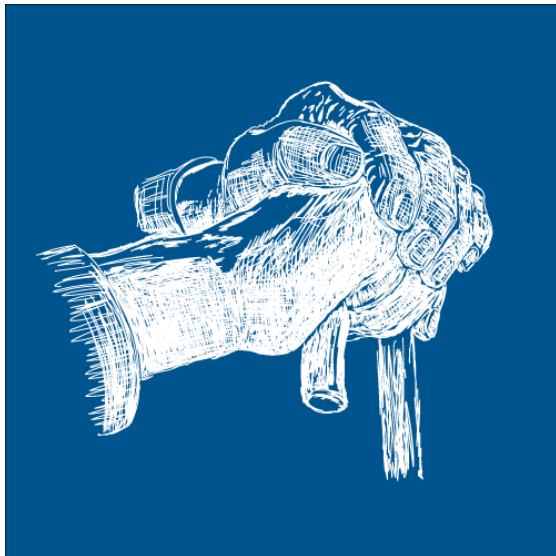




The Old Age Psychiatrist

Issue 74, May 2019

Old Age Psychiatry faculty
newsletter



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Update from the Editorial Team

by

Helen McCormack

Editor, Old Age Psychiatrists, Royal College of Psychiatrists

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As always, we have a packed and varied newsletter this time. It is a very busy and eventful time in our services and in our country, and our Conference in March, 'Meeting Challenges, Creating Opportunities, Shaping a Better Tomorrow', was very aptly named.

Even in these uncertain times, there is much to celebrate, and we have the winning essays in our Newsletter Essay competition, alongside the winner of the Old Age Faculty Medical Student Essay competition. They are all excellent essays, and we hope will leave you reflecting on our practice and our future in a positive and creative way.

Our conference this year was lively and well attended as always, and, to give you an insight we are featuring reflections on the Trainee's day, and the perspective of a colleague from India. If you didn't manage to get there I am sure you will find this gives you a flavour of the energy and commitment of our members.

On a European note, we have a very interesting article about the Swedish Association for Old Age Psychiatry, and an article about the European Association of Geriatric Psychiatry. I hope both of these will inspire you to feel optimistic for our future relationships with Europe.

There are important updates on the Mental Capacity Act, Integration, Research and Cochrane, and, two articles on Mental Health for people serving a sentence both in and out of prison. Add to that reflections on the General Adult Faculty Conference, and I think we have something for everyone!

Let us know what you think of the newsletter, and, as always, we love to receive articles to consider for future newsletters.

The faculty supports its members in many ways and these include offering prizes and bursaries. It's well worth taking a look as there may be an opportunity for you. [Find out more here.](#)

View from the Chair

by

Dr Amanda Thompsell

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

Taking back control

Any one reading a newspaper or listening to the news will understand the important changes that are happening in our national life. This is truly a time of change. A time for national debate. A time of risks and opportunity.

Writing within these pages I am, of course, not referring to Brexit. I am referring to the enormous opportunities arising from the NHS's long-term plan for England, which has been released in the period since my last "View from the Chair".



The long-term plan focusses particularly on provision of integrated personalised and multi-disciplinary community care. It advocates a "triple integration", breaking down the barriers between primary and secondary care, physical and mental health, and health and social care and on improving access to timely crisis response – all sensible ideas that we need to make work. Thankfully this has not expanded into a quadruple integration: there is no suggestion that ageless services should be promoted or expanded and we have finally managed to get older adults specifically mentioned as a group requiring special provision.

As old age psychiatrists we are right at the centre of triple integration. We feature not only in the adult mental health workstream (Chapter 3) but also in the integrated care for older people workstream (iCOPE) (Chapter 1) with its focus on ageing well, urgent community response and improving support to care homes. There are clear synergies between the commitments set out in the iCOPE and Adult Mental Health chapters, and we will need to work across and align both workstreams.

We have a central position in integration. We work across care settings and have skills of looking at mental health in the context of both physical health and social care issues. This provides a great opportunity for old age psychiatrists to shape how older people's mental health services should look as primary care networks are developed, in the context of increasing prioritisation and awareness of frailty, the ageing population and the rising prevalence of long-term conditions.

Delivering services in the same way as we do now will not work. There is a promise of money to be allocated for these transformations, but to make sure this money is spent wisely we need to be ready to articulate how we can deliver services to meet the growing needs.

There are already models where the old age mental health teams are integrated with physical health and primary care and several such inspiring teams presented at our Faculty meeting. We are particularly fortunate in having an old age psychiatrist, Ben Underwood, leading an integrated community and mental and physical health services for both older people and people with long term conditions in Cambridgeshire. So we have proof that integration of these services can work at scale. ([Read more about the service here](#))

What Ben has also demonstrated is that as old age psychiatrists we have the leadership ability and skill to seize the initiative and redefine our role.

Seeing the importance of seizing the opportunity to make our skills clear to everyone your Faculty has been working on a Vision Document that will demonstrate this. I want to particularly thank Mohan Bhat who has led on this. I believe it is a really vital document and it is needed to help articulate how we fit in to the long-term plans.

The development of the law relating to mental health is another area where we have needed to lead as these issues affect our patients on a daily basis. Since the last update, The Mental Health Act Review has been published. There are over 150 recommendations but only two have so far been accepted, so this is still a work in progress. We have also been extremely busy in responding to proposals relating to Mental Capacity Amendment Bill (MCAB) and I am pleased to report that we are going to have a representative as part of the DHSC workstream writing the code of practice. In addition, we have also commented on the Ministry of Justice's suggested updating of the Mental Capacity Act code of practice and on the GMC update of their guidance on decision making and informed consent; I owe a particular debt of gratitude to Dr Hugh Series and Dr Sharmi Bhattacharyya who has worked amazingly hard to ensure we gave clinically and legally robust responses.

NHSI will be publishing information in the next few months on the workforce needed to meet this strategy and this is another area where we can show and have been showing leadership. The focus on frailty bears out the reasoning behind our Faculty's strategy of raising the profile of mental health in long term conditions and frailty and of developing a Faculty position statement on frailty. There is still a need for us to collect good examples to put into our position paper, so if you have any please let Kitti know so that we can ensure that we get the best examples described in a consistent way. I see the need for us to develop this as a matter of urgency.

These are interesting times. Whilst the Chinese may regard it as a curse to be born in such times, we in your Faculty Executive see this as a time of opportunity and a chance for our discipline, so often the Cinderella service, to take back control.

Meanwhile we continue to make progress in pursuing our published Strategic Aims and here is a roundup of some of the things that have been happening in relation to each of them.

Aim 1: To enhance National and International Profile Faculty of Old Age Psychiatry matters relating to Mental Health of Older people of all ethnicity

I am grateful to all members of the Executive for helping to ensure that our presence is felt in a wider range of discussions than we have been previously. These have included discussions with The Mental Health Hub of The Neurological Alliance; the British Geriatric Society (also in relation to developing end of life care guidance); Public Health England (where we are providing input into the mental health data set for older people); Royal College of GPs, Mental Health Foundation; NHSE; Royal Pharmaceutical Society; the Campaign to End Loneliness research; and NCCMH's community mental health care workstream. We continue to attend NHS England's Older People's Expert Mental Health Forum and The Adult Mental Health Steering Group, and Sujoy has continued working with the European Association of Geriatric Psychiatrists and some of our Faculty members will be speaking at its Conference in Nottingham on 3rd -4th October 2019.

Alzheimer's Research UK have been in contact with us about ascertaining the views of members on early dementia diagnosis and what it could mean for services. We will be sending out a survey to members to learn their views later on this year.

We have continued working with HEE on the core competencies in older people's mental health for health and social care staff and I am grateful to Sharon Nightingale for all her hard work on ensuring the expertise of our Faculty is influential.

We had a round table follow up discussion of our joint BGS and Faculty's Depression in care homes report. This roundtable was timely in light of the focus in the long-term plan on supporting care homes and the many organisations who were there including the devolved nations and NHSE seemed keen to take the recommendations forward.

The [guidelines on perioperative care for people with dementia](#) by the Association of Anaesthetists of Great Britain and Ireland with input from our Faculty have been published and are on our Faculty website.

Aim 2: To attract and successfully retain within old age psychiatry the best doctors for every level of their profession

Recruitment into old age psychiatry based on the results from the trainee survey produced by Alex Bailey and the trainees [has been published](#), and is worth quoting as it has helpful evidence for us.

We were delighted to have had a joint Faculty conference with the trainees and their passion and love of our discipline means we can be assured that old age psychiatry is in safe hands

By the time this is published we hope to have released a video about old age psychiatry as a career for First Years and Core Trainees as well as our Medical student leaflet which will include a link to the video.

As you will see in the long-term plan there is a mention of credentialing and we are looking at this, as if this is something that is going to happen we would like to be on the front foot and take a lead in this.

Aim 3: Membership engagement

The very exciting and diverse programme that Dr Krishnan produced for the Faculty conference shows just how interesting our speciality is and I hope that members enjoyed it as much as I did.

We are continuing to focus on ensuring that we give members the information they want. We are continuing to analyse the qualitative data of the Annual Members Survey. The [Physical Health document](#) has been published as has the [Transitions between services best practice document](#) along with the [Liaison Faculty's Report on All Age Liaison services](#), which stresses the importance of our input.

Kapila Sachdev and colleagues have been working on a report about Integration and ICS's based on the experience that members have had, and this I hope will be helpful to members when it is completed.

The website is regularly being reviewed by Dr Longe and he has some helpful ideas on how to improve it which he is taking forward.

Dr Sudip Sikdar continues to make sure our voice is heard in relation to outcome measures.

The issue of Section 49s was raised by the opposition in Parliament and I regularly get correspondence about this. The College is about to do a survey where they will be asking about Section 49s.

Aim 4. To increase awareness of mental health conditions of older people of all ethnicities

At our vibrant Faculty Conference we joined the World Delirium Say Campaign on 13 March with excellent social media activity promoting delirium awareness. The Twitter handle #WDAD2019 reached over 20 million Impressions. Prominent among the campaigners was our very own Dr Mani Krishnan who reached 977,000 impressions and was one of the top 10 influencers on that day globally.

The Faculty's report [Suffering in Silence](#) was launched and I hope you have all seen it. This garnered interest in the Media and on Radio 4 and has been timely ahead of an All Party Parliamentary Group for ageing and older people meeting on 24th April focussing on inequality in older people's mental health where we are to be represented. It is proving an extremely useful resource to refer to in response to such matters as when the Government's task force report on women and mental health failed to mention older women and in the context of the NHS's long-term plan's focus on addressing health inequalities.

Alex Bailey was quoted in The Guardian on the topic of challenging stereotypes in relation to older adults. Tony Rao continues to raise the issue of the impact of alcohol on older people in several interviews and articles. There was a report in the BMJ about Acute care assessments for older people with frailty, and thanks to the speedy support given to me by other colleagues we were able to get a rapid response letter in and mention the importance of older people's mental health when considering frailty

We have started developing a paper on "Psychiatry and Neurology: time for a change" with our neurology colleagues stressing the potential benefit within particular disease areas of a combined approach to service provision.

We have inputted into The Aging Profile Tool Development of PHE and we have developed a hashtag to increase our Social Media Profile.

We have continued to promote [our wonderful MindEd resource](#).

I have been working with Independent Age in raising the issue of older people's mental health.

Conclusion

Once again it has been a busy few months and I want to thank all my colleagues who have worked so hard to ensure we have been able to respond to the numerous issues that have emerged during the period as well as their unstinting hard work in pursuing our strategic aims.

This is such an exciting time where the leadership and passion of members can be recognised.

I am looking forward to celebrating good practice in the National award for older people's mental health services and if you have any innovative service examples in relation to frailty and/or integration that you would like to share with colleagues, please let us know about them by contacting Kitti.

We have the experience knowledge and skills to deal with the complex issues that arise and it is our time to come out of the shadows and take centre stage.

The faculty supports its members in many ways and these include offering prizes and bursaries. It's well worth taking a look as there may be an opportunity for you. [Find out more here.](#)

Update from the National Clinical Director for Older Peoples Mental Health

by

Alistair Burns

Professor of Old Age Psychiatry, University of Manchester

National Clinical Director for Dementia and Older People's Mental Health,
NHS England and NHS Improvement

The big news since the last newsletter is the publication of the NHS Long Term Plan (LTP). Everybody involved in our practice should read the LTP which contains a lot of useful information and gives a clear steer of the way forward for the NHS. If you feel you cannot face the 136 pages, then reading the excellent summary will stand you in very good stead. What profile does dementia and older people's mental health (OPMH) have in this most important of documents?

They figure significantly in a number of aspects of the plan. There is an exciting articulation of a new service model largely based around frailty and dementia. A significant commitment to increasing investment in primary medical and community health services will see growth occurring at a faster rate than in other areas of the health service. The model around older people was termed 'Integrated Care for Older People' (iCOPE – the names may mature over time) and revolve around three particular areas. First is the response of people to mental and physical ill health in the community. There will be flexible teams working across primary care and local hospitals who will meet local needs and consist of a wide variety of professionals including GPs, allied health professionals, district nurses, mental health nurses, therapists and re-enablement teams as well as pharmacists, community geriatricians and dementia workers.

The basis of these themes will be around primary care networks of which there will be 40 or so across the country (England) bringing together groups of practices. Dementia gets several mentions, both in terms of the neighbourhood teams which will specifically include these individuals but recognising that advice needs to be targeted at people suffering from frailty and other conditions such as musculoskeletal, cardiovascular and dementia.

Second, there is an ageing well element and this is where some of the work looking at prevention (which is additionally mentioned in the prevention chapter) sits. Third, there is also a significant strand of work on care homes and the NHS

will upgrade support to all care home residents, as we know, a quarter of people in care homes have dementia).

There is specific mention of carers and the recognition of the need to support carers and a specific section on dementia and delirium – the summary of the LTP emphasises that the improvements seen in dementia care will continue. There is explicit support to extend the Dementia Connect programme of the Alzheimer's Society as a model for dementia for post diagnostic support.

In the personalised care section, there are initiatives to roll out the personalised care model for conditions such as diabetes prevention but also making the case for online therapies for common mental health problems. As part of this, social prescribing (which was trialled a few weeks ago) will also be available and there is a specific commitment to accelerate the roll out of personal health budgets. Bearing in mind that the commonest cause of death in England is now dementia, the section on end of life care and proactive care planning for people identified as being in the last year of their life will be important.

In terms of older people's mental health, there is general support and agreement for the importance of older people and in the mental health chapter, when there is a mention of adults it always has "and older adults" afterwards. So, the commitment to expand IAPT services and explicit focus on people with long term conditions (many of whom but not all will be older) is welcome as well as a four-week waiting time to be tested for community and mental health teams involving older adults. In terms of mental health crisis, the importance of acute hospitals having access to an 'all-age' mental health liaison service specifically supporting the needs of older people is stated explicitly.

There is a specific note of the issue of credentialing whereby the skills involved in geriatric medicine, old age psychiatry and end of life care could be brought together in one specialty - at the very least giving practitioners of all disciplines permission to practice across all these areas.

So, the LTP, as with many other documents describing NHS policy practise and future plans, is full of opportunity. For dementia in particular it has been said that it is like the word running through a stick of rock and it is hard to see how many of the areas highlighted in the Plan do not impact on our practice – whether it be dementia, delirium or depression in older people. It is incumbent on us to make sure that we make the most of the opportunities, use our local networks and get involved in the new initiatives to realise the best for our patients.

I look forward to working with you and if you have any ideas or thoughts as to how we might proceed, please let me know at alistair.burns@nhs.net



This newsletter's picture quiz is multi-layered. It is a photograph taken at the Dementias 2019 Conference in February 2019 of the two organisers - you can tell because of the height differential that that's me on the left of the picture. The three questions this time are:

- a) Why do I have such a bizarre expression on my face?
- b) Who has taken over from Tom Arie as the co-convener of the annual meeting?
- c) If you look carefully, you can see a shadowy figure in the background – why is that?

Answers

- a) I will leave it up to your imagination
- b) John O'Brien
- c) I didn't have the technology to download it so I took a photograph of it on my computer and that's me in the background.

Competition Winners

by

Rugiyya Saeed

Trainee Editor, ST5 Old Age Psychiatry, Cardiff

This year the newsletter's essay competition topic was '*What role will technology play in old age psychiatry in the future?*'. We saw an enthusiastic response from our faculty members and also a number of creative submissions from medical students.

We would like to introduce our panel of judges, who very kindly helped out with the competition despite their hectic schedules:



Dr Joanna Cannon

Joanna Cannon is the author of the Sunday Times bestselling novel *The Trouble with Goats and Sheep*, which has sold over 300,000 copies in the UK alone and is currently published in fifteen countries. The novel was longlisted for the Desmond Elliott Prize, shortlisted for The Bookseller Industry Awards 2017 and won the 2016 BAMB Reader Awards.

Joanna has been interviewed in The Guardian, The Observer, The Sunday Times, The Times and Good Housekeeping magazine, and her writing has appeared in the Sunday Telegraph and the Guardian, amongst others. She has appeared on BBC Breakfast, interviewed on BBC Radio 4 and BBC Radio 5, and is a regular at literary festivals across the country including Edinburgh and Cheltenham.

Joanna left school at fifteen with one O-level and worked her way through many different jobs – barmaid, kennel maid, pizza delivery expert – before returning to A-levels in her thirties and graduating from Leicester Medical School. Her work as a psychiatrist and interest in people on the fringes of society continue to inspire her writing, and Joanna currently volunteers for Arts for Health, within the Midlands Partnership NHS Trust, bringing an opportunity for staff and service users to engage with the creative arts. Joanna Cannon's second novel *Three Things About Elsie* was published by HarperCollins in January 2018. It was longlisted for the Women's Prize for Fiction and is a Richard & Judy Book Club choice.



Dr Rahim Safeer

Dr Rahim Safeer is a Consultant Psychiatrist in Adult Psychiatry. He has had an interest in technology in healthcare from undergraduate time and worked with various information technology projects over the years. He was a member of the Royal College of Psychiatrist Mental Health Informatics Special Interest Group.

From early 2010, he was involved in a number of Wales's national IT projects and local health board projects; served in NWIS (NHS Wales Informatics Service) Clinical Reference Group for WCCIS (Welsh Community Care Information System) procurement process as clinical lead and currently serves as Clinical lead for the implementation of Welsh Community Care Information System (WCCIS).

He is serving as the chair for Divisional Mental Health Information Development Group, MH divisional steering group and vice chair for Gwent Senior Psychiatrists Committee. He has completed a year-long leadership and management training run by ABCi, ABUHB training and development department. He is also a member of various committees and task and finish group for IT and service development for various divisions of the health board. He has successfully completed various IT pilot projects for the physical health side and a notable one is the Welsh Clinical Portal electronic test requesting.



Dr Radhika Oruganti

After attaining dual CCT in General adult Psychiatry and Old Age psychiatry, Dr Oruganti has been working as a Consultant Psychiatrist for Older People's Liaison Psychiatry team in Cardiff and Vale University Health Board (CAVUHB). She brings along her experience of working in Australia and England in implementing good practice in her current post. She is passionate about improving the quality of life of elderly people with mental health problems.

She sits on the 'cognitive impairment inpatient pathway' committee in the CAVUHB and has actively influenced the care and experience of cognitively impaired patients when they are admitted to the general wards. She has been working with Public Health Wales in various projects aimed at improving Dementia care in Cardiff and wider area. She and her Liaison team colleagues helped Public Health Wales in devising and implementing 'Read About me document' in the Cardiff and Vale University Health Board. She has a keen interest in using technology in improving patient care. She has obtained iPads for her team to engage patients using online resources as part of their non-pharmacological interventions. She and her team have been actively raising money for Dementia and related charities.

Winning Essay

An interview with Professor Aida Lux, longest-serving Chair of the Digital Psychiatry Committee

By Dr Sophie Gascoigne-Cohen

May 2050

Professor Aida Lux is a Consultant Old Age Psychiatrist and has been Chair of the Digital Psychiatry Committee at the Royal College of Psychiatrists since 2035. She trained in various locations in the UK and Australia, was awarded an MSc in Computer Science in 2025 and became a Fellow of the College in 2030. She is the owner of a one-year-old Schnauzer robodog (Schnauz-bot), the latest pet prototype for care home residents. We catch up with her at her office in Devon, where her latest gadgets and screens jostle with the stunning view of the beach. Professor Lux is swathed in iridescent clothing, which she explains is both flattering and deflects non-ionising radiation.

How does working as a psychiatrist of old age now compare to your first consultant post?

I started working as a consultant in 2018 and there has so much progress! The art of history-taking continues but, in those days, we typed it all up on desktop computers. If a psychiatry trainee didn't touch-type before they started training, they generally could by the time they were a consultant! Now, we're accustomed to simultaneous 4D capture of a review and having decisions made almost instantly about investigations, diagnosis and treatment. Patients bring in data about their sleep, weight, mood etc., on their wearable biosensors – the most popular one in my clinic is the 'smartring' - and they expect us to assimilate this straight into their care plans. The benefit is that we get tailored treatment recommendations that consider the presentation as well as physical health investigations, genetic profile, potential drug interactions and risk of adverse effects.

What changes have you seen in tests for mental health disorders?

Well I've helped to establish easier pathways for mental health teams to arrange investigations. We used to send patients to the local radiology department for scans, and there was often a long waiting list. We would then try to discuss results remotely with the radiologists. It's a completely different situation now, with imaging onsite and 4D calls to our colleagues. I can discuss the images with the radiologist while the patient is still in the scanner. We can't read people's minds, but we are certainly getting better at visualising and understanding their brains. I can't forget to mention that blood tests are much easier as well. We simply shine a specially-designed light over a large superficial vein and we get

an instant list of results – that includes levels of medications, alcohol and most street drugs.

You led a national taskforce to streamline clinical assessments and the DVLA process. Could you tell us how you used your digital knowledge?

In the early 2020s there were enormous waiting lists for driving assessments for people with dementia and other conditions. Driving is an overlearned process and difficult to objectively assess in clinics. I worked with the DVLA and the Minister for Transport to improve this process. We developed artificial intelligence that could analyse a person's psychiatric and medical reports and combine them with their historical licence data to then allocate them to a specific category. For example, one category was 'immediate driving assessment required'. Those drivers were offered a simulated driving test at the clinic hub within 72 hours. It's an excellent simulation (we borrowed concepts from the aviation industry) and surveys tell us the vast majority of patients find it fair. The process is run by DVLA so it remains independent. With driverless cars becoming safer and more reliable, I'm actually hopeful this system will become redundant in another 50 years!

How is your work-life balance?

Better than it was! I still work quite long hours, as do many of my colleagues, but I can focus more on patient care, especially now that we've got better software for recording clinic notes and communicating reports.

Worst job or career choice?

I think the worst job I had wasn't so much to do with the work but more to do with the noisy open-plan office. I think it's fair to say that hot-desking is a relic that we happily left behind in the 2020s.

What unheralded technological change has made the most difference to Old Age Psychiatry?

That's difficult! I think I'd choose the psychiatric virtual assistant. These smart little devices (they're only pea-sized) can analyse a patient's speech to then describe psychiatric signs. If we input more information into them, such as cognitive assessments or clinical history, they can diagnose almost all psychiatric conditions in the ICD-20. It is actually more accurate than we are at detecting the early stages of dementia and prodromal states. These devices can also help the patients with their daily activities. Once a diagnosis is confirmed, the device reformulates spoken language so that the patient can better understand it – it's a bit like a hearing aid that modifies sounds to best suit the brain of the person wearing it. They can also synchronise with digital calendars to remind the person about events, such as appointments, medications and meals on wings deliveries.

What personal ambitions do you still have?

I daydream about the digital support worker that can help manage various presentations of delirium. We're getting closer with bedroom sensors that detect confusion or increased agitation and then change the ambient lighting, background noise and temperature but we haven't cracked it!

What is your pet hate?

You can probably guess that I can't stand poor coding!

What piece of technology should every psychiatrist have?

It's hard to manage without an approved digital synthesiser of 'smartware'- the wearable biosensors that continuously capture the wearer's physiological state.

If you weren't in your present position, what would you be doing instead?

Surfing and teaching healthcare staff how to code.

What do you wish you knew as a junior doctor?

You will never learn enough about technology in your training programme so keep abreast of it yourself – that way huge developments won't take you by surprise!

Runner Up

Tomorrow's Doctors

By Maham Ahmed (4th year medical student)

"The doctor will come and see you now" my nurse tells me

Her metal wheels scrape the carpet as she strolls in

I feel my throat do that thing again

When it closes up

Closing my voice in its own body

My eyes are blinded by her light

Palms pooling with nervous puddles

She speaks to me again

In that same unshaken tone

Her words seem to pass through me

Like water through a sieve

Instead I wonder

I wonder how she has managed to keep it together all these years

How her spine has no hunch

How her skin is free from wrinkles

How her stainless steel has no age spots like me

How her wheels still manage in those heels

She really is so perfect

The nurses often call her wonder woman

Yet there's something missing

I'm still figuring it out

Perhaps it's how she pauses for a few infinite seconds before consoling me when I'm yearning for her comforting words

Or maybe it's that buzzing sound I hear when she's deep in thought searching through the algorithms in her mind

Or is it how she repeats 'I can see how that may be difficult for you' when her pixelated eyes are not a deep brown universe like mine

Or perhaps it's something to do with her sterile metal skin that makes my soul twitch every time she offers me a handshake

But most of all –

When I see her being plugged into that wall overnight, my hopes of being taken care of slip away

Spilling and shattering like the cup of tea I no longer can seem to grasp

I tremble,

Not because I don't believe I'm safe with her like the nurses tell me

I already know this

But because when I search in her flashing screen all I see

is my own reflection

Perhaps me and her, we're not that different after all

Even though her wires don't share the same blood as mine,

I wonder behind that tough exterior

Isn't she just as lonely as me?

How can we help people living with dementia and their carers to live dignified and meaningful lives?

by

Natasha Sofia Dembrey (mmzynsd@nottingham.ac.uk)

4th Year Medical Student, University of Nottingham

Dementia is one of the most common diseases associated with old age in the UK with a prevalence of 7.1% in the over 65s. (Alzheimer's Research UK, 2018). Arguably it is also the most feared and stigmatized. The prevalence is only expected to rise as a result of the ageing population. The need for Old Age Psychiatry is paramount in caring for people with dementia because without it, dementia falls into a grey area between Care of the Elderly and Psychiatry. On the one hand, comprehensive medical care is required due the complexities of medical conditions in older people but Psychiatric care is invaluable due to the complex behavioural and psychological symptoms related to dementia. Old Age Psychiatry ensures that the needs of people with dementia can be met in a more holistic and specialized way.

During my attachment in Old Age Psychiatry, I visited an older gentleman living with dementia (Peter) and his wife (Janet). Janet was Peter's main carer but she was suffering from her own medical problems including COPD and arthritis. Her physical limitations and chronic pain meant that it was more and more difficult for her to care for her husband. Janet had recently started to feel very frustrated with her husband's disruptive behaviours and with the responsibilities of caring. On one occasion, Peter woke up in the middle of the night thinking that it was morning and decided that he wanted to go for a walk. His wife tried to argue with him but then gave up and said "well go on then I don't care". Later she felt regretful and hopeless about how she had managed this situation. Janet had reached a point where she felt that the only option was for Peter to go to a home. This was heartbreaking because she had clearly done an excellent job of caring for her husband for the past two years, almost all by herself but, owing to her own health complications, had reached a breaking point. With additional support and adequate respite care, people like Janet and Peter could continue to live in a way that is beneficial for the both of them, without adding extra pressure to institutional care.

This clinical situation made me think about some key questions that need addressing to best care for people with dementia:

1. Medical school curriculums need to reflect the healthcare needs of dementia within society.

The GMC have recognized the need to improve the quality and quantity of teaching on dementia in medical school curriculums, which they have highlighted in *Tomorrow's doctors* (GMC, 2009). However, there is still a lot of work to be done for medical school curriculums to reflect the health needs of our current society. A recent survey to medical schools found that the amount of teaching on Old Age Psychiatry varies between 1 hour of formal teaching to 25 days of teaching (if teaching on certain aspects of Old Age Psychiatry such as dementia are also covered within other specialties) (Bennett, 2017). This represents only a small proportion of the curriculum and only part of that will be dedicated to dementia.

Another reason why improving medical undergraduate teaching on dementia is important is because of the stigma that healthcare professionals may unconsciously attach to dementia. As medical students, we tend to define ourselves by the relationships we form and maintain, the knowledge we acquire and our perceived social status. In dementia all of these aspects are challenged. For many of us, the idea of losing our cognitive functioning, which would jeopardize our relationships and our knowledge is very distressing. In a qualitative study exploring GPs' perceptions of dementia, participants expressed their fears about dementia which included feeling like they would lose their sense of self and their own "*personal history and intellect*" (Gove, 2016). Because of these perceptions, there is a stereotype among healthcare professionals that people with dementia have a low quality of life and this can lead to unconscious healthcare discrimination. People with dementia, may for example, be refused certain investigations or treatments due to perceived low quality of life. (Gove, 2016)

2. The social stigma of dementia: portrayal and perception.

The nature of dementia, as a psychiatric condition which primarily affects older people, means that people with dementia are affected by both the stigma which surrounds mental health and ageism. People with dementia are likely to experience stigma and devaluation of self even from healthcare professionals and their own family and friends.

Films portraying dementia (*The Notebook*, *Away from Her*, *Aurora Borealis*...) tend to focus on the end stages of dementia which gives the public an unrealistic impression of the stages of dementia which makes it difficult to perceive people with dementia living a life that could ever be meaningful (Van Gorp, 2012). These films are likely contributors to the stigmatization of dementia because they do not portray the affected individuals as active members of society and they reinforce the sense of loss of self and depersonalization. Swinnen (2012) additionally argued that this type of portrayal can lead to an objectification of people with dementia which reinforces stigma even in spaces that should be

non-judgmental such as the family home or clinical environments (Swinnen, 2012).

More recently, Julianne Moore won an Oscar for her performance as a woman affected by early-onset Alzheimer's in the film *Still Alice* (2014). *Still Alice* was highly acclaimed and was a more accurate representation of the course of the dementia and the impact of the disease on the individual and those around her. However it was early-onset Alzheimer's which was portrayed in this film and early-onset dementia only represents 5% of all dementias (Young dementia UK, 2018). The problem is that it is not reflective of the vast majority of dementias. It also accentuates the fact that we are more likely to empathize with the struggles of being diagnosed with dementia at a young age and subconsciously we are more likely to think that dementias that occur later on in life are less consequential and possibly that they are a normal part of ageing. The success of this film demonstrates that the stigma of dementia alone is difficult to untangle from the stigma of ageing.

Outside of the media, when an individual's set of thoughts, feelings and behaviours that make up their personality are altered due to a change in cognitive function, family and friends often feel that the affected individual is "*no longer the person they once knew*". When this happens there is a risk that the person may become socially excluded and fail to be treated with the same level of respect (Gerritsen, 2018). In a qualitative study of people living with dementia, all participants could identify situations in which disclosing their diagnosis led to them feeling stigmatized and devalued (O'Connor, 2018). Certain individuals described experiencing discrimination as well, for example when applying for volunteering roles. Most participants had found that disclosing their diagnosis had, at some point, prevented them from participating in and contributing to society which they found deeply upsetting (O'Connor, 2018).

3. Caring for carers

In many cases, the main carers of patients with dementia are of older age which makes them more likely to be simultaneously managing their own medical conditions (Princess Royal Trust for Carers, 2011). All carers may need support and should be offered support, but caring may be even more challenging for older carers who may be limited by their own physical health. 1 in 8 people over 75 in the UK are carers and this number continues to rise (Princess Royal Trust for Carers, 2011). Nearly half of these older carers care for people with dementia (Carers UK and Age UK, 2015). Caring for a person with dementia has been associated with a higher risk of carer depression than for carers caring for people with other conditions (Schoenmakers, 2010). Carers over the age of 70 are much more likely to be caring for a spouse or a partner (Princess Royal Trust for Carers, 2011). A recent systematic review found that being a spousal carer for a person with dementia was associated with poorer carer quality of life (Farina, 2017). Additionally, the behavioural and psychological symptoms of dementia are negatively associated with carer quality of life whereas the functional

impairment and declining cognitive function are not (Farina, 2017). Therefore, to support both the patient and the carer, the foremost focus needs to be on managing the behavioural and psychological symptoms of dementia rather than the current focus of management which is to maintain or slow the progression of declining cognitive function.

As Healthcare professionals we need to learn to recognize the risk factors that are negatively associated with carer quality of life so that we can provide additional support and signposting to those who need it most.

For partner/spousal caregivers, there is often an unmet emotional support need that comes from declining emotional support that was previously supplied by the partner who has developed dementia (Tatangelo, 2018). Respite care has a positive impact on carer's quality of life because they are able to have independent time for themselves (Farina, 2017). However, partners may be concerned about sending their loved one to respite care because they may feel that it will upset them or because they feel a strong sense of loyalty and responsibility that prevents them from using it (Tatangelo, 2018). In addition, it is important to consider practical factors like accessibility or cost.

On the other hand, it is also important to acknowledge that there are positives that come from being a carer. The satisfaction associated with caring tends to increase with age and older carers may experience less depression and better quality of life than younger carers (Greenwood, 2016).

Conclusions

There is an important need for dementia to be covered extensively and comprehensively in medical school curriculums so that medical students can be best prepared to manage the care of their patients in the context of changing demographics. Teaching on dementia must emphasize the possibility of living a meaningful life in order to reduce stigma amongst healthcare professionals. Future doctors also need to be armed with the tools to best support carers and in particular older carers.

A lot of stigma surrounds dementia, this is partly to do with it being a mental health disorder and partly to do with it being a condition which mainly affects older people. It is difficult to separate these sources of stigma from one another. Healthcare professionals must be mindful of their own opinions and attitudes towards patients with dementia and must question possible healthcare-based discrimination. Stigma towards dementia in society is not helped by how it is portrayed within the media. We must ensure that we inspire hope in our patients with dementia and reassure them that it is still possible for them to live meaningful lives and that healthcare providers will help them to be independent for as long as is possible.

Carers of people living with dementia need to be supported as much as possible because their role is invaluable to the person receiving the care and the healthcare system. As the population ages, informal care is going to become even more important. Older carers may have additional needs and may need extra support but it is also important to acknowledge that they may gain even more satisfaction from caring than younger carers. This means that by providing older carers with adequate support tailored to the individual, the relationship between the healthcare system and older carers can be synergistic.

All names have been changed to maintain confidentiality.

All references are available from the author on request.

A whistle-stop tour of the Trainees' Day at the Old Age Faculty Conference

by

Rugiyya Saeed

Trainee Editor, ST5 Old Age Psychiatry, Cardiff

This year's Old Age Faculty conference took place at the beautiful venue of East Midlands Conference Centre in Nottingham between 13th and 15th of March. It was very well-attended and enjoyed by delegates hailing from all across the UK, and some from other parts of the world. One of the biggest changes to the conference this year was the inclusion of a trainees' day, which fell on the 15th of March.

The trainees' day started off with a fascinating and very topical talk on the use of medicinal cannabis for behavioural and psychological symptoms of dementia, delivered by Professor David Burke from Sydney. He spoke of his own experience in prescribing cannabis in order to manage behavioural and psychological symptoms in older people with dementia, with relatively good effect and no significant side effects. The session sparked an interesting discussion, with clinicians debating the possible pharmacodynamics of medicinal cannabis, and whether the 'older brain' responded differently to it.

Next, Fiona Marshall discussed the findings of a four-year longitudinal study looking at service delivery to people with dementia in the remote and rural parts of Peak Park. It was a thought-provoking talk and had me considering the challenges faced by clinicians and patients alike when delivering and accessing healthcare in these remote areas, where services can be patchy and inconsistent.

We then had the option of choosing between two sessions; Care Home Masterclass or Trainee Presentations. I chose to attend the latter, which included four very different presentations that lasted eight minutes each, ranging from various research studies to a presentation of a regional service improvement project in Yorkshire, which examined cardiac status monitoring in memory clinics when prescribing cholinesterase inhibitors, leading to a review of current evidence and development of new guidelines by a multidisciplinary team to avoid delays in commencing of treatment. In conclusion, not everyone being started on cholinesterase inhibitors require a pre-treatment ECG!

Professor Rose McCabe from City University of London, who is a professor of clinical communication raised some interesting discussion points around the ways clinicians communicate a dementia diagnosis in memory clinic; direct vs indirect delivery, based on findings from a study. The direct method seems to be preferred if the patient has a higher degree of cognitive impairment. It left us reflecting on how we relay this information to our own patients, and how we can improve our clinical practice when faced with 'breaking bad news'.

Promptly after tea break, we all gathered for the next set of sessions. Out of the ones on offer, my curiosity led me to the Learning Cafés for the trainees; yet another new addition to the conference. It turned out to be very useful, with an approach akin to speed-mentoring, chaired by highly experienced clinicians such as Professor Martin Orrell, Dr Amanda Thompsell and Dr James Warner to name a few. They offered valuable guidance on preparing for interviews, career development, and how to present our career vision. I found the change of pace of this session rather invigorating, and it also provided an opportunity to meet other trainees.

After a quick lunch, it was time for the trainee business meeting. It was encouraging to hear our current training curriculum is being revised, and as a group we felt incorporating aspects of physical health into the new curriculum would make our clinical work even more holistic in the future.

In line with the fast pace of the day, we were then signposted to the main hall for the first post-lunch session, which was a series of presentations on the use of psychological therapies for older people, ranging from Acceptance and Commitment therapy to Psychodynamic therapy. It reminded me once again, how much psychotherapy training can enrich our clinical practice and improve our understanding of patients. It was encouraging to see how fellow clinicians such as Dr Matthew Hager and Dr Cate Bailey continue to successfully use these approaches in their clinical practice.

Professor Clive Ballard's update on management of neuropsychiatric symptoms in people with dementia was much anticipated, and we were not disappointed. He gave a clear summary of all the existing treatments, and also discussed the studies currently looking at newer options, such as Dextromethorphan for agitation. Immediately afterwards, the last speaker of the day – Dr Liz Sampson from University College London, delivered a fantastic and very relevant talk on the role of palliative care in dementia in ensuring a 'good death'.

The conference was brought to a close after a brief but cheerful prize-giving ceremony for those who excelled in various competitions, including our newsletter's essay competition winner. It was a rewarding end to a busy, fast-paced day packed to the brim with excellent presentations covering a wide-range of topics. Hats off to the organisers! Overall, I really enjoyed the trainees' day of the faculty conference and would highly encourage trainees to attend next year, as it was a valuable learning experience for me.

The Annual meeting of the Faculty of Old Age Psychiatry: through the eyes of a Psychiatrist from India

by

Alakananda Dutt (MD Psychiatry, PGIMER Chandigarh)

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I participated in the Faculty's annual residential meeting at Nottingham this year as the recipient of the Overseas Bursary award of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists. It was interesting to note that in this era of medical specialization & super specialization, where clinicians develop the tendency to visualise patients through the narrow lens of specialization, the meeting focused on the need for integrated care of the elderly where psychiatrists join hands with general practitioners, internal medicine specialists, pharmacists, occupational therapists and dementia care homes to ensure holistic care of the patient. This theme vindicated my stand, inculcated from the time of my training in a general hospital psychiatry unit that the role of a psychiatrist is not only to improve the mental health but also to facilitate the overall wellbeing of the individual. Hence instead of stand-alone care of the mentally ill in psychiatric nursing homes or mental hospitals during acute exacerbation, they should be treated in multispecialty hospitals where they can be treated for co-morbid illnesses, which are often undetected and untreated in these people.

The emphasis given to delirium through the "World Delirium Day keynote address: Update on delirium" was another heartening aspect of the meeting as it highlighted the need for recognising and preventing delirium. Having worked in general hospitals all through my career, delirium has always been an area of interest to me and the presentation has given me an added impetus to promote prevention and management of delirium in our hospital.

The theme of "integration" was also reflected in the presentations on Dementia where different aspects of this neurodegenerative condition like preventing delirium to prevent onset or exacerbation of dementia, young onset dementia, use of technology in dementia care, management of neuropsychiatric symptoms and psychological therapies were discussed in the different presentations made during the three days of the meeting. The above presentations as a whole clearly stated that the medical profession, the society and the state are equally responsible in promoting the quality of life of people with dementia and their care givers.

Working as a psychiatrist in India, I came back with the realization that the overall needs of the elderly with mental illness here are quite similar to the UK and the efforts made in their management despite the financial limitations we face is slowly progressing towards the right direction. I am grateful to the Faculty of Old Age Psychiatry, Royal College of Psychiatrists for giving me this opportunity to attend their meeting as it has validated several of my beliefs and has given fresh impetus to my efforts.

The Swedish Association for Old Age Psychiatry celebrated its 20-year anniversary at the Nobel Forum in Stockholm in October 2018

by

Elizabeth Aller, President, Swedish Association for Old Age Psychiatry

Karin Sparring Björkstén, Immediate past President

The Swedish Association for Old Age Psychiatry was founded in 1998 by a group of Swedish physicians that were interested in old age psychiatry and felt the need for a forum for physicians in this field. Old Age Psychiatry was not a recognized specialty, and there is a destructive split between dementia and non-dementia, despite the gradual changes of cognitive function in old age and the overlap of symptoms. In some regions, dementia and other mental disorders are cared for in the same organisation. In other regions, there is a total split between dementia and non-dementia. The organisation is different everywhere.

What have we achieved in 20 years?

To start with, **we translated the WHO-documents of Old Age Psychiatry to Swedish**. The first version was printed in 1999. It was very good to have a printed document to give to politicians, journalists and everybody interested in the field. We have written articles in major newspapers and medical journals, participated in debates in radio and television. We have made Old Age Psychiatry known influenced legislation in Sweden!

Presenting facts is crucial when trying to influence decision-makers. Therefore, we have made **national surveys of all old age psychiatric care in Sweden**. We counted every hospital bed and every position as physician or psychologist in old age psychiatry. The surveys were published in 2000 and 2009.

We also made a national survey of **lectures of old age psychiatry in our medical schools**, after which some of us were asked to teach.

There many clinics, congresses, courses and several organisations focussed on dementia, but other parts of old age psychiatry like depression, anxiety and psychosis were hardly ever addressed. Geriatricians in training complained about the lack of **courses of old age psychiatry** other than dementia, so we started a **one-week full time course**. It is very popular and held annually since 2001.

Thanks to a Grant from the East Europe Committee, we were able to realise Project Old Age Psychiatry in Latvia 2002. We arranged translation, printing and distribution of WHO-documents of Old Age Psychiatry and two one-day congresses on old age psychiatry for Latvian psychiatrist, and mutual professional exchange and friendship.

The annual meetings of the Swedish Association for Old Age Psychiatry have become a forum for continuous education. The meetings consist of one day filled with lectures by Swedish and foreign speakers. We have built up international connections and friendship.

The Swedish Psychiatric Association asked us to edit and write **Clinical Guidelines of Old Age Psychiatry**, and the book was published in 2013.

A major goal was to **make Old Age Psychiatry a recognized specialty**. After years of lobbying, this was finally achieved in 2015. In order to become a specialist of old age psychiatry, a speciality of either general psychiatry or geriatrics is required. Then, an individual training programme of 2,5 years will be designed depending on previous experience. In 2018, there were 6 specialist of old age psychiatry in Sweden.

In 2018, three members of the Swedish Association for Old Age Psychiatry participated in the Faculty of Old Age Psychiatry Annual Scientific Meeting in Newcastle. We look forward to further contact between our associations.

Karin Sparring Björkstén

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Promoting Old Age Psychiatry, The European Story

by

Dr Sujoy Mukherjee, Consultant Old Age Psychiatrist, immediate past Executive Member of Faculty of Old Age Psychiatrists, RCPsych and currently General Secretary, EAGP

The UK was an early pioneer of Old Age Psychiatry as a speciality and it is definitely a world leader in the field. We have a very well-structured training programme, large number of specialists and a vibrant faculty. While the speciality is still evolving across the world, the practice of old age psychiatry in mainland Europe particularly merits our attention.

The umbrella organisation for Old Age Psychiatrists in Europe is the [European Association of Geriatric Psychiatry \(EAGP\)](#), based in Germany. The association was originally formed in 1973 and currently have eight countries as members including the UK. Finland is likely to join in the near future. The current president is Professor Martin Orrell, Institute of Mental Health, Nottingham.

The objectives of the EAGP are research promotion, pre- and post graduate education, further development of geriatric psychiatry and the cooperation with national and international bodies engaged in the field.

The EAGP has participated in a number of collaborations in recent years. The EAGP workshop was part of Spanish Psychogeriatric Society Congress in Bilbao in 2017 and one is scheduled in May 2019 at Essen, part of annual congress of German Psychogeriatric Society. A summer school for Old Age Psychiatry Higher trainees is now in it's fourth year (it runs every alternate year) at University of Lausanne, Switzerland, that boasts one of the oldest Psychogeriatric departments in Europe. The course is run by Professor Armin Von Gunten, Vice President of EAGP on behalf of the organisation. It could bring unique opportunity for a UK higher trainee in Old Age Psychiatry to interact with peers from across Europe and learn from a very comprehensive programme. It is scheduled for 11-14th September, 2019 at Lausanne, Switzerland and all details are on EAGP website.

One flagship programme for EAGP was a refresher course for Old Age Psychiatrists (mostly consultants) at Leuven, Belgium in 2016 , run jointly with Dutch and Flemish Psychogeriatric societies. It was a great success.

This year, we are organising the second refresher course in Old Age Psychiatry hosted by Institute of Mental health, University of Nottingham , 3-4th October and it will be a joint programme between EAGP and our Faculty and the aim is to

have a interactive clinically focussed meeting with a limited number of delegates and programme delivered by renowned academics from UK and Europe. This meeting is primarily aimed at Consultants and senior clinicians working in Old Age Psychiatry both here and from mainland Europe and hopefully will be an unique opportunity to bring expertise from both the UK and continental Europe together.



[European Refresher Course for Old Age Psychiatrists, Nottingham, UK 3rd & 4th October 2019](http://www.institutemh.org.uk/ERCOAP)

Behind Bars – The Ageing Population

by

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Great Britain has the highest rate of imprisonment in Western Europe (1), and at the end of February 2019 the prison population for England and Wales was 82,525 (2). The numbers of older prisoners is increasing, with those over 60 representing the fastest growing age group (1). As of 31 December 2016 there were 234 prisoners over 80, 14 were over 90 and 1 was over 100. 87% were in prison for sexual offences (1). In view of this, a number of organisations including the HM Chief Inspector of Prisons, the Prison Reform Trust, the Prisons and Probation Ombudsman and Age UK appealed for a national strategy for older prisoners (1).

The London Prison Psychiatrists Network (LPPN) is a group of consultant psychiatrists working in prisons in the London area whose aim is to: promote good mental healthcare for prisoners; to influence policy; to promote training in prison psychiatry; and to participate in and lead academic research in prison psychiatry. As a group we have observed a small but increasing number of older prisoners, and they come with their own particular difficulties.

In many ways older prisoners who have a severe and enduring illness such as schizophrenia or a clear affective disorder, are easier to manage. If they are unwell enough, they can be transferred to hospital under Part 3 of the Mental Health Act 1983. And whilst there may be some debate about the most appropriate hospital for them to be admitted to, there are options to admit to local secure units, or to specialist secure units for older prisoners if required/appropriate (and funding is agreed, as these units tend to be in the independent sector). Even if these prisoners do not require hospital transfer, prison mental health teams are usually happy to follow them up.

In practice it is those older prisoners with cognitive impairment and other organic presentations that present a greater challenge. Even when considering assessment, there are few prisons with access to an in-house old age psychiatrist, old age physician or neurologist. At HMP Bronzefield the ACE III cognitive screening was offered to everyone over 55 in a pilot project to improve the diagnosis of dementia (3) but in many places these assessments are likely to be carried out by (usually general or forensic) psychiatrists or GPs working in the prison. It would perhaps be better practice if these prisoners were referred to the local memory clinic, albeit this comes with a number of logistical considerations. If diagnosed with dementia, there is then the debate about who

would follow them up, as prison mental health teams may not ordinarily have these prisoners on their caseloads.

For older prisoners with a cognitive impairment, depending on their level of functioning, there is a question as to where they should be located. HMP Whatton has a cell with soft lighting, larger clock and braille signage for prisoners with visual impairment or dementia, as well as a ground floor wing with wider access corridors and cells to assist those with mobility aids (3). However, the layout of prisons is often not conducive to those with mobility issues or cognitive impairment, and this in combination with other social care needs, mean that a number of older prisoners may be located in Healthcare. This in itself can lead to further difficulties as it is difficult to move them. It often means beds are occupied for very protracted periods, when they are already very few in number. What is more, after sentencing it is not possible to transfer these prisoners to a more appropriate prison to accommodate their needs, as generally transfers do not take place from Healthcare. Unsurprisingly, given the age of these prisoners, it is not uncommon for them to have concomitant physical health problems which further complicate their situation. Anecdotally, several prisoners have remained in Healthcare for a number of years as a result.

Responsibility for social care falls to the local authority in which the prison sits. Social care provision varies but for many accessing it can be a slow process. The West Midlands cluster has developed a "social care needs tracker" to try to manage their older population (3). Other prisons, such as the Greenwich cluster, have a third sector organisation providing social care, but this is only after the local authority has completed an assessment and made a referral. Less resource intensive is the employment of other prisoners, after training, to carry out non-intimate activities (3)

Release planning is also difficult. For those prisoners who have committed certain offences, such as sex offences and arson, it is even harder to identify suitable accommodation. In one case the judge made it clear he did not want the prisoner to be in custody, but given a placement could not be identified, he remained in prison (and on Healthcare) for over a year. In contrast Age UK Evergreen 50+ Advocacy Service in HMP Leicester "actively sought funding to ensure that older people are released from prison into suitable accommodation." (3)

There is a broader question about whether some of these prisoners should be in custody given their health and social care needs, when they may pose little risk to the public. It seems unlikely there would be widespread public support for many of these offenders to remain in the community, and for the time being the status quo is likely. Being in custody means there are additional complexities to accessing healthcare, and with this, delays may occur. Whilst theoretically the principle of equivalence in relation to the healthcare of prisoners exists, in reality, this is challenging. For the older London prison population, many may be located in remand prisons, even if sentenced, and the numbers are small. As a

result, Service Level Agreements addressing the needs of older prisoners are difficult to draw up. Whilst there are areas of good practice around the country, until there is a national strategy, prison psychiatrists and GPs, may need to think more creatively about how to address the mental health needs of our older prisoners.

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Treatment requirements (TRs) in conjunction with community sentences could be coming to your area

by

Dr Amanda Thompsell, Chair, Faculty of Old Age Psychiatry

Professor Pamela Taylor, Chair, Faculty of Forensic Psychiatry

For people convicted of less serious offences, community sentences or suspended prison sentences may be an option. In making such sentences, the courts may tailor them to an offenders' needs in respect of staying out of trouble by imposing one or more 'requirements'. One of these is a Mental Health Treatment Requirement (MHTR).

The Ministry of Justice, Department of Health, NHS England and Public Health England aim to increase the use of community treatment requirements. Since October 2017 a team has been rolling out models for primary care treatment requirements in five test-bed sites. Secondary health care need is likely to be identified through this process, which could fall under an MHTR, but we also know that secondary care MHTRs are currently seriously underused.

Community sentences with an MHTR are currently rarely made, but where they have been studied evidence is that they reduce reoffending. The principle is that the offender, a representative of probation and a senior clinician (consultant psychiatrist/psychologist) make a contract before the court that the offender will attend for probation supervision and psychiatric treatment as well as desist from offending.

Not many of these orders are being made at present, but a high number of 'revolving door' offenders with serious mental disorders are repeatedly in prison for short periods for nonviolent offences or low-level violence. Older people may be especially vulnerable as residential services are fearful of anything to do with offending.

The MHTR provides that, on the day of sentencing, offenders with capacity to make such a commitment may agree to psychiatric treatment as a component of their sentence. An **Old Age Psychiatrist** might be approached to supervise an MHTR.

This would **rarely, if ever**, mean going to Court or writing lengthy reports. Rather, the prospective 'responsible clinician', here the Old Age Psychiatrist, would have to have sufficient knowledge of the case to sign to effect that they would be willing to supervise the person and liaise with the Probation officer supervising the Community sentence. Clinical management should be no different from that for any other patient, with the one exception that, in the rare event that the Old Age psychiatrist considered the clinical part of the order had broken down (such as the person not attending or engaging with therapy) then s/he must report that to the probation officer, with a recommendation on how to proceed.

If the problem could be dealt with by additional support, the Probation Officer should be able to help with that. If it were considered that the order had irretrievably broken down, and only then, the probation officer would take the case back to Court, with a brief account of the evidence that the clinical component was unsustainable. The Court then decides how to proceed – sometimes, but not invariably replacing the order with a prison sentence.

It is very doubtful that, as Old Age Psychiatrists, we would be getting a large number of cases but this should be kept under review. The system could mean less work for the Old Age Psychiatrist and their team because of the extra resource in probation and the fact that in the event of non-compliance, somebody else (namely probation) will take the matter back to court.

We are currently working on a document of guidance for the named psychiatrist in such arrangements. In the meantime we will keep you abreast of any changes and links to any information about this initiative.

Mental Capacity Act Amendment Bill update

by

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Visiting Professor, University of Chester

It has been a busy few months and a lot of work has been done by the faculty behind the scenes on the MHA/MCA since the last newsletter was published. This has mainly been on responding to formal consultations by the college on various issues around the Mental Capacity Amendment Bill update. Dr Amanda Thompsett, Dr Hugh Series and Dr Sharmi Bhattacharyya have all been involved in responding in a timely way to these consultations.

The Mental Health Review recommendations were published in December 2018. The MCA/MHA interface was included; however the recommendation remains same as before i.e. to use MHA in those scenarios where patient is 'objecting'. Objection still remains the dividing line between the two acts. Please see <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review> for further reading.

With regards to the Mental Capacity (Amendment) Bill (MCAB), as we know there have been increasing concerns around the Bill as it appears to weaken safeguards for patients and may not be any more fit for purpose than its predecessor. Following the debates in the Commons and the Lords, a number of amendments have been made. Those relevant to our faculty were:

- The term 'Unsound mind' to be removed and replaced by 'mental disorder'
- The definition of deprivation of liberty is still an active area of debate, with the Lords narrowly defeating the Government proposed definition
- Health minister committed to speaking to MoJ about improving the situation on Sec 49 reports however without removing the provision to request such reports
- Status of registered medical practitioners will be further discussed in the Code of Practice
- With regards to fluctuating capacity the Government declined to legislate to allow a deprivation of liberty to continue if capacity was regained for a short period of time where foreseen, but did commit to include the issue in the Code of Practice and to consult on its development

Hence in spite of some positives, the concerns around Sec 49 reports, fluctuating capacity issues, as well as concerns around defining deprivation of liberty remain.

A draft definition of Deprivation of Liberty was then consulted on in December 2018 and the Faculty once again gave feedback in a very short time frame. Some concerns were raised around the ambiguity of terms used and how it left certain scenarios open to interpretation. Following this, the Department of Health and Social Care were then looking to compile patient scenarios around the DoL definition both to inform this definition and also for potential inclusion with the Code of Practice, and once again our Faculty responded with examples in very short time frames.

Dr Amanda Thompsell, Dr Hugh Series and Dr Sharmi Bhattacharyya also made a submission to give evidence on the MCAB to the House of Commons Public Bill Committee in early January 2019. Some of the areas highlighted were

- the new test of 'necessary and proportionate': what is it necessary for and what is it proportionate to?
- Hospital and care home managers have extensive new responsibilities which will require time, training and resources.
- There is a very disturbing lack of weight given to P's wishes and feelings. Although consultation is required to ascertain what they are (p.17), they do not appear to be given any specific weight in the decision to deprive P of liberty.
- Authorisation in advance for up to 28 days (p.22) will often not be sufficient time to ensure that arrangements for discharge from hospital to a care home can be made.

The committee stage of the LPS finished on 22nd January 2019.

The Ministry of Justice then opened a call for evidence for a revised Code of Practice for the LPS, which closed on 7 March 2019. The rationale behind this was that since the MCA came into force in 2007, the COP has been used extensively by a wide range of stakeholders. However, in light of changes in case law, and lessons learned through practical use of the COP over the past 11 years, revision of the COP was thought to be essential in order to better reflect current needs. The MOJ made it clear that The Act itself was currently not under review, however the survey would provide an opportunity for relevant stakeholders to comment on the practical guidance outlined in the COP. We duly responded with many comments and case examples involving older adults

It was also highlighted that, following the final report from the Independent review of the Mental Health Act 1983, the Government proposes to introduce a new Mental Health Bill to transform mental health care, and the COP should align with this.

Finally, thanks to Dr Hugh Series' careful reading of the amended bill, he pointed out that subsection 4 of amendment 1 appeared to have been lost when the Bill was sent back to the Commons. This subsection reads as follows:

- (4) A person is not deprived of liberty if—
- (a) the arrangements alleged to give rise to the deprivation of liberty are put in place in order to give medical treatment for a physical illness or injury, and
 - (b) the same (or materially the same) arrangements would be put in place for any person receiving that treatment.

The reason that we think this is so important is because, it means that the complex and potentially burdensome deprivation of liberty procedures would not normally need to be used for patients with physical illnesses attending the accident and emergency department or admitted to general hospitals for medical or surgical treatment. It appears to us that subsection 4 above provided an excellent way of avoiding the problem (and in fact it extends the judicial thinking from a significant recent case known as Ferreira which considered the situation of a person lacking capacity who was in the ICU) and hence why we expressed our concerns about it not being in the Bill. This will be considered by the Commons when they debate the Lords amendments as the Bill continues its 'ping-pong' (yes, that is the official term) through Parliament.

Our Faculty has continued to highlight our wish to be involved in the Code of Practice for the MCAB and we are pleased to report that the Faculty has now got representation on two of the workstreams involved in preparing the new Code.

For further reading and update on MCA amendment Bill, a useful summary is available.

It is expected that the Bill will complete its Parliamentary passage within a few weeks and receive Royal assent soon after. However, it will be some time before it is likely to come into force as the new Code has to be developed and many agencies will need time for training. This is unlikely to be sooner than next year.

Integration insights

by

Dr Kapila Sachdev

Consultant Old Age Psychiatrist, East London Foundation Trust

Hello and it was good to see a lot of you in the conference. The conference had a number of interesting talks and what was exciting was the presentations about integration followed up by a workshop. It was good to hear Dr Ben Underwood discuss about the integration model in Cambridgeshire which came out of the impending crisis in the service and the role of the old age psychiatrists in bringing it all together. There was a lot of discussion about the skills we bring to the integration table and the ways we can influence the change.

In contrast the Surrey model presented by Kate Jeffries was introduced by the CCG seeing a need for change in the way care is delivered and how this has again brought the old age psychiatrists as system leaders in influencing a change.

The presentation by Dr Joels on the Camden model for patients with dementia which looks after patients from "diagnosis to death" and the role of care coordinators and Old age psychiatrists in ensuring support for the patients and carers in the community.

Dr Osman-Hicks talked about the integration model in the hospital in Southampton which was about supporting patients with dementia and/or delirium in hospital and the role of Old age psychiatrists and geriatricians in co-managing the patients.

Dr James Dove talked about the role of old age trainees and psychiatrists in A&E diversion service and the various skills that we as clinicians with our expertise bring to the team.

The workshop helped to bring together the clinicians to discuss about how they can be involved in co-production of the integration model. It is of course important to remember that various CCGs are in different stages of growth with regards to this. The discussion was about our identity as old age psychiatrists in the multidisciplinary teams. It was heartening to hear that all the clinicians who have had involvement in the integration model feel that it has been a useful model to work in. There will be challenges along the way but it is important that we do remember to be involved in co-production. The most inspiring words that I heard during the conference were "Don't be shy, get involved".

Integration is here to stay as we all know and the NHS long term plan of course mentions it in a lot of detail. It is time for us the old age psychiatrists to find a

way of engaging locally in the model as the future of our practice would be more integrated care work. The integration partners may vary and there would be a number of challenges but if the care in the community is a model we are looking at we have to work closely with partners and stakeholders.

Among the articles that have been published by Kings fund on the topic of integrated care , "Payments and Contracting for integrated care: the false promise of self-improving health system" was particularly interesting. The report calls for an urgent reform for paying and contracting services in the NHS.

The article talks about the use of financial incentives to improve the services of NHS which have been used in the past and how they may not be useful in the new integrated care systems. Commissioners and providers in many health systems have now started the transition from arm's length contracting to working collaborative relationships. Although these are early stages there is emerging evidence of benefits. The suggestion is for organisations across local systems working collaboratively and the money that would have been used for contracting being used for improvement.

References

Payments and contracting for the NHS: The false promise of self-improving health system

Guidelines for perioperative care of patients with dementia

by

Dr Kapila Sachdev

Consultant Old Age Psychiatrist, East London Foundation Trust

This document was published in *Anaesthesia – Peri-operative medicine, critical care and pain* in January 2019.

It is a consensus document produced by expert members of a Working Party established by the Association of Anaesthetists of Great Britain and Ireland. It has been seen and approved by the Board of Directors of the Association of Anaesthetists. It has been endorsed by the British Geriatrics Society, the Royal College of Anaesthetists, the Age Anaesthesia Society and the Royal College of Nursing.

The guidelines were published as there is no national guidance on how people with dementia, and their relatives/carers, might best be supported through an episode of surgery and anaesthesia. In common with other Association of Anaesthetists guidelines, this guideline was developed by a Working Party consensus review of current evidence about not only best practice in peri-operative care but also recommends best practice in circumstances where evidence is controversial or incomplete.

The main recommendations are:

1. People with cognitive impairment should receive the same standards of, and access to, healthcare as people without cognitive impairment.
2. Pre-operative assessment processes should identify people with cognitive impairment so that their management and follow-up can be tailored to their needs.
3. Pre-operatively, the risk of peri-operative cognitive changes should be explained to people and their relatives.
4. Rigorous assessment and management of cognitive impairment should apply equally to people requiring elective or emergency surgery.
5. Carers and relatives should be involved appropriately in all stages of the peri-operative process.
6. Carers or relatives should be invited to accompany a person with cognitive impairment into the operating department before and after surgery.
7. Anaesthesia should be administered with the aim of minimising peri-operative cognitive changes.

8. Anaesthetists should participate fully in multidisciplinary care and communication about people with cognitive impairment at all stages of the surgical process.
9. Each department of anaesthesia should have a lead anaesthetist for cognitively impaired adults.
10. All relevant staff should receive training in the assessment and treatment of pain in people with cognitive impairment.

Link to the guidelines:

<https://onlinelibrary.wiley.com/doi/10.1111/anae.14530>

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

by

Rugiyya Saeed

Trainee Editor, ST5 Old Age Psychiatry, Cardiff

"Research is formalized curiosity. It is poking and prying with a purpose."

Zora Neale Hurston

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

Improving the quality of life of care home residents with dementia: Cost-effectiveness of an optimised intervention for residents with clinically significant agitation in dementia

Renee Romeo, Darshan Zala, *et al.* *Alzheimer's & Dementia*. 2019. 15. 282-291.

Within this cluster-randomised factorial study including 549 care home residents from 69 care homes in UK, a cost-effective analysis was conducted, comparing the use of Well-being and Health for people with Dementia (WHELD) intervention against treatment as usual (TAU) to reduce agitation in residents with dementia over a nine-month period. The WHELD intervention is training delivered to care home staff that focuses on person-centred care and promoting person-centred activities, and provides care home staff and GPs with updated knowledge on optimal use of antipsychotics and their monitoring. The outcomes measured were health and social care costs, agitation, and quality of life. The WHELD intervention group had better outcomes for agitation and quality of life compared to the TAU. While the WHELD intervention had additional costs compared to TAU (of £2,629), this was offset by the higher health and social care costs (1.2 times higher) incurred for residents in the TAU group (mean difference £2103; 95% CI -13 to 4219). The authors concluded that WHELD in addition to TAU was more cost-effective than TAU alone in this population group.

Self-harm in older adults: Systematic review

M. Isabela Troya, Opeyemi Babatunde, Kay Polidano *et al.* *The British Journal of Psychiatry*. February 2019. (online first)

This systematic review appraises both quantitative and qualitative studies, identified by a comprehensive search of online databases from their inception to February 2018. Overall, a sample of 40 studies (n = 62 755) examining self-harm in older adult populations (aged 60 years or older) met the full eligibility criteria. 28 studies were of a moderate methodological quality, with 10 being of a high quality. The prevalence rates of self-harm was found to range from 19 to 65 per 100 000. The most commonly reported method of self-harm in older adults was self-poisoning, and the results show an increased risk of repetition of self-harm and suicide in older adults. Previous history of self-harm, current psychiatric treatment, and being a younger older adult (60-74 years old) were among the factors strongly associated with self-harm repetition. Common self-harm motivations were reported as loss of control, increased loneliness and perceived burdensome ageing. As current research on this subject is mostly limited to hospital-based settings, the authors highlight a need for community-based studies to further understand self-harm in this population.

Cognitive tests for the detection of mild cognitive impairment (MCI), the prodromal state of dementia: Meta-analysis of diagnostic accuracy studies

Alexandre Breton, Daniel Casey, Nikitas A. Arnaoutoglou. *International Journal of Geriatric Psychiatry*. 2019. 34. 233-242.

In this meta-analysis, the authors included studies 66 studies that met the eligibility criteria. Sensitivity and specificity of 8 cognitive tests (ACE-R, CERAD, CDT-Sunderland, IQCODE, Memory Alteration Test, MMSE, MoCA, Qmci) were assessed using bivariate random-effects meta-analysis. The summary sensitivity of the MoCA, CERAD, Memory Alteration Test and ACE-R was identified to be significantly higher than that of MMSE for MCI, with the Memory Alteration Test having the highest sensitivity. Comprehensive cognitive tests such as MoCA, CERAD and ACE-R showed similar sensitivity and specificity for MCI. In comparison to the other cognitive tests analysed in this study, MMSE was inferior in sensitivity. The sensitivity and specificity of the Qmci was not found to be significantly different from the comprehensive tests. Based on the results of this meta-analysis, the authors identified the Memory Alteration Test and Qmci as short tests with diagnostic accuracy that would be suitable for use in primary care for patients presenting with cognitive complaints. One of the limitations of the study identified is its exclusion of patients with psychiatric comorbidity, pre-existing medical illness or sensory impairments.

Interventions to improve gait in older adults with cognitive impairment: A systematic review

Weihong Zhang, Lee-Fay Low, Josephine Diana Gwynn, Lindy Clemson. *Journal of the American Geriatric Society*. 2019. 67. 381-391.

In this review, 36 studies were included, both RCTs and non-RCTs with participants aged 65 and older who had mild cognitive impairment or dementia. A narrative synthesis was carried out. The interventions to improve gait in these studies fit into three categories, which were medications or medical devices, exercise alone, and lastly exercise plus cognitive training. This review found that while antidementia medication may play a role in improving gait variability, interventions with exercise, or exercise plus cognitive training improve overall gait performance. Exercise programs incorporating strength and balance training with functional mobility training (e.g. walking) showed strong evidence of improving gait compared to those focused only on static, resistance and flexibility training. Similarly, there is strong evidence for combining exercise (strength and balance training plus functional mobility training) with cognitive training programs (focusing on attention and executive function) to improve gait performance in this population. Hence, this review highlights the importance of considering both physical and cognitive factors in interventions designed to improve gait in people with dementia.

Cochrane Corner

by

Jenny McCleery

Joint Co-ordinating Editor, Cochrane Dementia and Cognitive Improvement Group (CDCIG)

How useful are short informant questionnaires to help identify dementia?

The majority of members of the faculty will be assessing patients in memory clinics after they have been referred by someone else who suspects dementia, perhaps a GP or a colleague in an acute hospital. Therefore, although there is no community screening programme for dementia, there is a mixture of targeted and opportunistic screening in various settings to identify those who might benefit from a full diagnostic assessment. This first stage on the memory assessment pathway may be performed by health professionals with a range of backgrounds and levels of experience. Identifying possible dementia can be particularly challenging in settings where patients may have acute illnesses affecting their cognition and, in these contexts, a longer-term perspective from an informant might be particularly useful. However, taking a good informant history can be time-consuming and require considerable skill. What tools might colleagues in these situations use to help them make the best referral decisions?

CDCIG has recently published a [new review on the diagnostic accuracy of the short informant questionnaire AD-8](#). This adds to a set of earlier reviews on the IQCODE in different settings (community, primary and secondary care). (See [this excellent blog about the IQCODE reviews](#) by the authors, with links to the reviews themselves). By using diagnostic test accuracy methods, the reviews are not suggesting that these tests can be used alone for the diagnosis of dementia, but synthesising evidence on their diagnostic accuracy statistics (sensitivity and specificity, positive and negative likelihood ratios) is still needed to understand their utility in the diagnostic pathway.

It is worth thinking about what performance we might want from a screening test intended to identify patients for further assessment. Typically, the net should be cast fairly widely at a preliminary stage of assessment like this, so that cases are not missed, i.e. sensitivity may be valued over specificity. However, if specificity is too low, large numbers of patients will be made unduly anxious about a much-feared disease and specialist services may be overwhelmed by referrals.

The authors were able to include in their AD-8 review data from nine studies with 4045 participants of whom 27% had dementia according to the reference standard of criterion-based clinical diagnosis. Four of the studies were conducted in the community, one in primary care, one in acute secondary care and three in specialist memory clinic settings. Some studies provided data using an AD-8 cut-off score of 2, some of 3 and some of both. Overall, across all settings, an AD-8 cut-off of 2 identified dementia with a sensitivity of 0.92 (95% confidence interval (CI) 0.86 to 0.96) and a specificity of 0.64 (95% CI 0.39 to 0.82). From the data available, using a cut-off of 3 was equally sensitive (0.91; 95% CI 0.80 to 0.96) and more specific (0.76; 95% CI 0.57 to 0.89). The test was more sensitive but less specific in secondary care than in community settings. There were some significant quality concerns, but the biggest limitation of the evidence for the question I posed above is the lack of studies from primary care and acute secondary care settings.

The IQCODE reviews also found a serious lack of studies to include from primary care settings (only one study done in Hawaii), but more studies in the community (11) and secondary care (13, of which three were in general hospital settings, six in specialist 'memory' settings and four in both). There are 26-item and 16-item versions of the IQCODE; both seemed to perform equally well. Again, there was heterogeneity between studies, including a very wide range of dementia prevalences (10.5% to 87.4%) and there were limitations of study methods and reporting. Across all the secondary care studies and using a mean item score cut-off as close as possible to 3.3, the IQCODE identified dementia with a sensitivity of 0.91 (95% CI 0.86 to 0.94) and a specificity of 0.66 (95% CI 0.56 to 0.75). The positive likelihood ratio was 2.7 (95% CI 2.0 to 3.6) and the negative likelihood ratio was a quite impressive 0.14 (95% CI 0.09 to 0.22). Interestingly, there was a statistically significant difference between general hospital and specialist memory clinic studies, with better performance in the general settings.

Whether we want to talk about 'screening', 'triage' or 'case-finding' to select patients for referral to memory clinics, there is at the moment little evidence on informant-based tools for use in primary care. There is a greater body of evidence from secondary care. For the general hospital setting, this is predominantly for the IQCODE rather than the AD-8 and, from the evidence available, the IQCODE looks like a good rule-out tool, i.e. if a patient has a mean item IQCODE score of <3.3, then dementia is very unlikely.

Changing the definition of Alzheimer's disease

Faculty members are no doubt aware of the 2018 National Institute on Aging - Alzheimer's Association (NIA-AA) Research Framework for Alzheimer's Disease (1) which proposes a new, biomarker-based definition of Alzheimer's disease for research purposes. For a critical opinion on the framework from a group of CDCIG editors, take a look at our commentary, [When is Alzheimer's not dementia?](#), in *Age and Ageing*.

To keep up-to-date with all our reviews or to comment on them or on evidence-based dementia care in general, follow us on Twitter [@CochraneDCIG](#) or [visit our website](#).

References

(1) Jack CR, Bennett DA, Blennow K et al NIA-AA Research Framework: Towards a biological definition of Alzheimer's disease. *Alzheimers Dement* 2018;14:535-562

Reflections of an Old Age Psychiatrist on 'Better Data, Better Care': General Adult Faculty Conference

by

Carol Wilson

Consultant Old Age Psychiatrist, Bedfordshire and Luton Mental Health and Wellbeing Services provided by East London NHS Foundation Trust

On the 22nd of February 2019 the General Adult (GA) Faculty hosted an ambitious conference on how we understand and use data to improve the quality of service we provide. Dr Lenny Cornwall, the faculty chair, admitted to some reservation when the idea was put to him. Would there be enough interest amongst the membership to pull this off? Isn't it a bit niche?

The reality was a highly engaged audience of over 120 delegates. Dr Asif Bachlani, GA faculty committee member, orchestrated the event. The conference saw its twitter hashtag 'trend' in England such was the social media traffic coming from within and outside the room. The conference felt timely and important; a niche topic finally moving towards the mainstream. At a time of transformation, the relevance to older adult services is clear.

As might be expected at a conference entitled 'Better data, better care' there were thought-provoking presentations on quality improvement, evidence driven service design, and workshops on operationally meaningful dashboards. A highlight was Dr David Somerfield and Prof. Martin Pitt describing a clinical/academic collaboration to model health systems and capacity in Devon. The outcome? A successful bid for a [new mental health ward in Torbay](#).

Stephen Watkins, Director of [NHS Benchmarking](#), gave us an overview of trends in NHS mental health service provision. The NHS Benchmarking Network is now one of the largest healthcare benchmarking groups in the world, and its membership now includes all NHS providers in England, Wales and Northern Ireland, and a proportion in Scotland.

At a national (English) level some NHS Benchmarking data about older adult services was shared. In March 2018 there were 3840 'older adult acute' beds in England. Amongst all acute inpatient services, our wards have amongst the lowest number of consultants, nurses, psychologists and occupational therapists for each 10 beds. NHS Benchmarking data confirmed that relative to working age adult wards, old age wards have higher levels of violence towards both staff and other patients, but far fewer ligature incidents. It was reported that between

2014/15 and 2017/18 caseloads and patients contacts in older adult community services fell by 14% and 16% respectively. Food for thought was plenty, but for an old age psychiatrist many questions remained. With the complexity and variation of our services, how is an acute older adult bed even defined? How is the separation of memory services from older adult community services in most areas bearing on the statistics being quoted? For adjustment purposes, how is local mental health need being quantified for older adults? When asked the latter question Stephen Watkins conceded needs are “not well adjusted for” in the older adult cohort. There is much to be done.

Dr Andy Moore, a former Clinical Director, gave an absorbing presentation on ‘capacity and demand’ in working age mental health services. He reflected that the right data probably existed, if only time had allowed him to go looking for it. Fundamentally, it was very difficult for him to know how much of the challenge he saw related to a lack of total resource and how much related to an imbalance of resource between core and specialist services.

Dr Moore described a ‘perfect storm’. In the early 2000s there was period of increasing investment in working age services, primary (possibly exclusively) on specialist services such as early intervention in psychosis, crisis care and assertive outreach. The financial crash of 2007/2008 brought an end to this increase. In real terms, working age adult CMHTs have seen a reduction in funding, he explained. This has coincided with a period of increasing demand and expectation likely based on the success of efforts to promote parity of esteem and reduce stigma.

The ‘perfect storm’ for older adult services has come at us from several extra directions. Likely more than any other health condition, dementia has been a consistent political priority. Policy focus has remained on early diagnosis, increasing diagnostic rates, shorter waiting times and post-diagnostic support. This will not be new information to any old age faculty member. In the 5 years between 2011/12 and 2016/17 the [all-age recorded dementia diagnostic prevalence](#) increased from 0.5% to 0.8% in England. A change on that scale would be unlikely to happen without significant re-distribution of resource or substantial investment. What was the impact of this on the wider mental health services we provide to older people?

Of course the population is set to continue to age over the next two decades. As seen in Figure 1, there will be large absolute increases in numbers of those in their 70s, and proportionately the largest increases will be in the very elderly.

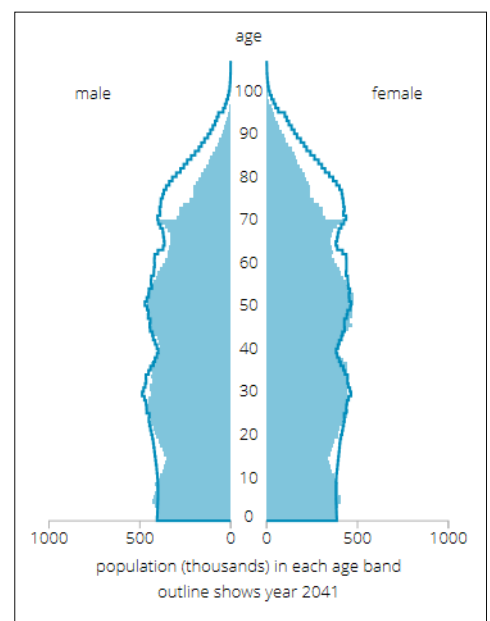


Figure 1: UK population by age in mid-2016 vs. mid-20141 (Source: Office for National Statistics)

Sir Austin Bradford Hill is quoted as saying: “health statistics represent people with the tears wiped off”. However, it is only by categorising people and building statistics that inequalities are identified. Edward Davie, Lambeth Councillor, spoke about how informatics are being used to promote mental health, particularly for those of African or Caribbean heritage who are vastly over-represented in secure psychiatric settings in his area. He reminded us that “when people are not valued or empowered they get ill”. He and his local authority colleagues are positioned where many of the important levers that influence the wider determinants of health exist.

Sharing the insights and information we have with colleagues working in local authorities arms them with a vital political tool necessary for action. On one hand it is encouraging to see the local council [Mental Health Challenge](#) and all of the information being shared, on the other hand there appears to be little mention of older people on these webpages. Could we influence that?

Example sources of data and information:

Trust Specific:	Local:	England (but local data extractable)
<ul style="list-style-type: none"> NHS Benchmarking Annual Report 	<ul style="list-style-type: none"> Joint Strategic Needs Assessments (JSNA) – for example click here 	<ul style="list-style-type: none"> PHE Fingertips, e.g. dementia, mental health and wellbeing JSNA
<ul style="list-style-type: none"> Trust Board Papers and Trust Strategy 	<ul style="list-style-type: none"> CQC Local System Data Summary: Older People's Pathway 	<ul style="list-style-type: none"> Mental Health Dataset,
<ul style="list-style-type: none"> Trust internal quality, performance and finance data/reports 	<ul style="list-style-type: none"> Local Public Health data and reports – for example click here 	<ul style="list-style-type: none"> Hospital Episode Statistics

Figure 2: A summary of available data sources. Accessibility of Trust-specific reports will vary by organisation. Many sources of data and information listed are relevant only to colleagues working in England.

When it comes to mental health, many would agree older adults are under-served. Whether it relates to ethnicity, sexuality or any of the other protected characteristics there will be further inequalities, i.e. under-served populations within an under-served population.

For those newly interested in these broad areas of clinical data, quality improvement and population health, where is a psychiatrist to start? The answer, as ever, depends on the question being asked. Enter Dr Geraldine Strathee who will likely be known to most of us from one of her many roles,

including as National Clinical Director for Mental Health (2013-2016). Her presentation 'From board to floor & floor to Board: What Information is at your fingertips to improve care?' pointed us all in the right direction with great enthusiasm. Figure 2 summarises the main data sources, with a slant towards older adults (apologies to colleagues in the Devolved Nations that this information relates primarily to an English context).

It was clear the General Adult Faculty have made accessing and using the right data at the right time a priority. They seek to understand systems and to form a nuanced understanding of capacity and demand. The Old Age Faculty and its members are rising to the same challenges.

In an NHS with finite resource, what would be the consequence for our patients and our services if other faculties got this right, but we did not? What would be the consequence if 'physical health' mastered this but mental health services lagged increasingly behind?

