

**Old Age Psychiatrist Newsletter of the Old Age Faculty of the Royal College  
of Psychiatrists**

**January 2017 Issue 67**

**Editorial Team: Helen McCormack, Sharmi Bhattacharyya, Anitha Howard, Ayesha  
Bangash**

**Old Age Psychiatrist (67) 2017**

**CONTENTS**

**EDITORIAL**

Update from the Editorial Team, Helen McCormack.....	3
Update from Alistair Burns, National Clinical Director for Dementia and Older People's Mental Health .....	4
Update from Amanda Thompsell, Chair of the Old Age Faculty.....	7

**NEWS**

Stop Press, breaking news for Trainees, Old Age Liason Psychiatry.....	10
International Psychogeriatric Association , Call for new members.....	11

**FEATURES**

Collaborative Working across continents to develop holistic services for Older People in India. Sujoy Mukherjee, Gautam Saha, Amanda Thompsell and Sharmi Bhattacharyya.....	12
Noise making in dementia: has a remedy been found? Ayesha Bangash and Ather Malik.....	13
Dementia Simulation Programme. Alister Gomes-Pinto, Pamela Jenkins, Sharon Sorungbe and Natalie Bayley.....	17
Social care for older people – Home truths. Mella McCarthy and Martin Curtice.....	20
Co morbidity and Polypharmacy in Dementia - Time for Action? Fiona Clague and Bruce Guthrie....	23

**INTEGRATION**

Integration of Care and its impact on Older Peoples Mental Health, Faculty Report. Helen McCormack .....	26
--	----

**BOOK REVIEWS**

Beloved old age and what to do about it: Claire Hilton.....	29
The Hundred Year Old Man Who Climbed out of the Window and Disappeared. Arogunmati OA.....	31
Elizabeth is Missing. Matthew Devlin .....	32

**FILM REVIEW**

Barney's Version (2010). Thomas C. D. Lewis.....	33
--	----

**PLEASE KEEP WRITING FOR THE NEWSLETTER**

Tips on writing for <i>Old Age Psychiatrist</i> , : Editorial Team, Old Age Psychiatrist. ....	34
--	----

**Update from the Editorial Team, Helen McCormack**

**[helenjmccormack@hotmail.co.uk](mailto:helenjmccormack@hotmail.co.uk)**

In this edition of the Old Age Psychiatrist, there is a real mix of important announcements, thought provoking features, and book and film reviews for whiling away the winter evenings.

There is some good news for trainees in our Stop Press announcement that the GMC has now approved Old Age Liaison Psychiatry. You will find there a link providing you with more information.

There is a flyer from the International Psychogeriatric association, 'a community from all around the world to discuss, learn, share and research information about behavioural and biological aspects of geriatric mental health.' One of our features in this edition explores the theme of collaborative working across continents as an illustration of this in action.

The latest Faculty's report, 'Integration and its impact on Older People's Mental Health', has now been published. It was officially launched at the joint Old Age Psychiatry and British Geriatric Society Conference on November 7th. We publish here an executive summary, with a link to the full report, which we would urge you to read, and to share widely. We would welcome responses or comments, and for anyone who has been working to provide innovative integrated services in their area, we would love you to share your experiences by sending us an article.

The newsletter held a writing competition on the theme: "Old age psychiatry: how I see it 20 years from now" with the deadline for entries being 30th November 2016. Twenty six impressive entries ranging from poems to short stories were received. The judges were Dr Claire Hilton and Dr Susan Benbow (consultant psychiatrists) and Mike Maran, playwright. Fifteen entries short-listed by the editorial team were submitted to the judges for the selection of the top five including the winner and runner-up. Dr Amanda Thompsell will award the winners with cash prizes at the Faculty of Old Age Conference to be held in March 2017. The top five entries will be published in the May edition of the *Old Age Psychiatrist*.

We have a feature article on Noise making in Dementia, a common, but little understood, symptom in people who have dementia. A review article gives a great summary and evaluation of the report "Social care for older people – home truths", and we have a description of the use of dementia stimulation in Avon and Wiltshire. The second of our articles from the BGS, Co morbidity and Polypharmacy in Dementia, is particularly relevant to our practice. We hope you will find these features interesting and relevant to your practice.

For a different perspective on your work, we have a range of book reviews for you, and , in this edition , for the first time a film review. We hope you enjoy the recommendations, and that your reading is both educational and thought provoking.

As always, we welcome your feedback, and submission of articles for publication in future newsletters. You will find 'Tips for Writing' at the end of the newsletter.

### **Update from Alistair Burns**

#### **NHS England's National Clinical Director for Dementia and Older People's Mental Health**

The implementation of the 5 Year Forward View for Mental Health continues apace with significant investment announced for child and adolescent mental health, perinatal mental health and general adult psychiatry. Whilst older adults are included in many of the general psychiatry initiatives, there is little specific mention for our patients. However, in terms of improving access to psychological therapies (IAPT) hospital inpatient liaison and A&E, there is no doubt that much of the work will be relevant to older people.

Therefore, we all have a crucial role in making sure that these streams of work take into account the needs of older people, lest they fall behind. For example, some 12 percent of IAPT activity would reasonably be expected to be with older people but the figure is around 6%. Contrary to popular opinion, older people engage with IAPT well and recovery rates are in fact better than younger people.

I sense there is general support for age appropriate services to be provided but one of the challenges is to realise that investment specifically.

The older person's depression CQUIN was not supported in its current form and we are exploring alternatives and options here.

The Age UK report 'Hidden in Plain Sight' (reference below) has been very effective in raising the profile of older people's mental health and has four (a very manageable number) of key recommendations. These are:

- Implementation of Mental Health Taskforce recommendations should include a work stream dedicated to meeting older people's mental health needs. This should include ensuring wide use of the new CQUIN for depression in older patients.
- Local health and care commissioners should fully understand the prevalence of common mental health conditions among the over 65s in their areas.
- Each clinical commissioning group and local authority should consider appointing "older people's mental health champions".
- All services should be appropriately funded and equipped to deliver fully integrated care that addresses mental and physical health and comorbidity.

Learning from work with dementia, I think it is fair to say that focussing on particular areas was a key to success and most people to whom I have spoken have agreed that concentrating on depression in older people is the right strategy. The parallels between depression and dementia are interesting – both are under treated, under diagnosed, and often attract therapeutic nihilism. Depression is also associated with loneliness which carries the same morbidity and mortality as smoking 15 cigarettes a day.

A link between the two would be to concentrate on the carers of people with dementia, most of whom are elderly themselves and a significant proportion have depression and anxiety.

In August 2016, the Clinical Commissioning Group Improvement and Assessment Framework was launched, a powerful initiative, which concentrates on measures across six clinical priority areas - mental health, cancer, diabetes, children/maternity, learning disability and dementia.

The two measures for dementia are the diagnosis rate and a measure of care planning as recorded in the Quality and Outcomes Framework (QOF). It is helpful that the discussion on dementia is now moving forward to encompass not just diagnosis (and diagnosis rates) but post diagnostic support as well. We will shortly be publishing guidance on care planning.

If you get a chance, look at your local Sustainability and Transformation Plan (STP's) and see if it includes mental health/dementia – several are majoring on dementia and there is a great opportunity to become involved.

We are producing a Right-Care document giving two scenarios of dementia which will be properly costed, work on an access standard for the diagnosis and treatment of dementia is being developed (more next time)

The Dementia Intelligence Network information on dementia has a range of robust measures across the Well Pathway (preventing well, diagnosing well, supporting well, living well and dying well). This is available at <https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>.

Of course, there is the disappointing news that Solanezumab did not reach its primary clinical endpoints which may give rise to discussions about the amyloid hypothesis of Alzheimer's disease and encourage studies to look earlier in the illness.

Finally, it was a pleasure to be at the UK Dementia Congress on the third of November 2016 and to be one of the presenters of the Dementia Awards that evening. Congratulations to Sube Banerjee and the team at Brighton Medical School for the award winning work around raising the profile of dementia with medical students.

Attached is the picture for this issue, an image taken at the event picturing me next to Russell Grant (that's me on the left). Russell told a moving story of his personal experience of a family member with Alzheimer's disease and he now dedicates around a third of his time to raising the profile of the condition.



This issue's quiz is:

What star sign am I?

- A) Sagittarius
- B) Taurus
- C) Cancer

As I have said before, there are lots of opportunities, it is still a great privilege to go around the country and talk with individual clinicians and to see their service work at first hand. Please write to me ([Alistair.Burns@nhs.net](mailto:Alistair.Burns@nhs.net)) with any thoughts, comments or invitations.

Reference

[http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Policy/health-and-wellbeing/Hidden\\_in\\_plain\\_sight\\_older\\_peoples\\_mental\\_health.pdf?dtrk=true](http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Policy/health-and-wellbeing/Hidden_in_plain_sight_older_peoples_mental_health.pdf?dtrk=true)

Alistair Burns

National Clinical Director for Dementia, NHS England

Professor of Old Age Psychiatry, University of Manchester

**Executive News from Amanda Thompsell, Chair of the Old Age Faculty.**

***A vision for the Faculty***

At the Faculty Executive meeting on 24<sup>th</sup> November 2008 we agreed the following as our four strategic aims:

1. **To increase our profile /voice** when policy or service changes are discussed and to raise the profile within the College and externally so that the Faculty of Old Age Psychiatry is seen as a go to organisation for any matters relating to Older Adults Mental Health.
2. **To improve how the Faculty engages with its members** and help ensure member retention.
3. **To identify and mitigate the current barriers to improving recruitment** within Old Age Psychiatry with attention across all levels of training, aiming to improve recruitment rates, to at or above those currently seen in the most popular specialities in Psychiatry.
4. **To increase awareness of mental health conditions in older people** focusing firstly on depression.

The Executive brainstormed an impressive range of ideas for moving forward with each of these aims and we chose our two best ideas for each aim. I am looking forward to telling you how we have got on with these.

Meanwhile, we have not been standing still and we have made progress on all these fronts over the last 4 months:

***Raising profile***

We have had meetings with Age UK, the Centre for Ageing Better, the Mental Health Foundation, the British Association for Counseling and Psychotherapy, the British Geriatrics Society and the Royal College of General Practitioners and the Alzheimer's Society where we discussed raising the profile of older people's mental health and made these organisations aware of the Faculty and its priorities.

Internationally, we have joined the European Geriatric Psychiatric Association which means that members of the faculty can have reduced access to their conferences. We have endorsed a position statement by the Australian and New Zealand faculty of Old Age Psychiatry which focuses on work force and training. We have also been in contact with the Indian Psychiatric Society and we are looking into possibly looking at opportunities to be involved in training.

***Engaging with members***

We have also now got our own Twitter page follow us at @RCPsychOldAge

However, along with the newsletter our pages on the College website remain the key means of communication and we have been revamping these pages for a better look and to make the information more accessible. However, this is still work in progress and we are going to look to increase the amount of useful information available.

We have also been accepted as a pilot for the communications department at the College to help us with our messaging.

On behalf of our members we have been working with Geraldine Strathdee (the lead of the National Mental Health Intelligence network) and the College with regards to older peoples' outcome measures and the new Commissioning structure that is coming in to force. These are changes that could shake up the way that our services are commissioned and paid for and it is important that our members have a voice in this.

### ***Improving recruitment***

We ensured that we were represented at the College recruitment day and have been busy developing the curriculum for older adult trainees to fit with the forth coming new GMC guidelines.

In the longer run we think it is important to highlight to students the exciting developments occurring in our field. Our newly appointed "New Therapies" lead attended a meeting on the role of biomarkers in assessment and diagnosis of pro-dermal and early dementia in September in Edinburgh.

### ***Increasing awareness of mental health conditions in older people***

We have been working with NHS England on an older people's mental health primer which should be going out to GPs soon focusing on mental health of older people.

We have also made sure that we have been involved in numerous initiatives emanating from a wide range of bodies:

- We supported Age UK's report on Hidden In Plain Sight - The Unmet Mental Health Needs of Older People
- We published our report on Integration at the highly successful joint BGS /Faculty in November conference.
- We inputting into the Older People's Mental Health expert advisory group which is a forum to advise NHS England on current developments particularly in relation to raising the profile of Older People's mental health.
- We are starting to review and update College Report 153 which looks at transitions between services.
- We have put in submissions on behalf of the Faculty to The House of Commons Suicide Prevention enquiry and to the enquiry in to Adult Social Care.
- We have also had input to The Law Commission into the DOLs legislation review. We have responded to over 23 NICE guidelines and inputted into HEE's mental health workforce strategy.
- We have been advising on the reading friends project to reduce isolation and support older people by engaging a reading activity and liaising with the Liaison faculty about how the transformational liaison money will be used .



- We have been to a roundtable discussion at the House of commons on GP led holistic reviews  
We are advising on guidance for people who have dementia who are undergoing anaesthetic procedures.
- We have reviewed and endorsed the Alzheimer's Society dementia guide for families and attended the **launch** of the Pan-**London Dementia Action Alliance** at **City** Hall.

So in summary – we have been pretty busy! I want to use this opportunity to thank all the members of the Executive for their hard work over 2016.

We exist to promote the interests of our speciality and its members so that we can improve the lives of older people with mental illness and their carers. If any of you have any ideas about what we should be doing or want to bring an issue to my attention, please get in touch via the website. Meanwhile I wish all our Faculty members a Happy New Year .

Amanda

***STOP PRESS, Breaking news for trainees!***

***Excellent news for old age trainees who wants endorsement in liaison psychiatry. The GMC has formally approved old age liaison psychiatry. To gain endorsement you need to be in old age liaison post for a year and meet the liaison curriculum.***

***Your supervisor does not need to be endorsed in liaison psychiatry but should have CCT in old age psychiatry and is recognised by the GMC as clinical/educational supervisor .The local Head of School (via ARCP) will then need to confirm whether they have the appropriate skills. A supervisor without an endorsement is expected to have been in a liaison post at least a year before supervising higher trainees in a liaison placement. The policy is explained at this link:***

***[http://www.rcpsych.ac.uk/pdf/Specialty\\_training\\_FAQs\\_24-06-16.pdf](http://www.rcpsych.ac.uk/pdf/Specialty_training_FAQs_24-06-16.pdf) (Question 22)***



International Psychogeriatric Association  
Better Mental Health for Older People

IPA NEEDS YOU! 

#### About IPA

The International Psychogeriatric Association (IPA), founded in 1982 and representing members in more than 50 countries, is a unique and diverse professional healthcare community promoting better geriatric mental health – across disciplines, across borders, and across geriatric issues. Psychiatrists, scientists, neurologists, geriatricians, primary care physicians, epidemiologists, nurses, psychologists, occupational therapists, social workers, and many other healthcare professionals come to the IPA community from all around the world to discuss, learn, share and research information about behavioral and biological aspects of geriatric mental health. IPA promotes research and education, facilitates an international exchange of ideas, and fosters cross-cultural understanding of the latest developments in the field.

#### IPA Membership

The International Psychogeriatric Association (IPA) encourages professionals from all backgrounds related to geriatric mental health to join our healthcare community. Here are some of the many benefits of joining IPA:

- Unique opportunities to interact with colleagues around the world who share an interest in advancing research, education, and theory about mental health care in older adults.
- Valuable discounts on participation in education and scientific meetings which reflect the full spectrum of disciplines related to psychogeriatrics. Reduced registration rates for the annual IPA International Congress and IPA Regional Meetings are included.
- Relevant publication on updates in the field, including *International Psychogeriatrics*, IPA's peer reviewed journal which publishes twelve issues per year and additional special-focus supplements.
- Access to online educational materials and *The IPA Complete Guides to Behavioral and Psychological Symptoms of Dementia (BPSD)*.
- Subscription to the *IPA Bulletin*, IPA's newsletter which features articles on advances in the field and information on upcoming programs around the world.
- Participation in the IPA Member Forums – smaller member groups which enable members to connect with one another and collaborate on research and clinical care practices. These forums reflect the diversity of interests within geriatric mental health.

#### How to Join

To learn more about IPA and become a member, please visit our website: [www.ipa-online.org](http://www.ipa-online.org). IPA offers a one-year membership for \$160 USD. One-year student or retired memberships are available for \$99 USD. A limited number of Lifetime Memberships are also available for \$1000 USD. The IPA Secretariat is available to answer any questions you may have about IPA or membership. Please contact us at +1 414 918 9889 or by email at [info@ipa-online.org](mailto:info@ipa-online.org).

#### Have Questions? Contact us!

International Psychogeriatric Association  
555 East Wells Street, Suite 1100  
Milwaukee, WI 53202  
United States  
Phone: +1 414 918 9889  
Fax: +1 414 276 3349  
Twitter: @IPA\_Online  
[www.ipa-online.org](http://www.ipa-online.org)  
[info@ipa-online.org](mailto:info@ipa-online.org)



## FEATURES

### **Collaborative Working across continents to develop holistic services for Older People in India.**

Dr Sujoy Mukherjee, Dr Gautam Saha, Dr Amanda Thompsell and Dr Sharmi Bhattacharyya

Globally and specifically in India the older adult population is increasing fast with a predicted 12% increase by 2020. Life expectancy has also doubled from 1946 to 2011. Welfare of older adults has been a low priority for the Government and there are almost nonexistent geriatric care facilities. Elder abuse also remains a hidden problem. Evidence shows that 10% of older adults in India suffer from depression and 40-50% of older adults require psychiatric intervention.

Since 1999, the government in India has attempted to improve Older people's care by bringing in statutory legal requirements such as a National policy for older people and Maintenance of parents and Senior citizens Act (2007). More recently the National Programme for the Health care of Elderly (NPHCE) was launched in 2010 specifically for those aged over 60 to improve and develop both physical and mental health services for older adults in India. This policy although still in its infant stages has been positive in supporting development of 8 Geriatric Regional centres and other important aspects of holistic care for Older people although progress has been very slow. On a positive note there is now post doctorate (DM) training available in Geriatric Psychiatry in Lucknow.

An initial project group meeting was set up in August 2016 with representation from Royal College of Psychiatrists (RCPsych) U.K., British Geriatric Society and Indian Psychiatric Society. The aim was to develop support to improve holistic care for working with older people in India. Interesting discussions were held around the challenges facing this collaborative and joint working including focused training needs and being able to approach the right level and grade of staff. Influencing the government to raise the profile of this population and its needs was also suggested. There are many challenges to working across continents due to differences in service and care models and the cultural differences to approaching care. A recent report by Royal College of Psychiatrists, Faculty of Old Age highlight that integrated care models are beneficial to patients although may not be cost effective. There are excellent examples of collaborative working already in place with Memory services being developed in Nepal and BGS doing work with clinicians in Taiwan.

The Intellectual disability Faculty of the RCPsych has long experience of delivering bespoke training in India. One suggestion was to consider encouraging participation in the Diploma in Geriatric Medicine to support training for Senior Clinicians. There was also the suggestion of developing basic holistic Old Age psychiatry training for clinicians at primary care level but it was acknowledged that there would need to be greater clarity on the training needs before this could be developed further. The possibility of speakers from the Old Age Faculty speaking at their annual conference in January to raise awareness of older people was also discussed.

The challenges are many - cultural, demographic and organizational however the meeting was an exciting stepping stone to start off links between the two countries to support development of holistic care for older adults in India.

Colleagues are invited to contact Dr Sujoy Mukherjee on [Sujoy.Mukherjee@wlmht.nhs.uk](mailto:Sujoy.Mukherjee@wlmht.nhs.uk) if they have suggestions.

#### **Attendees**

Dr Gautam Saha, Honorary General Secretary, Indian Psychiatric Society

Dr. Amanda Thompsell, Chair, Faculty of the Old Age Psychiatry, Royal College of Psychiatrists

Professor David Oliver, President, British Geriatric Society (BGS)

Mr Colin Nee, Chief Executive, British Geriatric Society (BGS)

Dr Apurba Chatterjee, Consultant Geriatrician & Clinical Lead, Royal Berkshire NHS Foundation Trust

Dr Kaushik Mukhopadhyaya, Consultant Old Age Psychiatrist & Medical Director, Hertfordshire Partnership University NHS Foundation Trust,

Dr Sharmi Bhattacharya, Consultant Old Age Psychiatrist (North Wales) & Joint Editor, Faculty of Old Age Newsletter

Mr George Fraser, International Division, Royal College of Psychiatrists

Dr Sujoy Mukherjee, Consultant Psychiatrist and Executive Committee Member, Faculty of Old Age Psychiatry.

#### **Noise making in dementia: has a remedy been found?**

Dr Ayesha Bangash, ST5 old age psychiatry, Dr Ather Malik, consultant in old age psychiatry,

Coventry and Warwickshire Partnership Trust

Inappropriate vocalization is a term that was first documented by Alois Alzheimer in 1906 when Auguste Deter, the first person diagnosed with Alzheimer's disease, used to scream. Inappropriate vocalization is now more commonly referred to as disruptive vocalization, vocally disruptive behaviour, verbal agitation and even noise making. It includes all types of disturbing or unacceptable vocal expression. The list is not exhaustive but includes moaning, crying, complaining, screaming, repetitive speech, chattering, and singing <sup>1,2</sup>.

The prevalence of disruptive vocalization varies between 10 to 40 percent in nursing home patients with dementia in general. It is the most difficult behavioural expression to manage second only to physical aggression<sup>3</sup>. It is especially problematic in nursing homes where even one disruptive vocalizer can cause distress among caregivers, residents and visitors. It is hard for others to comprehend the interactional significance of the noise and nearly impossible for the vocalizer to help in giving them a meaning. Thus it is important to understand this problem. Unfortunately, explanations for the occurrence of disruptive vocalization still need to be established<sup>4,5</sup>.

### **Causes of disruptive vocalization**

Noise making could be attributed to advancing frontal lobe damage or interruption of the complex subcortical circuits. Damage to orbitofrontal structures leads to disinhibition and damage to dorsolateral prefrontal structures leads to deficits in decision making. Studies also suggest that disordered serotonergic systems can lead to dysregulation of vocalizations via disruption of impulse control<sup>6,7</sup>.

There are several interpretations of vocalizations; in individual residents different causes may be applicable at different times. They include lack of autonomy and humiliation when receiving care. Utterances can express dissatisfaction with a situation or aspects of care, unmet needs, sleep deprivation, thirst, hunger or unhappiness over changes in room temperature. "Sun-downing" has been associated with the time of evening when visitors come and go and nursing shifts change leading to patients becoming verbally agitated. Deaf and/or blind patients can cry out due to being under-stimulated or even frightened. The problem is aggravated when they fail to realise the volume of their vocalisations. Vocalizations may provide a source of self-stimulation and even a form of self-soothing to compensate for the low sensory input in nursing homes<sup>1,8,9</sup>.

Pain, physical illness, confusional states, and psychosis can lead to vocalizations. It is not fully clear as to whether depression causes DV or vice versa. However, it is possible that disruptive vocalizations leading to avoidance by residents and staff could lead to depression<sup>7</sup>. Patients could be suffering from post-traumatic stress disorder in that they are possibly reliving war experiences or abusive relationships. The vocalizations of those with Cluster B personality disorders (borderline, histrionic, narcissistic, antisocial) can reflect an underlying difficulty with being left alone and thus they appear to be attention-seeking in nature<sup>6,7</sup>.

Screams (considered to be the commonest form of verbal agitation) that cannot be deciphered are often found in the end-of-life stage. It has been noted that patients with severe cognitive impairment and physical impairment have a high probability of dying within the subsequent 6 months<sup>9</sup>.

### **Treating disruptive vocalization**

Various types of interventions have been evaluated:

#### Pharmaceutical treatments:

Medication should be used when all other options have been tried. Low serotonin levels have been associated with lack of impulse control thus providing a rationale for using medications with serotonergic properties such as SSRIs and trazodone. Some studies suggest that SSRIs can be useful even when depression is not suspected<sup>2</sup>.

#### Non-pharmaceutical interventions including psychosocial interventions and environmental modifications:

Positive reinforcement used during periods of calm behaviour has shown varying results. Any behaviour other than disruptive vocalization was reinforced socially or with food or music<sup>9</sup>.

Singing, teddies, rocking beds/chairs and one-to-one interventions by staff can help. Music, based on a patient's preference, can be useful especially if it is of the classical, traditional or religious type<sup>10</sup>. Reducing noise levels or increasing the amount of time spent in communal areas may help.

An amplifying device has proven helpful in reducing screaming in hearing-impaired patients thus making them aware of the volume of their noise-making. "White noise" helps, for example patients were quieter while in the hairdressers or listening to audiotapes of gentle music<sup>1</sup>.

Reminiscence therapy, validation therapy, "snoezelen", aromatherapy, light therapy, animal therapy, massage and exercise can be useful<sup>2</sup>.

#### Use of multiple interventions:

Due to the complexity involved in understanding behaviours and the difficulty in achieving any improvement multiple interventions can be tried concurrently. Such interventions should be tried after following individual assessment and identification of the likely meaning of the screaming. This technique can help if it is applied consistently<sup>9</sup>.

However, most of the evidence surrounding the management of disruptive vocalization is weak considering that it is mostly derived from case studies which leaves us uncertain of the generalization of results. Interventions have been proved to be unsuccessful or the effect lasted for as long as the intervention lasted. The "one-syndrome one-treatment" model of research may not be particularly effective as it ignores the complexity of behaviour associated with dementia which is believed to be influenced by a combination of issues ranging from disease progression to environmental factors<sup>11,12</sup>.

#### **Potential avenues for research**

There have been no controlled studies of antidepressant use in disruptive vocalization despite the frequent association with depression. There are no studies that report the use of mood stabilizers, sedative/hypnotic agents or benzodiazepines. It has been seen that vocalizers tend to receive less analgesia compared to other patients in long term care. A validated tool to assess pain in the cognitively impaired and non-communicative patients is needed<sup>1,8</sup>.

The expertise of families and caregivers has been given little consideration for research. Action research involving families and caregivers could produce interventions more attuned to the complex reality of daily life in care homes as well as develop interventions to help those exposed to the behaviours such as fellow residents. Studying disruptive vocalization as part of the interaction between patients and carers could help describe or investigate the functions of vocalizations. Even disruptive vocalization in the absence of anyone else's presence could be seen as part of interaction, either as a result of termination of interaction or leading to interaction as a result of the vocalization<sup>5,9</sup>.

Studies on interventions aimed at modifying the environment seem to provide strong evidence and could benefit from more research including the use of quasi-experimental designs. The association between disruptive vocalization and end-of-life deserves to be explored more fully. Studies of the epidemiology and natural history are needed. Unanswered questions include whether disruptive vocalization predates more challenging behaviours<sup>6,9</sup>.

### Until we have a stronger evidence base...

In essence, one needs to adopt a trial and error approach. Most cases are highly idiosyncratic and need approaches suited to a particular individual. Disruptive vocalization often signals the appropriateness of a hospice-type approach to management<sup>6</sup>.

Due to financial constraints and staff shortages interventions must be easy to use and inexpensive. Family and volunteers could augment staff time whenever possible. Community psychiatric nurses can provide support. Progress notes and behavioural charts also provide useful information. Assessment of a caregiver's levels of distress could be considered to be an important constituent of a practice guideline. Interventions can be accompanied by a staff management system that involves ongoing performance monitoring and feedback. Effective leadership along with regular support to caregivers is needed.<sup>6,13</sup>.

Information regarding personality traits (which remain stable throughout adulthood and moderate stages of dementia) and past experiences can be used as a guide to help provide a range of recreation activities for individuals. Family members and care staff are generally accurate raters of personality. The more contact caregivers have with the person, the better the chances of decoding challenging behaviours<sup>13</sup>. Lastly, the literature emphasizes the importance of creative thinking in overcoming the great challenges in dementia care<sup>4,14</sup>.

### References

1. Barton S et al. The management of inappropriate vocalisation in dementia: a hierarchical approach. *Int J Geriatr Psychiatry* 2005; 20:1180-1186
2. Yosupov A et al. Vocalizations in dementia: a case report and review of the literature. *Case Rep Neurol* 2014;6(1):126-133
3. Palese A et al. The effectiveness of multistrategies on DV of people with dementia in institutions: a multicentred observational study. *J Neuroscience Nurs* 2009;41(4 ): 191-200
4. Fick WF et al. The effect of a lollipop on vocally disruptive behaviour in a patient with frontotemporal dementia: a case study. *Int Psychogeriatr* 2014; 26(12):1-4
5. Hyden LC. Non-verbal vocalizations, dementia and social interaction. *Communication and Medicine* 2011;8(2):135-144
6. Sloane P et al. Management of the patient with disruptive vocalization. *Gerontologist* 1997;37(5):675-682
7. Dwyer D et al. Disruptive vocalization and depression in older nursing home residents. *Int Psychogeriatr* 2000;12: 463-471)
8. McMinn B et al. Vocally disruptive behaviour in dementia. *Ageing and mental health* 2005;9(1):16-24
9. Bourbonnais A et al. screaming in elderly persons with dementia: a critical review of the literature. *Dementia* 2008; 7(2): 205-225
10. Casby J et al. The effect of music on repetitive DV of persons with dementia. *Am J Occup Ther* 1994; 48: 883-889
11. Randall E. What are the relative merits of interventions used to reduce the occurrences of disruptive vocalization in persons with dementia? – a systemic review. *Int J Older People Nurs* 2016;11(1): 4-17



12. Bourbonnais A et al. The meaning of screams in older people living with dementia in a nursing home. *Int Psychogeriatr* 2010; 22(7): 1172-1184
13. Bird M, Moniz-Cook E. Challenging behaviour in dementia: a psychosocial approach to intervention. In: Woods B, Clare L, editors. *Handbook of the clinical psychology of ageing*. United States: John Wiley and Sons; 2008: 571-594
14. Kolanowski AM et al. *Ther Recreation J* 2001;35(3):220-235

### **Dementia Simulation Programme**

Alister Gomes-Pinto, Registrar in Old Age Psychiatry, Pamela Jenkins, Senior Liaison Nurse, Sharon Sorungbe, Occupational Therapist, Natalie Bayley, Liaison Nurse

Avon and Wiltshire Mental Health Partnership NHS Trust

#### **The challenge**

Dementia is an increasingly recognized condition affecting people over the age of 65. One of the complications of dementia which can result in hospital admission is BPSD (behavioural and psychological symptoms of dementia). Professor Sube Banerjee described these as 'agitation, aggression, wandering, shouting, repeated questioning and sleep disturbance' in his 2009 Report, Time for Action (1). BPSD can also develop as a complication of conditions which can precipitate a delirium or acute confusional state, such as infection.

Based on our experience of caring for people with dementia we would describe BPSD as the communication of an unmet need, and if that need is understood then the behaviours in theory will reduce.

#### **The survey**

Last year we surveyed staff members of all healthcare backgrounds working at a geriatric unit in the Royal United Hospital (Bath), to capture their views about how they would respond to various BPSD scenarios. Out of the 15 staff members who completed the questionnaire: 53% of staff surveyed did not feel confident in managing BPSDs, 60% said they would not know how to manage situations involving patients searching for a deceased relative, and 33% stated they would not be able to stop a patient from absconding.

#### **The method**

Blackhall et al (2011) describe a communication framework that could be used by healthcare professionals who come into contact with people who have dementia. The framework is based on four key concepts: validation, emotion, reassurance and activity (VERA). It describes a stage-by-stage process of communication that guides nurses towards providing compassionate and caring responses. (2)

Validation in particular is a concept that was first developed by Naomi Feil. One of the tenets of Validation therapy is this: 'painful feelings that are expressed, acknowledged and Validated by a trusted listener will diminish. Painful feelings that are ignored or suppressed will gain strength.' (3)

Historically simulation has been used in healthcare to teach clinical skills. Simulation fits many adult learning traits and provides an efficient, effective and enjoyable method of educating health and social care staff (4). We undertook a form of dementia simulation using the VERA approach. In the scenario, 'Elsie' is an 84 year old lady who has dementia and is trying to leave the ward. A 'member of staff' asks if she can assist in any way. Elsie states she wants to get home to her children to give them their tea.

The staff member asks how old Elsie is, and points out that this means her children must be grown up - which produces an adverse response from Elsie and makes her more agitated. The staff member replies, 'But you kids are all grown up, and don't need your help now.' This makes Elsie more agitated and upset.

Apply VERA here.

'You must miss you children Elsie. Did you used to pick them up from school? What did they like to eat? Let's have a walk and chat about your family and then we can have a cup of tea.' Elsie calms down and her anxiety and distress lessens.

During the group reflection, the feedback suggested that the group initially thought the first approach was acceptable. But then saw how the VERA approach acknowledged Elsie's feelings and entered her reality - demonstrating a caring and compassionate response from staff and enabling Elsie to settle faster.

### **The application**

Six sessions were run from April to June 2016. We came on to the ward to conduct dementia simulation training with staff members of any grade. Two of us would enact a scenario and a third would set the scene and facilitate discussion, with feedback and reflection afterwards involving the whole group. Staff were invited to attend in small groups as training was live on the ward and timed to finish in roughly twenty minutes per session.

Staff were very keen to engage and receptive. Good discussion was generated which further embedded learning and understanding of the need to connect with patients' emotions in difficult situations. Positive feedback was received regarding the concise times of the sessions (short and sharp) which occurred in the workplace, saving time normally wasted in travelling off the ward.

The sessions all ran in the afternoons as this was identified as working better with the routine of the ward.

### **The results**

Nineteen staff members had completed feedback forms in total by the end of the pilot. Of these 63% found the workshop very useful; 74% expected to implement this learning in their work environment; and 63% felt the material covered was relevant to them. 58% felt the content helped them to meet their personal goals/objectives.

A month later the pre-intervention questionnaire was sent out again, and 8 of the 14 respondents confirmed they had attended the training. Of these, 100% stated they had applied the training in practice; 100% indicated that they would recommend the training to others. 88% felt they now knew how to respond to a patient asking for a deceased relative; 75% felt confident in managing the needs of a patient attempting to leave the ward and 71% acknowledged their confidence in managing the needs of a patient with dementia. This represented a clear improvement on previous figures.

One staff member recorded, 'I found the training very helpful, it is good for new staff and good for a refresher.'

#### **What worked well, and what didn't**

Overall, the project was successful after the realization that it was good to have a contact on the ward who could liaise with ourselves, take on the organization of the project within the ward and make entries in the ward diary. In this case the link person was a junior ward sister.

It was difficult at times for us to synchronize our own schedules due to conflicting commitments. In the end we resolved the issue by announcing our availability in advance.

Difficulty was experienced at times due to clinical demands on attending staffs' time. The project was also postponed for a period of a few weeks due to the lead ward sister being off with sickness.

We realized we needed to be flexible in order to meet the needs of the ward. There was a need as well to be creative and adaptable in the locations where the sessions occurred.

Generally we enjoyed delivering the sessions and being part of the pilot. For future pilots we might try to increase publicity by advertising the training in the staff room within the ward environment.

#### **And finally..**

Staff on the pilot ward verbally fed back that this would be a useful exercise on other wards in the hospital.

An account of the pilot and results will be presented to the joint RUH/AWP (Royal United Hospital/Avon and Wiltshire Mental Health Partnership NHS Trust) Operational Committee to see if the project can be replicated elsewhere in the general hospital. There have already been expressions of interest from other wards generated over the course of the pilot.

Training will subsequently be provided to other members of the Bath Mental Health Liaison Team to enable them to undertake future sessions on other wards at the RUH.

## References

1. The use of antipsychotic medication for people with dementia: Time for action. A report for the Minister of State for Care Services by Professor Sube Banerjee (2009)
2. VERA framework: communicating with people who have dementia. Blackhall A et al (2011). Nursing Standard 26, 10, 35 - 39.
3. The Validation Breakthrough: Simple techniques for communicating with people with Alzheimer's-type dementia. Naomi Feil, 1993.
4. Dementia Education and Learning Through Simulation [DEALTS] Resource File. First Edition, 2014

## Social care for older people – Home truths

**Dr Mella McCarthy (Higher trainee in older adult psychiatry, Worcestershire Health and Care NHS Trust)**

**Dr Martin Curtice (Consultant in old age psychiatry, Worcestershire Health and Care NHS Trust)**

The report “Social care for older people – home truths” was published in September 2016 jointly prepared by the Kings fund and the Nuffield trust. Its aim was to better understand how social care for older people in England has fared since the cuts to local authority spending over the past 5 years. It analyses national data and local interviews to get a clearer picture of change and affect. The bleak outlook for the next 5 years is then projected alongside potential strategies for policy makers to consider. This article outlines the salient issues arising from an important report.

### Introduction

The report notes the current social care system is not meeting the needs of older people. Many fear that the entire social care market is at breaking point. Unlike health care in England, individuals must satisfy a means tested needs assessment, and most do not qualify for help. Despite growing demand from an ageing and increasingly complex population public spending on adult social care is expected to fall to less than 1 per cent of GDP. Already, 26% less individuals get help, and increasingly wealth rather than need is steering services. Accessing help remains problematic and the report reminds us of the difficulties older adults and their families still have in navigating our fragmented health and social care system.

The impact of social care cuts on an already strained health care system is visible by increased hospital admissions and growing numbers of delayed discharges in its older adult population. The report also recognises that shortfalls in social care provision will impact families and carers who are not only unqualified but more importantly unprepared. The voluntary sector is heavily relied upon as other services reach capacity, but it too is feeling overwhelmed.

### Structure of the report

The report uses both national and local evidence, including analysis of national trends in adult social care expenditure and activity for older people since 2009/10, related NHS data and trends in

independent sector care provision. Semi-structured interviews of key representatives in local authority, NHS, private providers and Healthwatch provided the local perspective. In addition, the Richmond Group of Charities commissioned 7 older adult/carer interviews to be undertaken to enable insight from a user perspective.

### **The impact on local authorities**

The report states that local government funding has been cut by 37% in real terms since 2010/11 (National Audit Office 2014). Consequently, 80% of local authorities have reduced spending on older adult social care. Despite government strategies such as the “Better care fund” set up to transfer money from the NHS pot to social care there still remains a substantial shortfall. Fewer individuals receive help, with community-based services particularly affected with a 30% reduction in funding, despite the political drive for people to reside longer in their own homes. National projections forecast a “widening gap between resources and needs” (£2.8 billion by 2019).

Locally, authorities have reduced staff numbers, placements, services and most conflictually frozen or reduced fees to the providers. Most interviewees didn't know where to make the further expected savings. Some worried the continued financial squeeze threatened their ability to meet their statutory duties e.g. under the Care Act 2014. There was also concern about the “gradual erosion of prevention strategies”. The report went on to describe future strategies including reallocating the limited resources to those most in need, or decreasing demand for services. One area described returning more autonomy to individuals, encouraging them to take responsibility for themselves and being signposted to community groups and other non-statutory resources. In this way people could potentially put off the need for social services.

### **Impact on providers**

The report describes how care home providers are failing across the country, referring to a BBC Radio 4 program suggesting 28% of care homes are at risk of financial failure. Reduced fees from local authorities play a large part but just as important is the increasing shortfall in recruitment and retention of staff. Although the crisis situation of fees seems to be changing as local authorities readdress their offers, the workforce demand is only intensifying in light of the referendum vote to leave the EU. Around 28% of current staff originated in Europe (the report notes that 266,000 or one in five care workers were born outside the UK). In addition, the introduction of the national living wage in 2015 although widely encouraged has placed even more strain on an already fragile situation. Many providers are fearful of failing to meet expected regulatory standards under these pressures.

More successful homes have begun to charge higher fees to self funders, sometimes by as much as 40%, to make up the deficit. This has led to a polarisation of the market where providers in affluent areas are doing better than those in areas reliant on local authority placements. Homecare providers are most affected.

The increasing complexity of clients has also meant current provisions are often inappropriate. Some providers explained how they have survived by shaping market developments, changing their

business model or up-skilling staff. Others have changed their admission processes to accept more NHS and self-funders who come with more money than offered by the state.

### **Impact on older people and their families and carers**

The report documents that 26% less older people are now receiving state funded care. Yet it was unable to discover what happens to those ineligible for public funding. Instead the report cites that more than a million older people who have difficulty with basic daily activities such as washing or dressing are not getting the help they need. This accounts for an increase of over 100,000 people in just 1 year. Interestingly, national surveys reveal that 90% of older people who are still funded by local authorities remain satisfied with the care they receive. This is in contrast to increasing complaints to the ombudsmen. Carers however, despite the expectations for their better support since the Care Act 2014, are less happy (74% satisfied).

### **The impact on the NHS**

The report evidenced increases in both older adults' admissions to, and 'delayed discharges' from, hospitals as costing £820 million per year (National Audit Office 2016). Older adults account for the most bed days (62% of all hospital bed days) and also the longest stays in acute hospitals (52% of admissions that involve hospital stays of seven or more days). However, the social care cuts are only one of many contributing factors.

The report opines that increased hospital admissions reflects demographic changes with growing frailty and more complex presentations as individuals have been encouraged to stay in their own homes longer. Reduced numbers of primary care and community beds also contribute to this. There has also been a decrease in relative numbers of GPs and district nurses.

### **Discussion**

The report concludes that the changes affecting health and social care will inevitably make it harder for older people to get the right care, in the right place, at the right time. This in turn will risk older people spending more time in acute hospitals or in long-term care, which will perpetuate financial and service pressures. The truth is that older people will not be fairly treated, care will be provided to people who can afford it rather than according to need. Expectations on families and carers will continue to increase, overwhelming all involved.

The report noted that providers are already failing, and there's a real fear that the entire social care market is at risk from collapse. The 2014 Care Act was described as too ambitious; just 2% of local authorities feel confident of being able to meet their statutory duties in 2019/20 and carers have noticed "little change". There is no further clarity on the situation faced by older adults ineligible for funded care, yet the gap between demand and supply is projected to reach £2.8 - £3.5 billion by the end of this parliament.

### **Strategies for the future**

The report discusses the challenges ahead in reshaping the social care system. Can more be achieved with less? Perhaps, with better management of demand, promoting independence, better

commissioning and procurement and implementing models of integrated care. However, there has been limited success so far with such approaches. One fundamental concern is that there is no clear strategy to improve the workforce capacity for both health and social care which is only going to intensify. An alternative suggestion is for an entirely new offer of transferring responsibility onto individuals, families and communities. However, the concern with this strategy is how to prepare the public. There may also be increasing levels of conflict between individuals, professionals and organisations about who should pay.

This report gives a truly valuable insight into the impact of austerity on older adult social care. By including interviews with key professionals and older adults themselves, it paints a picture of how cuts have already changed services and individuals lives. Anyone concerned for the future of older adults should be serious about the somewhat bleak projection emanating from this report.

**Take home messages from this report:**

- Social care for older adults is failing
- Older adults are living longer with more complex needs, yet the gap between need and resources is growing with no clear plans to improve.
- Care providers are already failing as they cannot meet the increasing demands
- Local authorities are struggling to fulfil their statutory requirements
- The report concludes that a “frank and open debate is needed on how to fund health and social care on a sustainable basis into the future”.

**References**

National Audit Office (2014). *Financial sustainability of local authorities 2014*. HC 783. London: The Stationery Office. Available at: [www.nao.org.uk/report/financial-sustainability-of-local-authorities-2014/](http://www.nao.org.uk/report/financial-sustainability-of-local-authorities-2014/)

National Audit Office (2016). *Discharging older patients from hospital*. HC 18. London: The Stationery Office. Available at: [www.nao.org.uk/report/discharging-older-patients-from-hospital/](http://www.nao.org.uk/report/discharging-older-patients-from-hospital/)

Social care for older people – Home truths (2016)  
[https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Social\\_care\\_older\\_people\\_Kings\\_Fund\\_Sep\\_2016.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf) (accessed on 9th November 2016).

**Co morbidity and Polypharmacy in Dementia - Time for Action?**

Reflections on a recently published article in Age and Ageing by Clague et al. (2016)

Dr Fiona Clague, Clinical Psychologist, Perth Area Psychological Therapies Service, Murray Royal Hospital, Perth PH2 7BH.

Prof Bruce Guthrie, GP & Professor of Primary Care Medicine and Head of Population Health Sciences, Dundee University

## The context

Populations are ageing across the world, leading to increasing numbers of people surviving to develop dementia, many of whom will have complex care needs.

"Today, 47 million people live with dementia worldwide, more than the population of Spain. This number is projected to increase to more than 131 million by 2050, as populations age. Dementia also has a huge economic impact. The total estimated worldwide cost of dementia is US\$818 billion, and it will become a trillion dollar disease by 2018."

World Alzheimer Report 2016    Alzheimer's Disease International (1)

Previous studies have had mixed findings as to whether people with dementia have more health conditions or use more medications than others of the same age, although such studies have often been small or have been based on highly selected samples (2, 3). Our study analysed numbers of comorbid health conditions and medications in a sample drawn from 314 Scottish general practices of 291,169 people over 65, of whom 10,258 (3.5%) had a dementia diagnosis recorded, making this one of the largest population analyses carried out to date.

## What did we find?

People with dementia had higher numbers of comorbid conditions (mean number of conditions 2.9 vs. 2.4;  $p < 0.001$ ). After adjustment for age and sex, people with dementia were more likely to have five or more physical conditions (not including dementia) and to be on five or more repeat prescriptions. Parkinson's disease, epilepsy and constipation had the highest relative prevalence among people with dementia compared to controls. Our results rely on the recording of "diagnosed" dementia and may underestimate comorbidity, for example among residents in long term care with "known" but not formally diagnosed dementia.

People with dementia were also prescribed larger numbers of medications than age and sex matched controls (mean number of repeats 5.4 vs. 4.2;  $p < 0.001$ ). Over half of those with dementia were on five or more repeat prescriptions with 43.2% on five to nine repeat prescriptions compared to 32.4% of controls and 14% on ten or more compared to 8.4% of controls.

Others have found that increased comorbidity and polypharmacy are both associated with increased cognitive and functional decline (4,5), in addition to possible associations between higher levels of medication use and increased mortality (6). A study of US claims data indicated that, when illness burden is controlled for, the care costs of patients with dementia may be up to 34% higher than those of aged matched controls, where medication is the main reason for cost difference (7). Previous work using our Scottish dataset has shown that people with dementia are seventeen times more likely to be prescribed an antipsychotic and twice as likely to be prescribed an antidepressant or a hypnotic/anxiolytic than older people without dementia (8).

## Implications

These findings highlight the importance of effective multidisciplinary integration between specialist and non-specialist services. People with dementia have many other care needs, making it important



that their other care needs are accounted for by specialist dementia services, and that their dementia is accounted for by other services. Supporting primary care is a key role for specialist services, both by providing specialist care on referral, and to provide advice and education.

The findings support growing international consensus about the care needs of people with dementia.

"Healthcare for people with dementia needs to be:

- Continuous: treatment options, care plans and needs for support must be monitored and reviewed as the condition evolves and progresses.
- Holistic: treating the whole person, not single conditions, organs or systems and mindful of that person's unique context, values and preferences.
- Integrated: across providers, levels of care, and health and social care systems"

World Alzheimer Report 2016    Alzheimer's Disease International

Polypharmacy in particular needs careful review, since people with dementia will often (but not always) have lower expected benefit from preventive medications and are usually at higher risk of harm, making it important to minimise overmedication in this frail population.

Please see link below if you would like to read more - we hope these findings offer helpful information and impetus to future care innovation:

<http://ageing.oxfordjournals.org/content/early/2016/10/13/ageing.afw176.abstract>

#### References

- 1) Prince M, Commas Herrara A, Knapp M, Guerchet M, Karagiannidou M *World Alzheimer Report 2016: Improving healthcare for people living with dementia*. Alzheimer's Disease International, London: September 2016
- 2) Schubert CC, Boustani M, Callahan CM, Perkins AJ, Carney CP, Fox C, Unverzagt F, Hui S, Hendrie HC: Comorbidity Profile of Dementia Patients in Primary Care: Are They Sicker? *JAGS* 2006, 54:104-109.
- 3) Bunn F, Burn A, Goodman C, Rait G, Norton S, Robinson L, Schoeman J, Brayne C: Comorbidity and dementia: a scoping review of the literature. *BMC Medicine* 2014, 12(192).
- 4) Leoutsakos JM, Han D, Mielke MM, Forrester SN, Tschanz JT, Corcoran CD, Green RC, Norton MC, Welsh-Bohmer KA, Lyketsos CG: Effects of general medical health on Alzheimer's progression: the Cache County Dementia Progression Study. *Int Psychogeriatr* 2012, 24(10):1561-1570.
- 5) Melis RJ, Marengoni A, Rizzuto D, Teerenstra S, Kivipelto M, Angleman SB, Fratiglioni L: The influence of multimorbidity on clinical progression of dementia in a population-based cohort. *PLoS*

One 2013, 30(8 (12)).

6) Onder GI, Liperoti R, Foebel A, Fialova D, Topinkova E, van der Roest HG, Gindin J, Cruz-Jentoft AJ, Fini M, Gambassi G *et al*: Polypharmacy and mortality among nursing home residents with advanced cognitive impairment: results from the SHELTER study. *J Am Med Dir Assoc* 2013, 14(6):450.e457-412.

7) Kuo TC, Zhao Y, Weir S, Kramer MS, Ash A: Implications of comorbidity on costs for patients with Alzheimer's disease. *Med Care* 2008, 46:839-846.

8) Guthrie B, Clark SA, McCowan C: The burden of psychotropic drug prescribing in people with dementia: a population database study. *Age Ageing* 2010, 39(5):637-642.

### **Integration of Care and its impact on Older People's Mental Health.**

#### **Executive Summary. Dr Helen McCormack.**

The Royal College of Psychiatrists report, '**Integration of care and its impact on Older People's Mental Health**', was published on November 7th 2016.

The full report is available using the link : [http://www.rcpsych.ac.uk/pdf/FR%20OA%2005\\_final.pdf](http://www.rcpsych.ac.uk/pdf/FR%20OA%2005_final.pdf)

This briefing provides an executive summary.

#### **Background.**

There are high expectations of integrated care, both in terms of providing better coordinated support for people with multiple health conditions, but also in using financial resources to greatest effect. For many conditions, such as diabetes, depression, dementia, and Parkinson's disease, prevalence is rising and the focus is increasingly on prevention, maintenance, and management of comorbidity rather than cure. The government's Five Year Forward View for Mental Health points to their commitment to improve mental health services for everyone. However, there are still integrated services in the UK which do not encompass the full range of peoples' physical and mental wellbeing.

Models of integrated care also vary widely, both internationally and within the UK. There is a lack of clarity about the most effective model for integration, to improve both quality and cost effectiveness. The Old Age Faculty of the Royal College of Psychiatrists commissioned a report, to review the literature on integration, specifically in relation to mental health in older adults, and to identify recommendations for further action.

#### **Method.**

A literature search for articles related to Integrated Care, specifically with reference to mental illness and older adults, was undertaken. The search words used were 'integrated health care system or integrated care, psychiatry, mental health, mental wellbeing, dementia, aging or later life, quality of

life, aged, frail elderly'. In addition to the literature search, a number of services across the UK were visited and a semi-structured interview conducted.

### **Findings.**

Although definitions vary, Integration broadly describes coordination of care for individual patients and their carers, with the intention of providing better outcomes. The literature review highlighted a paucity of research focusing specifically on mental health. Furthermore, the published literature was difficult to interpret because not all countries have old age psychiatry as a specialism, populations studied varied, outcomes measured varied, and methodology used was not consistent.

### **Models of Care.**

No evidence was found in the literature for large scale, population based integration encompassing mental health, although the evidence from the United States suggests that such models can be successful for managing physical illness. Whilst there is evidence that large-scale systems are more difficult to implement, as they require changes to existing legislation and policy, there are benefits to a single administrative structure and single funding envelope giving leverage to ensure seamless care and good communication systems.

There is some evidence of success for single disease management programmes, particularly for depression, in terms of clinical outcomes and experience, but not cost. However, several studies have highlighted that pursuing a disease specific approach for people with multiple conditions is likely to fragment rather than integrate care. Therefore, for older adults with multiple conditions, a holistic approach is to be favoured over a disease specific approach.

Qualitative research in the UK has shown that having access to a multi-disciplinary team assists with diagnosis and treatment for people with multiple conditions, and leads to improved outcomes. There is not a single definition of an integrated multidisciplinary team, but the principles of input from professionals with specialist knowledge, a coordinated continuum across health and social care services, and effective care planning, are accepted. A single point of entry into the system, independent case management, and an integrated information system, alongside system level policies and procedures improve outcomes.

### **Effectiveness of Care.**

The evidence from the international literature on integrated care for frail older adults demonstrates variable improvements in both clinical outcomes and cost effectiveness. Whilst there are some studies that demonstrate cost savings, others do not evaluate it. There are studies in which a cost saving has been demonstrated in one area without investigation of whether that cost was shifted to another part of the system. There is little evidence that community based integration saved costs, and there are programmes which identify clear increases in costs.

There is evidence in the literature of improvements in clinical outcomes, although the results are not consistent. Improvements in patient experience are more consistent, with most studies demonstrating that patients and their carers feel better supported and better informed as a result of

more integrated care. Care coordination is highly valued by patients, care givers, care providers and the coordinators themselves.

#### **Implementation of integrated care.**

There is no clear difference in demonstrated outcomes between larger scale initiatives across organisations in an area, and those that focus on small scale change within an individual service. Some studies identify the importance of designing programmes in the local context and building in flexibility to adapt to changing circumstances.

Success in implementing effective integrated care is also found to depend heavily on interpersonal relationships, and the literature highlights that as much attention needs to be paid to the way organisations and individuals collaborate as to the service design or strategy. There is evidence that structural integration of services is less important than attention to developing effective working relationships across services.

A number of studies and initiatives also highlight the benefits of adopting a particular method of quality improvement, in order to better identify the issues that need to be changed, and to monitor progress. However it is stressed that improvement techniques requires expertise and sound knowledge of improvement methodology to be successful.

#### **Learning Points**

- There is a paucity of research on integration and mental health for older adults.
- Many integrated services overlook mental health problems and fail to incorporate provision of mental health expertise.
- For older adults with multiple conditions, a holistic approach is to be favoured over a disease specific approach.
- The literature does not provide a consistent body of evidence for quality improvement or cost savings with integration.
- Improvements in patient experience are much more consistent, with most studies demonstrating that patients and their carers feel better supported and better informed as a result of more integrated care.
- Care coordination is highly valued by patients, care givers, care providers and the coordinators themselves.
- Designing programmes in the local context and building in flexibility to allow the programme to be adapted to changing circumstances is critical to success.
- Multi-disciplinary cooperation between professionals is an essential prerequisite to providing integrated care.

#### **NEXT STEPS**

##### **In Planning and providing Integrated services for older adults;**

- The findings of this report and the learning points identified should be taken into account.

- Mental health and physical health must be considered together.
- Old Age Psychiatrists must be involved in their redesign and development.
- Multidisciplinary clinical teams need to include qualified mental health professionals.
- Development of a workforce with appropriate skills for delivery of integrated care is essential. This will need to include physical health staff having basic awareness of mental health symptoms including depression, and mental health nurses being aware of monitoring needed for physical health conditions.
- Sufficient investment in establishment of effective working relationships needs to be made to maximise potential for success .
- A focus on cost effectiveness will be more successful than achievement of cost saving.

## BOOK REVIEWS

### **Beloved old age and what to do about it:**

**Margery Allingham's *The Relay* handed on to Julia Jones**

**(Golden Duck (UK) Ltd, 2016)**

**ISBN 9781899262298**

**pp 145**

**£10**

**Claire Hilton**

For old age psychiatrists, learning about twentieth century history means learning about the context of the life-time experiences of our patients. *Beloved old age* comprises an autobiographical account (*The Relay* by Margery Allingham) about caring for older people in the mid-20<sup>th</sup> century, together with reflections by Julia Jones on caring for her mother who has dementia in the 21<sup>st</sup> century. *The Relay* was only published in 2016 when Jones, inspired by it, added her own commentary.

*The Relay* symbolises taking up the 'baton' to care for an elderly relative. A relay includes preparation, team work, personal improvement, and a time to pass on the baton, in this case, to the next generation in the relay of life. The caring baton is a gift. According to Jones, 'Families should care for their older members at the end of their lives for their own sakes, not as a duty or even out of altruism. They should do it because they will gain from the reabsorption of those older people's experience and qualities back into the family pattern. This is their inheritance.' Such comments are

worthy of consideration, but risk inducing a sense of disquiet in those who are unable to fulfil the task.

Allingham wrote about caring for older people, Jones about caring for someone with dementia. The tasks overlap, but different problems may predominate and may require different solutions. Allingham's model is tinged with mid-20<sup>th</sup> century stereotypes and assumptions, such as that most older people 'withdraw quietly and indicate that [they] do not want to play anymore.' Those ideas would be familiar to the generation who may require care in 2016, and may have been formative in their understanding about old age and expectations of it. Other past practices such as the 'dower house', the kindly, respectful staffed home for the older generation, provided by the heirs while allowing each to continue to live separate lives, is a useful concept. The heirs did not provide hands on care, but paid others to do so while remaining in charge.

Jones reflects on Allingham's advice that carers<sup>1</sup> must look after themselves, in order not to 'hold up [their] own sprint'. In Allingham's view: 'Old people sometimes take lives without noticing it. It is up to everybody to protect his own.' It is sound advice. How often do we encounter carers who refuse to take a break, fearing that is it a sign of giving up the caring role, rather than a way to re-charge their batteries? Allingham's style of advice, though dated, might chime for some carers.

Allingham commented: 'The general artificial segregation of the old is as dangerously unnatural as general artificial insemination and, in a way, rather like it. Integral pieces of human experience are by-passed and lost by both.' Her analogies can shock or entertain, and are certainly novel and thought provoking. Well-worded wisdom includes: 'Before deciding that an old person is "impossible" it is as well to give one's mind to every aspect of his physical condition'; too often today, delirium triggered by physical illness, is overlooked by families and professionals. Allingham also warned: 'There are some people who put their full trust in doctors, which is frankly dangerous. The new civil-servant medico is an overworked man...' Apart from the gendered language, one wonders how far this perspective is justified today under the current NHS austerity measures.

I have quoted more extensively than usual in book-reviews because the aphorisms are particularly memorable. The book's sensitive literary style may give clinicians tactful and meaningful ways to express therapeutically some of the delicate conundrums experienced by carers. For junior doctors applying for jobs when carers and patients may sit on interview panels, the book would give them valuable understanding of a carer's perspective. Overall the book is inspired with tenderness, humanity, patience and painstaking thought concerning the wellbeing of carers and cared for. It is a little long winded, but clinicians and carers who read it are likely to find something meaningful in its pages. Some carers may like its leisurely approach to advice, rather than the bullet-point format found in many sources today.

---

<sup>1</sup> Allingham did not use the word 'carer'. Defined as 'A person whose occupation is the care of the sick, aged, disabled, etc.; one who looks after a disabled or elderly relative at home', it was first used in 1978 [Oxford English Dictionary](#)

**The Hundred Year Old Man Who Climbed out of the Window and Disappeared.**

**Written by Jonas Jonnasson and Translated by Roy Bradbury**

**Published as Paperback in 2012 by Hesperos Press Limited**

**Number of pages 103,ISBN no9780349141800**

Arogunmati OA, (CT1 Old Age Psychiatry),Queen Elizabeth Hospital, Gateshead

This book was recommended by a colleague and corroborated by the librarian as a comedy and my initial response was a bit of cynicism and dread despite the wrap: 'what is there to find interesting about a runaway hundred year old – sounded quite dangerous 'except that this was no ordinary story of a 100 year old. It revolves around Allan – a geriatric gentleman who came across as the proverbial 'cat with nine lives'.

It is of interest that the author is Swedish and also that what I read was actually a translation which I hope did justice to the original- in other words I was glad I took the option to read this and thoroughly enjoyed it.

This book is about Allan as he weaves through adventure, an unusual old age crises, resilience and seizing life by the ears at any age. It mixes a lot of unexpected probabilities, twists, circumstantiality and unlikely occurrences steeped in real life history to create a basic plot. I am quite clear that I have not seen anything like it nor witnessed such a creative approach to an unusual story line. It is a story that could easily fit into a series and which makes me eager to read other books by the author.

There are a number of areas where it is easy to get a tug at the heart- starting from what seemed like an unwise choice by a centenarian to escape his abode at a care home, a subsequent theft and descent into crime, a murder which fits into an unexpected trend bordering on the psychopathic, accidents with a rounded dose of comedy which would not have worked so well in other presentations I presume.

This was quickly followed on the liaisons that bordered on the fantastic that would have been the stuff of dreams. At a point I kept waiting for the disappointments that surfaced but went as quickly as it came. A good mix of comedy, thriller, adventure and fiction would be my eventual conclusion. At a point I could feel the centenarian getting away and leaving me behind in the speed of the novel. A lot of it felt real with the way the facts were enmeshed and seemed quite plausible, juxtaposed with the flashbacks – each part of the creation seemed a gem. The end was somewhat unexpected and probably my favourite part of the book.

Somehow I felt that the author had a sense of humour hidden even in the sad scenes with a good sprinkling of mystery and tenseness. This book is guaranteed to place and keep a smile on your face whilst not gory or gripping enough to disrupt sleep. You are gently encouraged to return for another dose out of curiosity and the need to reacquaint with the next laugh. I must confess there were times when I was wondering if the author was pushing his luck but a part of me wished I was the main character- living the life of dreams, interspersing the vagaries of life on the voyage to the unknown.

This book I find challenges my preconceptions about ageing, it makes an argument for renewed focus on possibilities even whilst one ages- it is an easy read for all ages- hopefully we would not be seeing an increase in copycat crimes because of this.

I would definitely encourage this as light reading for those looking for an unusual adventure, an education, a diversion and an idealistic way to approach ageing. I believe the right words it engenders is 'Nothing is ever what it seems'- an indirect ode to the possibilities of life at any age.

### **Elizabeth is Missing, Emma Healey**

Dr Matthew Devlin, Foundation Year 2, Queen Elizabeth Hospital, Gateshead.

Published by Penguin, 275 pages, £7.99.

Maud is an unlikely hero. She is eighty-two, her memory is progressively failing her and she is becoming increasingly dependent upon carers and family to look after her. As her life as she knows it begins to break down events from her past come into sharper focus with surprising consequences. The book has certainly caused a stir and the TV rights have already been sold.

Emma Healey's debut novel oscillates between the present day and an unsolved murder in post-war Britain. However this is not a typical crime novel with the story playing out within an elderly lady's failing mind. With the prevalence of dementia patients set to surpass one million within the next twenty years it is a relevant vantage point. Most people will recognise the pattern of decline shown by Maud, yet the condition is generally understood poorly. Many readers will identify with the frustration and despair exhibited by the supporting cast of carers, family and acquaintances that Maud encounters in her daily life.

The book begins with Maud discovering an object in her friend's garden which takes her back to her childhood seventy years earlier. She knows that this discovery holds some significance from her past but can't pinpoint why. We are then treated to two parallel narratives that play out simultaneously in Maud's head. In the present day Maud is preoccupied by the apparent disappearance of her closest friend Elizabeth. Her quest to find her is thwarted at almost every step by her failing short-term memory despite her best attempts to write down all the clues. We share in the difficulties her illness wreaks both on herself and those around her.

Alongside this Maud reminisces of her childhood and the disappearance of her sister in post-war Britain and the genre would fall between crime and literary fiction. Maud's childhood memories are vivid as she describes her life with her sister and the circumstances that led to her vanishing from her life. As Maud's condition progresses the two worlds gradually blur with her steadily losing her grip on reality. As Maud tentatively retains a purpose to her life, driven on to solve mysteries past and present we arrive at an unexpectedly eventful finale to the novel.

The book is successful at improving insight into the insidious and far reaching effects of dementia. Experts on the subject matter may find the clarity and logical thinking found in Maud's later



reminisces implausible, however overall the book should be applauded for the accuracy with which it depicts the succumbing of a life to progressive cognitive decline. This success relies on the use of Maud as the narrator and by this means Healey gives us indirect snapshots into the life of her daughter and main carer Helen. There are moments of real tenderness captured with this style such as the time Maud and her daughter visit her late husband's grave.

Whilst having Maud narrate the story is an effective literary device it does become rather tiresome and I doubt it's a book many would want to read more than once. The persistent withholding of Elizabeth's whereabouts is perhaps a little excessive and the reader may be forgiven for asking how this information doesn't find its way onto one of Maud's many cue cards. For all that the book delivers in bringing the reader closer to dementia, I feel it falls a little short in terms of plot substance. By itself I don't think the crime story would create much excitement. The book successfully explores dementia in a unique style. It brings people within touching distance of the lives of so many people who either have the disease or act as their primary carer and for that reason it is a recommended read. It provokes thought, discussion and emotion and that was presumably the author's primary objective.

## FILM REVIEW

### Barney's Version (2010)

**Film Review by Dr. Thomas C. D. Lewis, MRCPsych, MBBS, B.Eng, ACGI, Core Trainee in Psychiatry**

***Canada 2010. Director: Richard J. Lewis***

Barney's Version was released in 2010 and chronicles the life of Barney Patrofsky, the epitome of an anti-hero. He is a balding, overweight, abrasive and politically incorrect television producer with a penchant for ice hockey, liquor, cigars and love. Patrofsky, a Jewish Montrealean, is so in love with the idea of being in love, that he has a go at marriage three times, meeting his third love, his true love, during the reception of his second marriage, whilst the ink on his marriage certificate is still drying.

In the opening few minutes of the film, Barney encounters a detective who is convinced that Barney got away with murder and has written a tell-all book about the unsolved case. He tells Barney that he's *"screwed over everyone [he] knew or ever cared about,"* setting the tone for the movie as Barney begins to attempt to recollect his misspent youth and we are taken on a journey spanning three decades of his life.

Despite his crass nature, the viewer can't help but warm to him. We watch a fresh faced, idealistic Barney of the 1970's become the jaded man we see before our eyes, slumped at a bar nursing a drink in downtown Montreal. His journey is punctuated with performances from Dustin Hoffman as Barney's straight talking, no nonsense father and Minnie Driver as his overbearing, mouthy, but interestingly never named, second wife. His three marriages break down, his career as a producer

stalls at making cheap schlock television programs and his mind begins to fail him as dementia casts a shadow over his cognitive functioning.

The gentle unravelling of his mind is first touched upon 40 minutes into the film where a flabbergasted middle aged Barney cannot recall where he parked his car, only to be told by his concerned daughter that he arrived by taxi. Though the diagnosis is never explicitly stated, the insidious onset of memory lapses and slow progression points to an early onset of Alzheimer's dementia. The gradual yet devastating disintegration of memory and cognition in this disease is well documented in medical literature and yet there is no cure. Families are often left shattered from the relentless toll this disease places on carers both physically and mentally. In a touching scene towards the end of the film, Barney, dining with his third ex-wife, regresses and believes them both to still be united in a state of marital bliss. His ex-wife sobs for the loss of Barney's mind, whilst Barney embraces her not understanding the reason for her tears, and whispers "*have I not loved you enough today? Is that it?*" These are the heart breaking moments that will resonate with any health care professional involved in the care of a dementia sufferer.

The movie is an impressive stab at attempting to bring Mordecai Richler's final novel to life and successfully interprets the first person narrative of the novel to the cinematic third person. The timeline of the film can feel choppy, often jumping from past memories to the present day. This is especially true of the aforementioned 'murder' scene whereby a drunken and armed Barney, confronting his freeloading friend near a lake outside his country house, slips, falls and fires a shot. We see his friend fall into the lake and Barney pass out on the floor, but events are unclear and a body is never recovered by the detective.

The uncertainty surrounding events may prove unsatisfactory for many viewers but the latter part of the movie, where Barney succumbs to the full torture of dementia, reminds us that we are watching these recollections of life through a clouded prism of a failing mind. After all, this is Barney's Version and Barney's memory is impaired and at the mercy of his dementia. Details are foggy, names escape him and timelines are distorted. This movie is an attempt to translate the chronically unreliable narrator from novel to screen. Anyone with an interest in dementia will enjoy this fascinating portrayal.

**Tips on writing for *Old Age Psychiatrist*, : Editorial Team, Old Age Psychiatrist.  
Helen McCormack, Anitha Howard, Sharmi Bhattacharyya, Ayesha Bangash**

The comments here are based on the combined experience of current and previous editors of *Old Age Psychiatrist (OAP)*. We receive many articles on important subjects, but some are badly written. In particular, they are too repetitive, are poorly structured, and grammar is often incorrect. Others have no direct relevance for psychiatrists working with older people.



**Suggested types of article:**

- Innovations / interventions which have or have not worked.
- 'The spice of life'
- 'How to survive the current round of NHS changes'
- 'The best thing I've done in the last month' (work related!)
- Case studies: they are not accepted by many journals, but for some people they can be thought provoking and a good way to learn. Case studies must be accompanied by a statement of consent from the patient or their representative and must be anonymised.
- Reviews of relevant clinical and research topics not readily found in text books or academic journals.
- Reviews of books, films and websites.
- Someone who has inspired you.
- Recent experiences and papers read recently: what has inspired, angered or influenced you which other people should know about?

**What we do not want:**

- Clinical research
- Papers with masses of statistics
- Audits

These should be published in peer reviewed journals.

**Please do not** send articles to more than one College newsletter! If an article is relevant in more than one Faculty, we can include a link.

**Word length**

500 to 1,500 words is good.

**Illustrations** are welcome, provided they do not infringe copyright.

**Submission**

Please use Microsoft Word and e-mail the article to us.

**Include**

Title

Names of all authors

Contact details

Page numbers

**Style**

We can be flexible about style, but **please be consistent**, including with capitalisation, referencing and punctuation.

**Tips on writing**

- Use language which shows you are passionate about your subject.
- Most of us have to put time into our writing. Regard your writing as a piece of art which has to be perfected to have the right impact.
- Sometimes finding the right words is a bit like pulling teeth. On line or Microsoft Word synonym finders can be very useful.
- Use a word processing package which automatically checks grammar and has a spell-checker set to UK English.
- Is your argument crystal clear and logical? Readers will want your message 'up-front' and will not have the patience or time to search for your meaning. Use headings to help structure your argument.
- Do not send an article to us it to us the second you have written a first draft! Put it away for a day or so, re-read it, and think about the style, the argument and the message you are trying to put across and improve it. Do that a few times. Get someone else to read it through and give you feedback. You may know what you are trying to say, but that does not always come across.
- Avoid words like 'obviously', 'certainly', 'clear' etc – if it was all so obvious there would be no need for the article.
- Weigh up the pros and cons of using 'patient', 'client' or 'user' in the specific context of your article. They are not synonymous!
- Define all abbreviations and acronyms: *Old Age Psychiatrist (OAP)* is read by old age psychiatrists abroad and by people in other disciplines.
- Write concisely e.g.
  - 'He was' rather than 'He appeared to be'
  - 'He walked' rather than 'It was also reported that he walked'
  - 'He described' or 'He told us' rather than 'He also gave further details regarding'
- Use positives rather than negatives: they convey more information and are less wordy e.g.
  - 'They had little contact' better than 'They had not had much contact'

**you are writing a book (or other) review:**

- Please give full details of the book including author, title, publisher, page length and cost, if not available free on line. Please give website if it downloadable.
- Try to make the first couple of sentences engaging for your reader.
- Say what the book is about and who it is for. There is **no need to summarise the whole book.**
- Point out strengths and weaknesses, things you liked or disliked.
- Give examples to back up your comments, both positive and negative.
- Does it fulfil its stated objectives? Is it targeted at the right audience? If so, why? If not, why not?
- Who would you recommend to read / buy it?
- Would you re-read it? Dip into it again?

**References**

Not all articles need references.

Consider if they will add to your article. If so, a little bit of effort in referencing to substantiate your arguments is well worth the time.

Please ensure that you have read and understand the article cited, not just the abstract!

Your style of referencing must be internally consistent. That includes layout, punctuation, abbreviations, use of italics. If you need a format to follow, then use the style of the *Psychiatric Bulletin* <http://pb.rcpsych.org/site/misc/ifora.xhtml>

### **Revising your article**

Some of the articles we receive are sent for peer review, others are just read by the editors. Most will require some revisions, once or twice.

Most people regard their writing as good and hate making revisions, but please make the changes the editors suggest. Don't just skip over them!

If you disagree with our suggestions then tell us.

Please ensure that the up-dated, corrected version is e-mailed to us.

### **Useful reference about writing**

For some good, brief tips, see Tim Albert, Getting published: 10 things to do before you sit down to write, *BMJ* (13<sup>th</sup> October 2012) <http://careers.bmj.com/careers/advice/view-article.html?id=20009242>

### **Mind your language ... or 'Let's abolish "the elderly"'**

As Professor Bernard Isaacs wrote in 1982: 'Let's abolish "the elderly"' *BMJ* (1982) 284: 112 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495641/>

Introducing a heterogeneous group of people with a homogenising definitive article is unacceptable!

*Dementia words matter: Guidelines on language about dementia*, produced by people with dementia in the Dementia Engagement and Empowerment Project (DEEP).

<http://dementiavoices.org.uk/wp-content/uploads/2015/03/DEEP-Guide-Language.pdf>

This is an excellent, highly recommended, brief resource on writing about dementia.

The journal *Age and Ageing* gives relevant guidelines on language:

'Try to avoid language that might be deemed unacceptable or inappropriate (e.g. 'older people' is preferred to 'the elderly', the word 'senile' is best avoided). Take care with wording that might cause offence to ethnic or cultural groups.'

[http://www.oxfordjournals.org/our\\_journals/ageing/for\\_authors/index.html](http://www.oxfordjournals.org/our_journals/ageing/for_authors/index.html)

We hope you will find these tips useful, and by all means give us your views.