.

References

- 1.Alzheimer's Society (2024, September 15). People living with undiagnosed dementia are three times more likely to visit A&E <https://www.alzheimers.org.uk/news/2024-09-16/living-with-undiagnosed-dementia-three-times-more-likely-visit-ae>
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UPDATE FROM ALZHEIMER'S RESEARCH UK

Vicky Cartwright, Clinical Engagement Manager, Alzheimer's Research UK
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ALZHEIMER'S RESEARCH UK FOR A CURE

Alzheimer's Research UK is the UK's leading Alzheimer's research charity aiming to find a cure for dementia. We fund pioneering research - from discovery science through to clinical studies - to change how dementia is understood, diagnosed, treated and prevented.

Here are some highlights from our recent work:

New policy report - Ready for a Cure: A blueprint for UK leadership

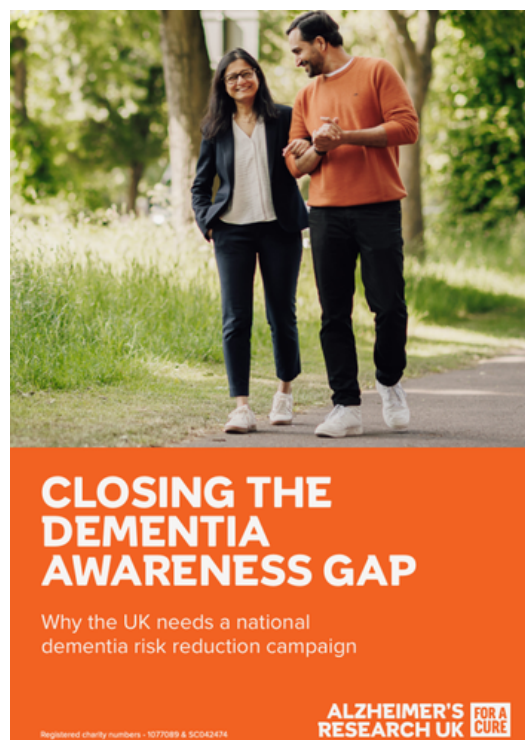
Read [Ready for a Cure: A blueprint for UK leadership in dementia research](#).

In July, we published Ready for a Cure: A blueprint for UK leadership in dementia research, examining what the UK must do to translate its scientific strengths into better outcomes for people affected by dementia.

The report sets out three priorities for government:

1. Provide national leadership and coordination across discovery science, diagnostics, clinical trials, regulation, reimbursement and NHS adoption.
2. Make the UK ready to deliver dementia trials at the scale and pace required, including by improving recruitment and widening access to research.
3. Accelerate the adoption of new diagnostics and treatments so that scientific advances reach patients and services.

These issues have immediate relevance for old age psychiatry. Memory and older people's mental health services will be central to identifying people who may benefit from new tests and treatments, discussing increasingly complex diagnostic information and supporting participation in research. Services must have the workforce, infrastructure and skills to fulfil this role.



New policy report - Closing the dementia awareness gap

Read: [Closing the dementia awareness gap: why the UK needs a national dementia risk reduction campaign](#).

Earlier this year, we published Closing the Dementia Awareness Gap, which sets out the case for a government-led, NHS-delivered national campaign to improve awareness of dementia risk reduction and help people take action to protect their brain health.

Evidence suggests that up to 45% of dementia cases globally could potentially be prevented or delayed by addressing modifiable risk factors. Yet our nationally representative poll of more than 5,000 UK adults found that only 8% strongly agreed it is possible to reduce the risk of dementia, despite 84% wanting more information about how to do so.

We are calling for a national dementia risk reduction campaign that provides clear, consistent and practical brain health advice, aligns with wider government prevention priorities, and reaches people through trusted NHS and community channels. A national approach would help ensure everyone has access to the information they need to support their brain health, while reinforcing conversations already taking place between patients and healthcare professionals.



Investing in ambitious dementia research – the Dementia Frontiers Fund

More information about the [Dementia Frontiers Fund](#)

Announced during the Alzheimer's Association International Conference in July, five international research teams have been awarded up to £1.5 million each through the Dementia Frontiers Fund to tackle three major scientific challenges:

1. Improving prediction and staging of dementia progression
2. Understanding why some high-risk people remain resilient to dementia
3. Unravelling how different brain pathologies contribute to dementia.

Led by Alzheimer's Research UK, Gates Ventures, Robertson Foundation and supported by Alzheimer's Disease Data Initiative, with support from Q Charitable Trust, the Fund is backing science that could transform how we understand, diagnose and treat dementia.

With nearly 160 potential dementia drugs in clinical development worldwide, there is genuine hope. But science alone is not enough: success must be measured by whether people living with dementia benefit from these advances. That will require political leadership and close collaboration between researchers, clinicians, the NHS and people affected by dementia.

As dementia research continues to advance, the expertise of old age psychiatrists will be central to ensuring new discoveries translate into better outcomes for people affected by dementia. We look forward to continuing to work with members of the Faculty as this rapidly developing field moves forward.

Keeping dementia research on the political agenda

In June, Alzheimer's Research UK welcomed 74 parliamentarians, including six ministers, to our Dementia Research Showcase in Parliament. Researchers and people affected by dementia discussed the action needed to expand access to clinical trials, strengthen the UK's global leadership and prepare the NHS for new diagnostics and treatments.

Supporting the next generation of dementia clinical researchers – new clinical fellowships

We have awarded six new Clinical Fellowships worth £2.6 million through our Clinical Accelerator Programme.

The projects span dementia diagnosis, AI, imaging, delirium, primary progressive aphasia and novel treatments, supporting the next generation of clinical researchers and helping bring more dementia trials to the UK.



[More information about the new clinical fellows and their research, and the Clinical Accelerator Programme.](#)

Clinical Funding Opportunities

Alzheimer's Research UK has a range of funding opportunities for healthcare professionals to support dementia research across different career stages.

Doctoral Clinical Fellowships

Up to £400,000 for healthcare professionals with limited research experience who do not yet hold a PhD. Applications close 15 October 2026.

Advanced Clinical Fellowships

Up to £750,000 to support clinicians developing a career that combines dementia research with clinical practice. Applications close 15 October 2026.

Clinical Research Award

Flexible funding to support high-quality experimental and clinical research that generates the evidence needed to progress promising therapies towards larger clinical trials and real-world impact. Expressions of Interest are accepted year-round.

These opportunities form part of our Clinical Accelerator Programme, helping to build research capacity, nurture innovation and bring more dementia clinical trials and research opportunities to the UK.

[Explore our clinical funding opportunities.](#)

Alzheimer's Research UK is launching a Drug Prioritisation Programme to identify potential drugs that could be progressed into clinical trials for Alzheimer's disease and related dementias.

We are keen to draw on the expertise of old age psychiatrists to identify drugs that may warrant further investigation for dementia. These could include drugs in development, existing drugs that might be repurposed for dementia, address an unmet clinical need or treatment gap, or have been overlooked as candidates for dementia research.

If you know of a drug candidate that you think should be considered - or a therapeutic mechanism, academic group or biotechnology company that could help us identify one - please tell us about it using our short [nomination form](#). Nominations close on 15th October 2026.

If you have any questions about the programme or would prefer to share your suggestions directly, please contact Doug Lopes, Clinical Research Manager Douglas.Lopes@alzheimersresearchuk.org.

ALZHEIMER'S RESEARCH UK FOR A CURE

Drug Prioritisation Programme

We're looking for potential drugs that could be progressed into clinical trials for Alzheimer's disease and related dementias.

[Find more information and submit your suggestions here](#)



RESEARCH

GET INVOLVED WITH RESEARCH: INCLUDING MEMORY SERVICES IN THE ADAPT TRIAL



The ADAPT (Alzheimer's Disease Diagnosis and plasma p-tau217) study is a flagship study, funded by Alzheimer's Research UK, evaluating the impact of blood biomarkers for Alzheimer's disease diagnosis in UK Memory clinics.

We would like as many memory services as possible from across the UK to join the study so that the findings reflect the breadth of NHS practice across the UK. Participants in the trial will receive results of their plasma p-tau217 blood test, integrated with the standard care delivered in their memory assessment service. We particularly are keen for sites that have less experience of research to join, and are also registered with the NIHR associate PI scheme which will allow for higher specialty trainees to get involved in research by learning from their more experienced colleagues.

Please contact the ADAPT team directly on cctu.adapt@ucl.ac.uk to register your interest, and if you would like an informal chat about what taking part might look like for your service, from the perspective of a current site investigator, please do get in touch with Dr Jo Rodda (joanne.rodde@kmms.ac.uk).

More information about ADAPT is available [here](#).

RESEARCH

RECENT JOURNAL HIGHLIGHTS

Dr Dansheela Makan, ST6 Older Adults Psychiatry Registrar, Oxford Health NHS Foundation Trust, **Dr Galina D'Souza**, ST5 Older & General Adult Psychiatry Registrar, Essex Partnership University NHS Foundation Trust
Trainee Editors of *The Old Age Psychiatrist*

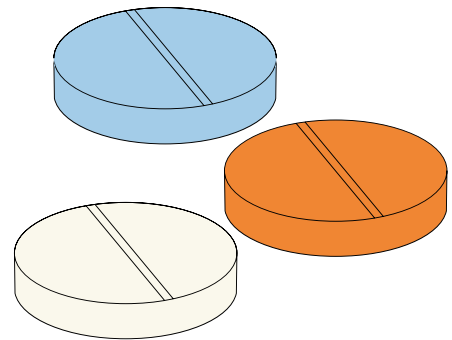
Efficacy and safety of oral semaglutide 14 mg (flexible dose) in early-stage symptomatic Alzheimer's disease (evoke and evoke+): two phase 3, randomised, placebo-controlled trials

[https://doi.org/10.1016/S0140-6736\(26\)00459-9](https://doi.org/10.1016/S0140-6736(26)00459-9)

Research demonstrates that treatment within the initial stages of Alzheimer's disease could have beneficial clinical, social and financial implications for patients and their families. Furthermore, Semaglutide, which is GLP-1 receptor agonist used in type 2 Diabetes Mellitus, can modulate neuroinflammation, vascular dysfunction and metabolic changes implicated in the pathogenesis of Alzheimer's dementia (AD), according to the literature.

The Evoke and Evoke + trials aimed to test the safety and efficacy of oral semaglutide in the target population group. This entailed conducting 2 multicentre, randomised, double-blind, placebo- controlled phase 3 trials across 566 sites in 40 countries. 3808 participants between the ages of 55 and 85 with amyloid-confirmed mild cognitive impairment or mild dementia due to AD, were enrolled. Evoke + incorporated 1953 participants with significant small vessel disease. Participants received either once daily semaglutide 14mg (flexible dose) or placebo for up to 156 weeks.

Ultimately, the primary endpoint was not met in either trial which led to their discontinuation. Change in Clinical Dementia Rating–Sum of Boxes score (CDR- SB) from baseline to week 104 did not significantly differ between semaglutide and placebo in both trials.



In Evoke and Evoke+, mean changes in CDR-SB score from baseline to week 104 were 2.3 (SE 0.1) and 2.2 (0.1) with semaglutide respectively, compared with 2.3 (0.1) and 2.1 (0.1) with placebo. Furthermore, no benefit was seen on secondary clinical measures, including ADAS-Cog-13, MoCA, ADCOMS, MMSE and composite Z score, or time to progression to more severe disease stages.

Although a CSF sub-study identified that semaglutide significantly reduced AD biomarkers, including p- tau 181, p- tau 217 and neuroinflammation by 10% when compared to placebo, it did not translate into clinical benefit.

Overall, oral semaglutide 14 mg did not slow cognitive or functional decline in early Alzheimer's disease over 104 weeks, despite reducing peripheral inflammatory and CSF biomarkers of AD pathology.

Low-Dose Lithium for Mild Cognitive Impairment - A Pilot Randomized Clinical Trial

doi:10.1001/jamaneurol.2026.0072

This study is based on the hypothesis that lithium deficiency may underlie neurodegeneration in Alzheimer's dementia and is a modifiable risk factor.

The single-centre, double-blind, randomized, placebo-controlled pilot trial included adults aged 60 years and older with a diagnosis of MCI with absence of major psychiatric or neurological illness and no contraindications to lithium. Participants underwent neuropsychological assessments, lithium blood level monitoring, MRI and a PET scan to measure brain amyloid. They were randomly assigned to either lithium or placebo for 2 years. A total of 83 patients were randomised. The mean age in the lithium group was 72.83 and in the placebo group in 71.22. Study medication was discontinued by 14 of 41 patients in the lithium group. 15 of 39 patients in the placebo group

The study did identify its limitations such as small pilot study with limited statistical power, many participants were amyloid-negative, potentially reducing the ability to detect treatment effects and finally, COVID-19 affected recruitment and follow-up processes.

The authors concluded that their study provides a foundation for larger, adequately powered studies to further evaluate its potential neuroprotective effects and confirmed the safety and tolerability of low dose lithium treatment in older adults with MCI.

The Primary outcomes included: Verbal memory (CVLT-II), Visual memory (BVM-T-R), Global cognition (PACC), Hippocampal volume, Cortical grey matter volume and Brain-derived neurotrophic factor (BDNF) levels

Verbal memory showed a promising signal:

Placebo group declined by 1.42 points/year and Lithium group declined by 0.73 points/year.

However, this was not statistically significant after adjustment for multiple comparisons. No significant differences were found for other outcomes.

MEDICAL EDUCATION

THE IMPORTANCE OF MEDICAL EDUCATION INVOLVEMENT FOR OLDER ADULT PSYCHIATRISTS

Dr Dansheela Makan

Trainee Editor & ST6 in Older Adult Psychiatry & Fellow in Medical Education, Oxford Health NHS Trust.

We are pleased to introduce a new Medical Education section to the Newsletter. This section aims to provide a platform for our readers to share their reflections, projects and research associated with Medical Education in Old Age Psychiatry. I have chosen to contribute a personal reflection on an experience which shaped my career.

A personal reflection

It was my first day in a new placement as a core psychiatry trainee. Predictably, my morning began with the familiar struggle of finding a space in the staff parking lot, followed by a frantic dash to arrive on time to meet my new supervisor while trying to navigate an unfamiliar outpatients' department. *My mind was racing. This is a fiasco. Late for my first day. Terrible first impression.*

When I finally met my supervisor, my anxiety quickly dissolved. He was friendly and down-to-earth, yet also firm and clear about his expectations of me in the role from the outset. He inquired about my previous experience, my interests and what I had hoped to gain from the placement. I found his encouraging, yet constructively challenging approach motivating.

I was met with genuine curiosity about my experience, interests and aspirations. He introduced the concept of tailoring teaching to my zone of proximal development (Figure 1). Right then and there, I realised this is the kind of supervisor I aspire to be.

Ultimately, my supervisor was interested in teaching me as an individual. It was his approach which inspired me to learn more about educational theory, leading to my decision to pursue a fellowship in Medical Education and Postgraduate Certificate (PGCert) in Healthcare Education.

Unfortunately, I had a contrasting experience during my undergraduate training. When I started medical school in South Africa, I vividly remember standing in the corner of a tutorial room while a stern professor pointed a large stick towards me and demanded that I enlighten the class on tumours of the paediatric cerebellum. Overwhelmed by anxiety, I stumbled through an answer, desperately hoping the moment would end. My anxiety and self-consciousness had hindered my ability to process and embed the key learning points.

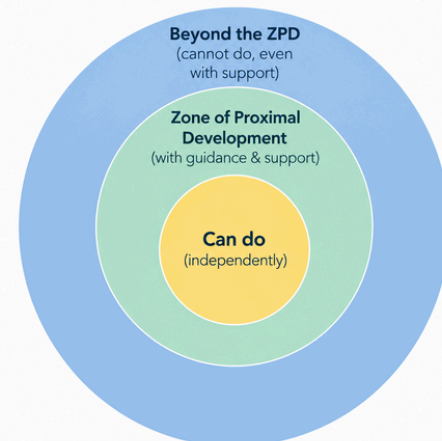


Figure 1 Zone of Proximal Development

Developed by the Soviet psychologist, Lev Vygotsky in the late 1920s, the zone of proximal development describes the gap between what a learner can achieve independently and what they can accomplish with the guidance of a more experienced individual. (1)

It is encouraging to observe that medical education has evolved since then with more emphasis on psychological safety being fundamental to effective learning.

Why Medical Education training is important to Old Age Psychiatry?

In Psychiatry, some of our most valuable insights are learnt through experience, teaching, and reflection. That is why I have chosen to share my view on how Old Age Psychiatrists can benefit from involvement in medical education.

Research shows that disparities in the quality and availability of teaching persist across higher training programmes in various localities². Greater investment in medical education within Old Age Psychiatry could support the development of more robust curricula to help meet training needs. Furthermore, shortages of supervisors continue to limit higher training posts within Old Age Psychiatry². Therefore, greater emphasis on the training and development of supervisors may help address these gaps and strengthen the training infrastructure.

There are many different forms of teaching approaches designed to address various learning needs. Simulation may serve as a valuable experiential learning tool, particularly for practising nuanced communication skills and managing medical emergencies in a safe and supportive environment. Immersive virtual reality has the benefit of simulating the patient's perspective. Other approaches, such as small-group teaching, lectures, and case-based discussions may help embed core knowledge.

Tailored medical education innovations can enhance the teaching of challenging and complex areas of Old Age Psychiatry. These areas include discussions around capacity, safeguarding, dementia diagnosis, end of life care, psychological manifestations of ageing, functional and organic mental illness, bereavement, social isolation, and multidisciplinary and interdisciplinary team working.

Involvement in medical education can open the door to a range of leadership roles, e.g supervisors, college tutors, training programme directors.

Developing a career as a clinician educator

A clinician educator is a health professional who alongside clinical work is actively involved in education, applying pedagogical theories in practice. There are many opportunities throughout training to develop as a clinician-educator.³ There is no single prescribed route and individuals, typically, must develop their own pathway based on opportunities that arise or that can be engineered.

Developing a career as a clinician- educator involves proactively seeking opportunities to teach, supervise and mentor across a range of educational settings involving learners at varying levels. Structured educational training, such as a PGCert in medical education or a fellowship in Medical Education can help prepare health professionals for the role. Equally important is learning from experienced trainers who may serve as role models or mentors.



There are numerous benefits to pursuing initiatives or qualifications in Medical Education. Fundamentally, they equip trainees with an understanding of educational theories and practice, enabling them to become more influential and effective teachers.⁴ The knowledge gained extends beyond teaching, to include the foundations of leadership and reflective practice, both of which are essential competencies for trainers and supervisors, and for personal development.⁵

As I continue my journey in Medical Education, I aspire to be an excellent educator, like the supervisor who inspired me on my first day in placement. What remains with me is not the information within the textbooks or research papers he shared, but rather, the way he made me feel valued.

Great clinician educators do more than impart knowledge, they create learning environments in which learners feel supported and empowered to reach their full potential, deliver the best possible patient care, and embrace a lifelong commitment to learning.

Medical education in psychiatry continues to evolve. We welcome contributions from psychiatry trainees, consultants, and colleagues involved in education.

How has medical education shaped your career? Do you have personal reflections or experiences to share? Are you involved in an educational initiative or project that you would like to share with others? Please submit it to The Old Age Psychiatrist by emailing oldage@rcpsych.ac.uk

REVIEW SECTION

FILM REVIEW - RELIC (2020)

Dr Thomas Rose, ST5 Older Adult Psychiatry Registrar, Oxford Health NHS Trust



In dementia care, we often hear the sentiment that watching a loved one develop dementia is like watching the person you know disappear to be replaced by a stranger. *Relic* plays on this idea to deliver a slow-build of anxiety and dread with some genuinely affecting moments and more than a few scares. Released in 2020, it is one of the more recent entries in the growing sub-genre of “dementia horror” – films that explore (and exploit) the cultural fears associated with cognitive decline to frighten and entertain, but it brings little in the way of new perspectives or original things to say.

The directorial debut of Natalie Erika James, *Relic* follows a family of women from three generations – Kay (Emily Mortimer) and daughter Sam (Bella Heathcote) go to Kay’s mother’s home to search for her after she has been declared missing. We learn that Kay has not spoken to her mother for some time, and when Edna (Robyn Nevin) reappears three days later with no memory of her absence and begins behaving strangely, it becomes clear that there is more going on than Kay and Sam have bargained for. As Kay and Sam pick their way around Edna’s hoarded, crumbling house, it is made obvious that Edna is experiencing dementia: she is forgetful and confused at times, and paranoid and hallucinated at others. Despite this, the word dementia is conspicuously never used in the film, with characters instead alluding to “memory problems”.

Perhaps a deliberate choice, this withholds from us the easy way out of a clinical label, and instead we stay with the experience of Edna’s family, watching as she becomes increasingly unfamiliar and unpredictable.



The choice to set the film almost entirely within Edna’s giant dilapidated house, with very few additional characters further emphasises this tight focus. We, like the family, are trapped.

The performances of the three leads carry the emotional weight of the film. Nevin portrays Edna as a woman in reluctant transformation, her performance going from disturbing in one moment to heartbreaking in the next. Opposite her, Mortimer’s delivery of a daughter grieving her mother in real-time while navigating guilt and shame is frequently affecting.

The film builds a gradual sense of dread, as events in the house become increasingly difficult to put down to dementia, though it could get to its point a little faster. I was surprised at how long it took before events became undeniably supernatural, even as the horror continues to grow. Edna is paranoid and disinhibited; she hallucinates and misidentifies family members – these create genuinely disturbing experiences for her loved ones without relying on ghosts and monsters.

Throughout the film, Edna is firmly positioned as the “other”. She is the source of danger to our protagonists, and her internal world is largely left a mystery to viewers. There are several moments in the film where Edna’s demeanour seems to change suddenly, from warm to distant, and we get a tight shot of Edna’s face, forced to guess what is going on behind her eyes.

Relic presents the person with dementia as a dangerous mystery – a stranger wearing the skin of our loved one. The film relies on this mystery to carry the tension, but this also serves to dehumanise Edna, and Relic spends little time asking what it must be like for her to be at the epicentre of her decline. The few moments it does linger in her shoes are some of the most devastating. This stands out in contrast with *The Father* (2020). Released the same year as Relic, it explores similar themes of cognitive decline, care, and family dynamics through the eyes of an individual with dementia with great effect. I wonder, if Relic had spent some more time in Edna’s shoes, whether the horror may have been more impactful.

Relic avoids giving audiences a literal explanation of the supernatural events. Instead, we are left to draw our own conclusions about the film’s intended analogy. Much of the movie is a believable narrative of the impact of dementia on loved ones, exaggerated with horror tropes. The film’s climax brings the predictable supernatural threat and body horror that is ubiquitous in modern horror, which serves at least to resolve the drawn-out tension with some scares.

“Dementia horror” films can and should be criticised when their portrayal of people with dementia becomes exploitative, though Relic feels somewhat more compassionate than some other examples like *The Visit* (2015) from M. Night Shyamalan. Like other entries, Relic does continue to neglect the firsthand experience of dementia, which could offer a more balanced story and maybe even better scares.

Relic offers an enjoyable slow-burn of tension and dread focussed on dementia and care, with a suitably scary climax and thoughtful conclusion. Strong performances and eerie production choices go some way to overcome concerns about how the film characterises individuals with dementia, but it will be interesting to see how future instalments to the “dementia horror” sub-genre can engage with the subject matter in more thoughtful and creative ways.

What’s on your reading list this Autumn? If you’d like to write a book, film or other cultural review for The Old Psychiatrist then please email us: oldage@rcpsych.ac.uk

REVIEW SECTION

BOOK REVIEW - A TATTOO ON MY BRAIN: A NEUROLOGIST'S PERSONAL BATTLE AGAINST ALZHEIMER'S DISEASE BY DANIEL GIBBS (2021)

Sanoj Jacob, Specialty Doctor, Bradford District Care NHS Foundation Trust, **Keerthi Raj**, Specialty Doctor, Leeds and York Partnership NHS Foundation Trust

Before the Illness Becomes Visible

During my induction into old age psychiatry, I learned that the pathological changes associated with Alzheimer's disease may begin as early as 20 years before dementia becomes clinically apparent. That idea stayed with me: what does it mean to live knowing that a neurodegenerative illness may already have begun while one still appears relatively well?

It was in this context that I came across *A Tattoo on My Brain: A Neurologist's Personal Battle against Alzheimer's Disease*, by Daniel Gibbs with Teresa H. Barker. Gibbs combines scientific understanding of a neurologist with the uncertainty and fear of a patient suffering from a progressive neurodegenerative disease. The book prompted us to reflect on diagnosis, early detection, treatment and the burden of knowing what may lie ahead.

The Neurologist Who Became the Patient

Gibbs's journey begins with a deterioration in his sense of smell. Parkinson's disease is considered, but investigations do not support it. A more significant discovery follows when genetic testing undertaken for ancestry reveals that he carries two copies of the APOE ε4 allele. With a family history of Alzheimer's disease affecting both his father and grandfather, he immediately understands what the genetic test result means for him.

At first, formal cognitive testing remains normal. Yet names become harder to recall, mistakes appear in complex tasks, and he relies increasingly on written records and routines. An avid teacher, he eventually has to stop teaching, even as repeated cognitive tests continue to show relatively reassuring scores. Later investigations demonstrate amyloid pathology. He adopts lifestyle measures, records his experiences and receives aducanumab, an anti-amyloid treatment, which is complicated by cerebral bleed and an acute confusional state.

The book's greatest strength is Gibbs's dual perspective. He explains the science while conveying the emotional consequences of becoming the subject of a disease he had previously encountered professionally. Although some scientific detail may feel dense, it adds authenticity and reflects the uncertainty surrounding early diagnosis and emerging treatments.

Is It Always Better to Know?

The book raises a difficult question: is diagnosis always beneficial when a disease can be detected but cannot yet be reliably prevented or cured?

Diagnosis may validate symptoms, provide an explanation and allow patients and families to plan. It may support decisions about employment, finances, driving and future care

while the person retains capacity. It may also provide access to research, risk-reduction advice and, for selected patients, newer treatments.

However, diagnosis can also cause harm. Once Gibbs knows his genetic risk and later learns that amyloid is present, ordinary lapses acquire a different meaning. A forgotten name may feel like evidence of progression, and the person may begin to monitor every hesitation and mistake.

Diagnosis may also alter how others respond. Families may become overprotective, professional competence may be questioned, and the individual may begin grieving losses that have not yet occurred.

The question is therefore not only whether we can diagnose early, but whether the person wishes to know, what meaningful choices the information creates and what support is available afterwards. Diagnosis should not be delivered as an isolated fact; it requires informed consent, careful communication and ongoing psychological support.

What Can We Detect- and What Can We Deliver?

Gibbs's experience highlights the gap between scientific possibility and routine clinical practice. His cognitive assessments remained normal despite changes affecting his daily and professional functioning. Evidence of Alzheimer's pathology became clearer only through specialist investigations.

In ordinary memory clinics, access to amyloid imaging, cerebrospinal fluid biomarkers, genetic counselling and emerging blood-based biomarkers remains variable. Their use also requires trained clinicians, appropriate counselling and clear pathways for acting on the results.

"There is also a danger in relying too heavily on brief cognitive screening. A highly educated person may experience significant decline from their own baseline while continuing to score

within the normal range. It is thus imperative that an assessment must include the history of change, occupational functioning, complex daily activities and collateral information.

Early detection is valuable only when services can respond. Identifying disease earlier without counselling, treatment pathways or follow-up may leave patients with knowledge, but little help in living with it.

Donepezil, Memantine- and Then What?

For many years, treatment for Alzheimer's disease changed little. Donepezil became available in the 1990s, followed by Memantine in the early 2000s. These medications may offer symptomatic benefit, but they do not stop the underlying neurodegenerative process.

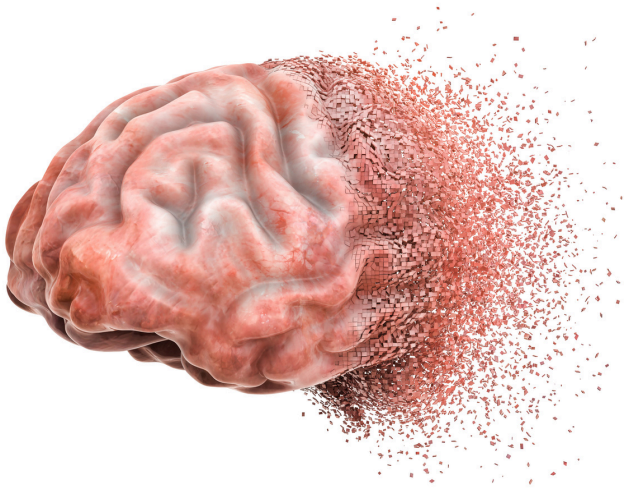
Clinicians have therefore continued to rely on medication alongside practical support, management of psychiatric and behavioural symptoms, attention to physical health and guidance for families. These interventions remain essential, but they do not alter the course of the illness.

If Alzheimer's pathology begins years before diagnosis, treatment at the stage of established impairment may already be too late to reverse substantial neuronal damage. Yet earlier treatment depends on earlier detection, which is neither universally available nor psychologically neutral.

From Biomarker Change to Patient Benefit

Gibbs's treatment with aducanumab was complicated by its side effects. His experience highlights a central difficulty with current anti-amyloid therapies: a drug may demonstrate biological activity while also causing significant harm.

For the patient, amyloid clearance alone is not enough. The meaningful question is whether treatment preserves cognition, independence



and quality of life, and whether any benefit justifies the risks and burden of treatment.

A change on a scan may show that a drug has reached its intended target, but it does not automatically mean that the patient is functioning better. As psychiatrists, our current focus must remain on the person rather than the biomarker.

Living While Waiting for the Inevitable

Perhaps the most enduring image from the book is of Gibbs learning in his fifties that he carries a substantial risk of developing Alzheimer's disease, and then having to live with that knowledge over the years that follow.

He responds - by exercising, modifying his diet, remaining cognitively active and carefully recording his experiences. These measures offer no certainty, but they allow him to retain a sense of agency and participation in his own future.

What is most striking is not simply that he waits, but how he waits. He does not withdraw from life or allow the possibility of decline to define him completely. Instead, he continues to work within the limits of what he can control, even as the future remains uncertain.

This is the long shadow of Alzheimer's disease: the illness begins to shape a person's thoughts, choices and sense of self before major impairment becomes visible. Early diagnosis may create opportunities for planning, but it may also bring years of grief long before independence is lost.

Gibbs's story therefore leaves us with an important responsibility. If we offer people knowledge of a disease before we can offer a cure, we must also help them live with that knowledge.

The book closes, for us, with the image of a man who knows what may lie ahead yet continues to move, plan and hope. His waiting is not passive surrender. It is an effort to remain fully present in a life that still holds meaning, even while the possibility of Alzheimer's lingers around him like a shadow.

CREATIVE CORNER

UNTITLED

Approaching the final quarter
the clock hands tire
and I take yours (older and lined)
wizened by the kaleidoscope of your life,
now greyscale

The push and pull of the tide now too great
Me, once your anchor, overwhelmed, wrenched
Lost at sea, you don't recognise me
Two ships passing in the foggy twilight
Faint echoes of laughter, singing, drowned out by
the building waves

Sold precious metal
But the golden years turned to rust
Minds mine collapsing, tangled
Slow, painless, but so f__king painful

So we sit, now perfect strangers
Baited breath for those flickers of recall
These coveted moments, I miss you...
and the clock hands tire
and I take yours (older and lined)

T C D Lewis

Dr Thomas C.D. Lewis

MRCPsych, MBBS, BEng (Hons), ACGI
Consultant Psychiatrist for the Newcastle upon Tyne Older
People's Community Treatment Team and Governor for Medical
Staff at CNTW (Cumbria, Northumbria, Tyne and Wear) NHS
Foundation Trust

The Creative Corner is a space where passion, psychiatry, and art come alive together. If you'd like to see your creative writing or art in print, then please submit it to *The Old Age Psychiatrist* by emailing oldage@rcpsych.ac.uk

TRAINEE FOCUS

MEET YOUR NEW OLD AGE FACULTY TRAINEE REPS!

Dr Ruzaika Jaufer

ST6 Specialty Registrar in Old Age Psychiatry, Norfolk and Norwich University Hospital

I am Dr Ruzaika Jaufer, though everyone calls me Ruzi, and I'm delighted to be taking on the role of Trainee Representative to the RCPsych Faculty of Old Age Psychiatry. I'm an ST6 trainee working in Liaison Psychiatry at Norfolk and Suffolk NHS Foundation Trust, while also undertaking an MSc in Medical Education.

I'm passionate about older people's mental health, particularly strengthening the links between physical and mental healthcare and championing truly holistic care. I'm also a keen educator and enjoy teaching. In this role, I hope to represent the voices, experiences and priorities of Old Age Psychiatry trainees, advocate for the issues that matter to us, and help foster a supportive and connected trainee community.

When I'm not working, you'll usually find me pottering in the garden or spending time with my two little girls—who do an excellent job of keeping me on my toes!

Please get in touch with ideas, issues you would like raised with the Faculty, or initiatives you would like to see developed. We look forward to working with you and building an active, connected and supportive Old Age Psychiatry trainee community.



Dr Connor Pinkney

ST5 Higher Specialty Trainee in Old Age Psychiatry, Somerset NHS Foundation Trust

I am Dr Connor Pinkney, an ST5 Old Age Psychiatry trainee working in Taunton, Somerset. I am passionate about older people's mental health, particularly dementia, frailty, and neighbourhood-based working.

My interest in the Higher Trainee Representative role stems from a desire to foster greater collaboration between old age psychiatry trainees. I believe this is a very exciting time to be working in old age psychiatry, and that sharing innovations and best practice between trainees is imperative for the future of our specialty.

When I am not at work, I spend most of my time with my family. My two young children certainly keep me busy, so I often joke that I go to work for a rest!

Best wishes,

Ruzi and Connor

Old Age Higher Trainee Representatives

Contact us via: oldage@rcpsych.ac.uk

CPD UPDATE

In this section, we offer some ideas about upcoming conferences and courses related to Old Age Psychiatry. The list is directed towards trainees, but of course these courses may be of interest across all career stages.

Please send any course recommendations and reviews you would like to be included to oldage@rcpsych.ac.uk

29 October 2026 , 09:30-16:00

RCPsych Wales Faculty of Old Age Psychiatry Conference

Wrexham Medical Institute, Wrexham, Wales, LL13 7YX

[More information here](#)

11 December 2026, 09:00- 17:00

Connected care: old age liaison psychiatry across the system

Online Event

[More information here](#)

1 day Online event ; 20th November 2026

2 day Online/In person event ; 3-4 December 2026

Cambridge Dementia Course

[More information here](#)

ICD-11 Requirements for Mental, Behavioural, and Neurodevelopmental Disorders

Free online course

[More information here](#)

DART-CU: Decision-Support for Alzheimer's Blood Biomarker Result Tool for Clinical Use

Free online course

[More information here](#)



CPD UPDATE



International Certificate *in Dementia*



Bookings are now open for the new International Certificate in Dementia, our online programme designed to support healthcare professionals in developing their knowledge and confidence in the assessment, diagnosis and management of dementia.

The programme adapts content from our International Diploma in Older Adults' Mental Health, providing a shorter, focused learning opportunity covering the full dementia pathway, from risk factors and diagnosis through to complex care, ethical considerations and end-of-life care.

Further information and booking
available here!

CPD UPDATE



Advancing Mental Health Equity (AMHE) Learning Community: Launch event

Be part of a growing community working to advance mental health equity

[Sign up here](#)

 Date: 7 October	 Time: 10am-12pm	 Location: Online via Teams
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At the launch event you will...



- ✓ Connect with others interested in mental health equity
- ✓ Hear examples of work and learning from across the country
- ✓ Help shape future topics

What is mental health equity?

Mental health equity is about understanding these differences, listening to people's experiences, and making sure that people and communities who face the greatest barriers receive the support they need.

Find out more on our [website](#).

For more information, email:
amhe@rcpsych.ac.uk

Who is the learning community for?

Join a free online community working to improve mental health equity across the UK.

- People with lived experience (patients and carers)
- Community and voluntary organisations
- Clinicians and frontline staff
- Quality improvement and involvement teams
- Local authority
- Equality, diversity and inclusion (EDI) and [PCREF](#) leads
- Leaders and decision-makers

Free online events will take place every 2 months.



The learning community will be facilitated by the **National Collaborating Centre for Mental Health** ([NCCMH](#)) and is free to join.

[Sign up here](#) to join the AMHE Learning Community

NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

