

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

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**Update from the Editorial Team, Helen McCormack,
helenjmccormack@hotmail.co.uk**

This spring edition of the Old Age Psychiatrist is bursting with good news. We have just had the Faculty Annual Conference which was a fantastic event, both academically, and in giving colleagues a chance to get together. You will find here a roundup of the Conference by Anitha Howard, alongside our Prize winning essays. There is the winner of the Philip Davis prize, established in 1991 in memory of Dr Philip R H Davis, a Member of the College for over 40 years. We also have the medical student essay prize, which is longer than usual for our publications, but I think you will agree, well worth reading. Lastly, we have the winner and runners up of our own essay competition. I hope you will agree they are wide ranging and thought provoking. We also announce our new essay competition for this year, 'A World without Dementia, Where would we be?', so take a look at the advert and give us your perspectives on the future.

We have two new articles in this edition, under the section 'Evidence'. Ayesha Bangash, our trainee editor has written a summary of the latest research on older peoples mental health. We also have Cochrane Corner, examining Cochrane systematic reviews relevant to our patient group. We hope both of these will become regular features, but tell us what you think!

The features section is really varied this time, covering topics as broad as the health and care of older people in England, and that we are pathologising old age, to the consequences of the use of physical restraints in older people. I found the features both directly relevant to our work and leaving me with plenty to think about.

This time, we also have a case review for you, highlighting the complex diagnostic issues that we often face in our work. If you have an unusual case you would like to share with us, please send it in. You will find our new, updated tips for writing at the end of the newsletter.

And finally, we say goodbye to Ayesha Bangash as our trainee editor. We would like to thank Ayesha for all her hard work for the newsletter including running the essay competition, and pioneering our new research summary feature.

As always, we welcome your feedback, and submission of articles for publication in future newsletters.

Update from Alistair Burns, National Clinical Director for Dementia and Older People's Mental Health

I would like, first, to offer many congratulations to Wendy Burn for becoming our new President. Wendy has already given us a shot in the arm about the need to focus on older people's services (1). We are entering into a very exciting time in old age psychiatry, there are huge opportunities and lots to play for.

The work on dementia continues apace and there is extant commitment from all levels of the NHS, the Department of Health and social care to pursue and extend the interest. We have achieved an immense amount on the three aspects on which we concentrated upon for the Prime Minister's Challenges - diagnosis rates, stigma and research.

The diagnosis rate ambition (that two thirds of people of the estimated number of people with dementia should have a diagnosis and post diagnostic support) has been achieved, there are 1.8 million Dementia Friends (anyone reading this who is not a dementia friend should immediately log onto Dementiafriends.org.uk and become one) and the announcement of the Dementia Research Institute with £250m (£150m from the government and £50m each from Alzheimer's Research UK and the Alzheimer's Society) has placed on a very firm footing, many aspects of dementia research.

Dementia is one of six major clinical areas in the Clinical Commissioning Group Improvement and Assessment Framework and many Sustainability and Transformation Plans (STPs) feature dementia. We have launched guidance on care planning (2), we have a specific focus of dementia on RightCare and, imminently, we have the National Collaborating Centre for Mental Health (NCCMH) treatment and support pathways. Other initiatives of which I am aware are the work of Dementia United (3) and the Dementia Pathway (4) which has been launched. All great stuff!

One of the next challenges for us is to make sure that older people are sufficiently represented in the work that is going on in relation to generic mental health. Mental health has had the biggest increase in interest and profile in a generation and older people must get their fair share of the initiatives being created. As with dementia, we have seen the benefit of focusing on a few sentinel issues. I think if we had a scattergun approach that tried to emphasise everything might risk the message getting lost. What I would propose is that we concentrate on one particular condition in some ways to attempt to mirror the success we have experienced with dementia.

The parallels between dementia and depression are palpable. Both are underrecognised, undertreated and understandable (the understandability of both conditions attract therapeutic nihilism - for dementia "It is part of normal ageing" and for depression "if I was like that I would be depressed too"). Also, we know

that depression is a risk factor for dementia, the majority of people with dementia at some time during their illness have been depressed and the majority of carers for people with dementia will experience at one point with symptoms of anxiety and depression.

Anxiety is as important but is less common, often associated with depression and there was something about the simplicity of the main message which is helpful.

It might be helpful to use loneliness as a vehicle by which to discuss depression. We know there is a significant overlap between them - loneliness can be a symptom of, a consequence of, or a cause of depression (and vice versa).

In terms of prevention of depression, there are opportunities to intervene as some of the risk factors may be based in the community and be psychosocial in character (compared to the largely vascular risk seen in dementia). Also, linking with organisations such as Age UK and Relate does raise the possibility to look at relationships.

Articulating the specific features of our discipline is helpful – dementia of all ages where there is significant coexisting physical illness and where aging per se influences the expression treatment and management of psychological and psychiatric problems in older people. At the same time that we have challenges about recruitment, we need to reinvent ourselves almost, we need to re-articulate the ingenuity, the similarity and the holistic nature of the work that we do which others do not, that was why and how old age psychiatry was invented in the 1970's and 80's we need to rekindle that enthusiasm. We are in a great place to do this, not only for the sake of our discipline but most importantly for the care of our patients and their families.

I am always looking for ideas so please send me your reflections and perhaps enunciate the one thing that you think we could do to improve things. I will collate these and present them in a subsequent blog. What you're not allowed to say is, "we need more money" and "we need to go back to the way we did things in the past"!

So, a golden opportunity to recast the innovation and genius behind the creation of old age psychiatry in the 1970' and 80's. I look forward to any thoughts or comments you have at Alistair.burns@nhs.net.

References

1. <https://www.hsj.co.uk/sectors/mental-health/exclusive-warning-over-neglected-elderly-mental-health-services/7016454.article>
2. <https://www.england.nhs.uk/mental-health/resources/dementia/>
3. <http://dementiaunited.net/>
4. <https://parkinsonsacademy.co/2017/02/15/new-dementia-toolkit>

This issue's picture Quiz:

1. Name the other four people in this photograph
2. Am I wearing a corset?
3. Am I standing on a soap box?



Answers:

1. L to R: Karen Franks, Amanda Thompsell, Helen McCormack, Sujoy Mukherjee
2. No, just a tailored shirt
3. Not physically

The View from the Chair Amanda Thompsell

Since November 2016 there have been numerous changes and events which have challenged us - and I am not just talking about Trump! Harold Macmillan is famously attributed as having answered the question of what a prime minister most feared as being "*Events, dear boy, events*" and this reminder that we are never in charge of what comes next has been amply borne out by the last few months of activity for the Faculty and the Executive.

ICD 11. First there was the request from our American colleagues to weigh in against a proposal coming to the ICD11 committee to reclassify dementia under Neurology rather than under Mental and Behavioural Disorders. This move was both illogical and potentially damaging. I thank the Executive for helping me write

a robust response on this and I also want to acknowledge the work of members of the Faculty Executive in a whirlwind of activity to garner support from numerous other organisations such as The European Association of Geriatric Psychiatry, the IPA, RANZCP to name but a few. Unfortunately, I cannot at this stage say that the issue has been resolved but I will update you when I get any more information

NHSE's five year forward view. Another area that has required urgent attention has been NHS England's Five Year Forward View which has moved into the phase of writing implementation guidance. There has been a lot to do to ensure that the mental health needs of the elderly are appropriately represented in this document. NHS E and Professor Burns has been very supportive of our input to this important process, and we have developed an excellent working relationship, but this increased profile has meant a flood of invitations to attend meetings and a huge amount of work commenting on large documents.

The All Party Parliamentary Group for ageing and older people. decided to focus on mental health and therefore when the opportunity came up to speak at the House of Commons about depression in older people this was too good an opportunity to miss.

However, we do try not to be driven by external events. We have a Strategic Plan and I am pleased to report that there has also been a great deal of planned activity that has been closely focused on our four strategic objectives

1. Raise the profile of the Old Age Faculty.

As the profile of the Faculty is increasing we are being invited to more meetings at national level where older people's health is under discussion such as the Steering Group membership of the Adult Mental Health programme at NHS England and the Older People Mental Health Expert Advisory Group. We have also been asked to attend the HQIP Review of the National Audits for both Stroke and Falls

2. To improve how the Faculty engages with its members and ensures member retention.

We are a national body and it is important to resist a tendency to be London-centric and to ensure that we all learn from each other. I am liaising more closely with the members of the Executive who leaders of the devolved areas and they will now be giving their updates at the beginning of the Executive so that we can bear their particular issues in mind in our later wider discussions. I would like to take this opportunity to thank them for all their hard work

I am looking forward to visiting Falkirk in May to meet colleagues in Scotland. I added my comments to the response on the new Welsh Dementia Strategy but I

want to congratulate Dr Aziz on his written responses and excellent presentation to the Welsh Assembly which can be seen on their webcast.

One area we can contribute to is to ensure that when new posts are advertised the job descriptions are appropriate to make best use of our skills and produce jobs that are doable.

Mike Walker has kindly taken the lead and is piloting a review of some job descriptions currently in place and I look forward to hearing if members find this useful.

Thanks to Dr Krishnan the Annual Conference had a wide range of presentations which I hope colleagues have enjoyed and we will be reviewing the feedback and using it to design next year's programme.

We continue to add more useful resources to the resource section on the website. Please do take a look and share with others your good practice examples.

3. *To identify and mitigate the current barriers to improving recruitment within the Old Age Psychiatry at all levels of training aiming to improve recruitment rates.*

We commissioned a survey looking at why trainees do or do not choose to train in old age psychiatry. The results are now being analysed so we can finalise our recruitment strategy based on the feedback.

We have also asked about trainees' training experiences to help with developing the curriculum. It is essential that we ensure trainees get an enjoyable relevant and inspiring experience when working in old age psychiatry.

I spoke at the National Old Age Trainees Conference and I was particularly struck by the enthusiasm, commitment and passion of the trainees who were in the room. I was also interviewed by the Student BMJ explaining why old age psychiatry is such a great career and I am looking forward to seeing the result of this in print.

4. *To increase awareness of mental health conditions in older people.*

I have had a piece published in *The Times* on depression in older people and, as mentioned above. I have spoken at the All Party Parliamentary Group on depression in older people.

Excitingly at long last the older persons' version of "Mind Ed" (a web-based educational resource which can be accessed by carers and people with mental health issues) has the go ahead. Claire Hilton will be the Editor. If this is something that any of you would like to help contribute with then please do not hesitate to

let us know. I am now looking at if there is anything we can do to raise awareness of the site when it is finished in about a year.

The Older People's Mental Health Primer for GPs is currently at the stage of seeking final endorsements before being disseminated. It will go on the resource page of the website when finalised.

We are starting a joint project with the British Geriatrics Society looking at depression in care homes and together we are developing an addendum to the *Improving the Physical Health of Adults with Severe Mental Illness: Report -Oct-2016*.

I have also had discussions with pharmacists about how the Faculty can support them with increasing awareness of the mental health needs of older people. The Royal Pharmaceutical Society will be focusing on mental health and at the end of the year. This will help get some real momentum behind raising awareness.

I have also been liaising with the communications department about our communication strategy and our stakeholder engagement. We have a real need for relevant and publishable case histories to help us engage effectively with the media so if you have anyone who could be contacted please let me know.

Finally, other new work

We are planning to update the "**CR165 Our Invisible Addicts**" report on Older Persons Substance Misuse with the help of the Addictions Faculty.

Conclusion.

I see the next six months as being a very exciting time. The wider community are beginning to realise that the mental health needs of older people are different and their needs must be met. We have support in this from our College's president-elect, Wendy Burn. She has just given an interview in the Health Service Journal that has warned that mental health services for older people are being "neglected" and that she will make it a priority for the College. This is fantastic news and I think this is a wonderful opportunity for us to explain to the public and commissioners the extent of the need and what specialist skills we bring to meet this need. We can use this momentum to make sure that our patients and their carers get the excellent care they deserve and our expertise in being able to deliver this care is realised.

Harold Macmillan also spoke of the "*winds of change*" and also said that we've "*never had it so good*". It would be great if both aphorisms become true for our specialism and our patients.

COMPETITIONS

2017 WRITING COMPETITION

£150 for the winner and £50 for the runner up!

Old Age Psychiatrist wants to hear your views on the following theme

A world without dementia: where would old age psychiatry be?

Creative or original writing welcome (including essays, short stories, personal accounts and poems) with word limit up to 1000 words

For doctors ranging from foundation trainees to consultants

Winners to be announced at the Old Age Psychiatry Faculty Conference in March 2018 and 5 short-listed entries (including those of the winners) to be published in the May 2018 edition of *Old Age Psychiatrist*

Please email your submissions to Anitha Howard at dranithahoward@gmail.com by 30th September 2017 along with your names, grades, work addresses and contact phone numbers

WINNER OF THE OLD AGE PSYCHIATRIST WRITING COMPETITION

The 2016 writing competition for doctors...and the top 5

Ayesha Bangash, trainee editor

Old age psychiatry: how I see it 20 years from now

Doctors of all grades were invited to take part in the writing competition whose advert was released in the June 2016 edition of the *Old Age Psychiatrist*. Creative and original writing in the form of short stories, poems, personal accounts and essays was welcomed. It had been decided to publish the entries of the top five contestants in the May edition of the newsletter.

Twenty-six impressive entries from contestants ranging from foundation doctors to retired consultants were received. For the first time in the history of the *Old Age Psychiatrist*, international doctors were invited to participate and we were delighted to receive a poem from a consultant in India.

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. The judges were consultant psychiatrists Dr Susan Benbow and Dr Claire Hilton and the singer, actor and playwright Mike Maran. The judges considered the entries to be of an excellent quality with plenty of 'wow' in them. They were able to capture both euphoria and dysphoria regarding the future of the specialty. Dr Amanda Thompsell, chair of the old age psychiatry faculty, awarded the winner and runner up with cash prizes at the Faculty of Old Age Conference held in March 2017.

The editorial team wish to thank all the contestants who supported the competition with their entries of an amazingly high standard.

Congratulation to the top 5 who are:

Winner Dr Kathy Liu, ST4 old age psychiatry, South London and Maudsley NHS Foundation Trust

Runners up Dr Sophie Gascoigne-Cohen, CT2 in psychiatry, Barnet, Enfield and Haringey NHS Foundation Trust

Dr Edward Chan Seem, CT1 psychiatry, 2gether NHS Foundation Trust

Dr Sue Ruben, retired consultant psychiatrist

Dr Kevin Morgan, consultant in old age psychiatry, Rotherham Doncaster and South Humber NHS Foundation Trust

The entries of the top 5 are as follows:

Old age psychiatry: how I see it 20 years from now

Dr Kathy Liu

I knock three times on the door of Mrs Clark's flat. The doorbell doesn't work, and her curtains are drawn. An old, dusty Ford car rests in her driveway, unused since receiving her free driverless transport pass. A moment later I hear the locks turn and a head of white hair peers out from behind the door. I step forward and clear my throat.

"Good morning Mrs Clark. My name is Dr Kathy Liu and I'm here for the home visit we arranged."

Mrs Clark's head of white hair nods eagerly and she lets me through. Her flat has remained virtually unchanged since she moved in at the beginning of the 21st

century. I feel like I have stepped back in time, surrounded by the original 'noughties' décor, an old flat screen TV and a landline telephone.

Mrs Clark says has been feeling well lately. She was diagnosed with pre-clinical Alzheimer's disease a decade ago and was started on an anti-inflammatory medication to delay the onset of the condition. Today she only has mild memory complaints and her global cognitive score is stable. She is still participating in her prescribed exercise programme of regular walks and yoga, and has been completing virtual reality cognitive training (VR-CT) sessions at home. I can see Mrs Clark's virtual reality headset on the kitchen table, which she uses to recall items from a virtual shopping list, navigate a virtual supermarket or plan and cook a virtual meal. A VR-CT team monitors her scores remotely, and it is clear that she doesn't need assistance at home yet.

However, it's not Mrs Clark who I'm worried about. Her husband, Mr Clark has recurrent depression and he is slumped in the armchair, looking more detached and gaunt compared to a few weeks ago. Despite receiving a number of treatments in the past, including SSRI antidepressants, ketamine, deep brain stimulation, and psychedelic therapy, he has relapsed again. However, there is something that may help to keep him well: stem cell therapy for depression. I am here to give them information about this new treatment, which has already shown impressive results for depression in stroke patients. I feel glad that there has been an unprecedented amount of investment in ageing and dementia research over the past 15 years, which has given us new avenues of treatment for older people.

Investment in services and research is one of the reasons we have seen a recent boost in Old Age Psychiatry recruitment. Psychiatry is now the second most popular specialty chosen by UK final year medical students and Old Age Psychiatry posts are frequently oversubscribed. The government's Drug Legalisation policy has also led to novel medications for older adults, although some of our patients still believe they are harmful and are relatively reluctant to try them. Another reason for our popularity is increased awareness of mental health and dementia in old age. This has been publicised in schools, offices, and through stories of older people portrayed in films, songs and plays. Older celebrities including Hugh Grant (aged 76), Meryl Streep (aged 87) and Judi Dench (aged 101) have won Oscars for their portrayal of the life transitions experienced by older adults.

Mrs Clark hands me a cup of tea. They are both in their 80's, which is relatively young for our service. Most of our patients are in their 90's and an increasing proportion over 100. Since the retirement age was increased to 75 years five years ago, our services have become less concerned about chronological age and more interested in someone's biological and psychological function. We will manage a 50 year old with early-onset dementia, but may not play a role in an active 70 year old with only a diagnosis of anxiety.

Another change to care provision was the introduction of the Old Age Psychiatry and End of Life service, a partnership with Palliative care. Within this service exists

the most controversial role for psychiatrists, which is conducting mental health assessments for the DAS clinic. DAS stands for Doctor-Assisted Suicide, and as with the abortion service within Obstetrics and Gynaecology, this job is not everybody's cup of tea. The DAS law was passed in Parliament eight years ago and allows those with a terminal illness and 'sound mind' with no more than six months prognosis to end their life.

At present, patients like Mrs Clark who have pre-clinical dementia are not allowed to make advance decisions to end their life. I am glad, because dementia care is the best it has ever been. We now have more effective treatments for agitation and have a better understanding of the mechanisms underlying delusions, apathy and hallucinations that can accompany cognitive decline. There are still many questions remaining and room for improvement, of course. One of the most pressing issues is the accessibility of dementia care and nursing homes: demand continues to outstrip supply and the costs for patients and carers are rising. I've heard many rumours: a new statutory dementia health insurance program, a personal budget policy, and yet another tax rise – the issue of how to manage a finite budget within a largely state-funded health service still persists.

Fortunately, it is also still the case that it is an exciting and rewarding time to be an Old Age Psychiatrist, and I am so glad that I chose to enter this specialty over 20 years ago. I say goodbye to Mr and Mrs Clark and set off to my next home visit.

Old age psychiatry: how I see it 20 years from now

Dr Sophie Gascoigne-Cohen

'The next patient I'll present is Mrs XX, DOB 30/09/1946...' The registrar speaks slowly and clearly into the microphone, trying to not look nervous as she faces the camera. She continues on, detailing the presenting complaint, glancing every now and again at her iHologram for some reminders. The weekly MDT has been using this format for years but somehow there are always registrars who get a bit screen-shy. The others, seated in the MDT room, are watching, taking the odd note as they sip on amino acid-infused coffee. Since the 117th reconfiguration of services, the patients, staff and managers alike are finally satisfied. The registrar, based in the community, triages and reviews the new referrals to the memory clinic and brings them to the MDT to determine their subsequent management pathway. Since the price of petrol escalated, bicycles have been the smartest option for community-based trainees but during inclement weather due to climate change, renewable-powered scooters are available to those quick enough to reserve one.

'The memory difficulties of Mrs XX were first noticed by her daughter, who took her to the GP', the registrar explains, as she describes the presenting complaint. It's not an uncommon history. Although most patients are referred in from care of the elderly teams in hospitals or GP screening, a significant portion are still brought in by concerned relatives. The campaigns to monitor for signs of dementia, coupled with an ageing population and some major breakthroughs in treatment rapidly overwhelmed GPs – we unfortunately surpassed the prediction of 1,142,677 cases of dementia in the UK by 2025 [1]. Memory clinics were set up in GP practices to speed up the process. While the screening tools were more sensitive, the age at which people were presenting reduced, and the subtlety of their concerns rose. The memory clinics acquired huge numbers of new patients and split into new referrals and follow-up teams. A special stream for centenarians was also established - the centums - with additional support programs and research. There was a tussle between geriatricians, neurologists and old age psychiatrists as to who was going to preside over dementia expertise nationwide but the psychiatrists advocated fiercely to maintain their diagnostic and therapeutic patch. With this expansion, it was helpful that psychiatrists' lifespans and retirement age keep rising and the oldest practising psychiatrist is 93.

'Her past medical history includes type 2 diabetes, hypertension, COPD...' The registrar reads the GP's summary quickly to the MDT. There are 10 further conditions and the patient has five specialists involved in her care. Fortunately, the GP coordinates everything, a job that has improved since the successful introduction of a nationwide electronic medical records system for both physical and mental health. With multiple comorbidities comes poly-pills and poly-pharmacy. There are now more medications and poly-pills for dementia subtypes, psychosis and affective disorders, and consequently more adverse effects and interactions to be mindful of. With computerised prescribing systems, the old age psychiatrist's role of reviewing medications has, however, become easier. Nowadays, even ECG tracings are incorporated into the computerised medication charts to facilitate monitoring of QTc intervals.

'Mrs XX's past psychiatric history includes severe depression, with one admission under section 2 in 2016...' Like the 9 other people out of every 100, Mrs XX has previously experienced mental illness. 20 years ago, it was difficult to get an inpatient bed in an older adult mental health unit. Patients who met the Royal College criteria for Old Age Services were frequently placed on general adult wards to move them out of an acute hospital bed. Fortunately, the Old Age Psychiatrists advocated successfully for increased inpatient capacity, as well as more residential care homes. They collaborated with trusts to redesign hospital wards to better suit those with delirium and dementia. Old Age Psychiatrists also became permanent and prominent members of mental health liaison teams, intellectual disability services and forensic units.

'Mrs XX lives alone in social housing. Her daughter lives in Manchester and visits monthly and her son lives overseas. She drinks 2 units of alcohol daily and smokes

three joints of cannabis per week. She quit smoking in 2017, when most mental health trusts went smoke-free but continued to use recreational substances, particularly MDMA. She is a divorcee and continues to engage in casual sexual intercourse using a dating app'. The registrar clears her throat at this moment and then resumes her history. She is competent with managing these issues as her own training has included an elective substance misuse post and a GP post. Drug and alcohol services now often have a sessional old age psychiatrist or a consultant with a special interest in the older population. As for sexual health, due to funding cuts the GPs had to reabsorb it all but old age psychiatrists became more attuned to enquiring about it and liaising with their GP colleagues.

'My differentials are...' At this point the registrar looks more nervous. Based on her assessment, she needs to justify her request for pathology and imaging as well as further neuropsychological testing. While the budget has expanded, the costs of diagnostic tests have risen. The scan to definitively diagnose dementia, or indeed other types of mental illness, remains elusive but functional imaging is certainly bringing this much closer. Pathology has become more comprehensive, with genetic testing almost routinely requested. It follows that challenging conversations around consent and familial implications of genetic neurodegenerative disorders are now more common for old age psychiatrists.

'So that is my suggested plan but I'd like your input....' The registrar looks up at this point, inviting the MDT in to share their views, which they do so enthusiastically, including the SHO, who doesn't need to write the notes because it is all recorded. Once everyone has spoken, she says goodbye and switches off her iHologram. As her image disappears into the table, the MDT briefly plans their afternoon. Having embraced the Swedish 6-hour working day, there were only four productive hours left to work in their ergonomic solar-powered office.

Dogs, drugs and depression

Dr Edward Chan Seem

It was 08.55 when Hitesh arrived in reception; cutting it fine as always. Anna had been there since 08.40 and was steadily ploughing through her new Oxford Handbook of Psychiatry (24th ed.)

"Made it, then?" Anna's standard morning greeting since the start of their 3rd year placements.

"Hey, it takes time and effort to look this good." Hitesh replied. It was one of his wittier stock responses. "Have I missed anything?"

"Nah, still waiting for Dr Brittain. The receptionist said she was running late. You've got time to sort your mascara out".

Hitesh's undoubtedly witty, unprintable retort was interrupted by the appearance of Dr Brittain, the consultant.

"Morning! Students?" Handshakes, introductions and a short adventure to the offices ensued.

Bags and coats deposited on the NHS-issue "comfy" chairs; and the office locked down; they found themselves outside of Reed ward. Dr Brittain stopped to untangle her electronic key from her ID badge.

"Welcome to Fen Bridge Hospital! Have you two done any psychiatry before?" Shaking heads. "Ok, good; clean slates! Well, Fen Bridge is our regional older age inpatient facility. We have two functional wards, Reed ward and Buckthorn ward, for patients with general psychiatric conditions like schizophrenia. Then there's Samphire ward for organic disorders..."

"That's dementia to you..." Anna muttered to Hitesh as Dr Brittain turned to open the door. Hitesh responded with a smirk and a hand gesture.

..."We also have Lavender high dependency unit; and Mustard ward, which is our older adult low secure forensic unit. Cromer house is our outpatient facility and we have an ADHD clinic this afternoon that would be good to go to. For now, let's go onto Reed ward..."

The ward was a bit of a surprise to the students; coming from the acute hospital with its beeping machines and unpleasant smells to the bright open space of Reed ward. The endemic "comfy" chairs were the same, as were the ghastly NHS curtains, but the communal tables, bookcases, games, and porch leading to a heavily flowered garden were a world away. The two dogs sat by the fish tank were also unexpected.

"Different, isn't it?" Dr Brittain commented.

"Why are there two dogs sat by the fish tank?" Hitesh asked.

"Tony and Siegfried? They're our therapy dogs. Tony comes in three times a week, goes on walks and is generally quiet and sociable. Sigi only used to visit when we had a problem with drugs..."

"Drugs?!"

"...He's an ex-sniffer dog and we had a real problem with drug drops last year. The folks who took cannabis and LSDs in the 70s are starting to come through our doors now. We bring Sigi back for Mrs Bloy in room 8 who took a shine to him during her last admission. She had psychotic depression and has been coming back for ECT. She lives alone out in the sticks so she stays with us overnight afterwards." The students were quiet for a minute while they digested this.

"Do many people still have ECT?" Asked Hitesh.

"Fewer now. When I first became a consultant we did three lists a week. Now that transcranial magnetic stimulation is up and running we're down to one list and that's mainly people who've had a good response to it in the past."

"Are those patient computers over there?" Interjected Anna, indicating four desks against the far wall displaying old fashioned desktop computers, their cables neatly bundled in a plastic tidy.

"That's right" said Dr Brittain. "We have four computers on Reed. Between this ward and Buckthorn is the internet café with another 12 computers for patients with ground leave to use."

"Wireless headphones..." Commented Hitesh appraisingly.

"Yeah; the internet café uses the old style wired ones. Can you think why we use wireless headphones on this ward?"

"Well, stuff's less likely to go missing on this ward than in the communal areas..."

"A good thought; in fact, it's the ligature risk. Patients have used the cords to self-harm: so we use wireless ones here until we're happy that they can leave the ward environment safely."

"And they can just do anything on the computers?" Asked Anna.

"Not anything. The nurses keep a pretty close eye on what happens..." Dr Brittain indicated the windows of the nurses' office opposite the computers. "...Particularly when people are elated or aggressive. When you come to ward round tomorrow you'll see some of the risk assessments and care plans we have to put in place around internet use. There's usually someone from IT that attends the ward round to advise and a computer technician in the internet café."

"So they don't get access to the internet?"

"Not automatically, no. Last year we had one chap with bipolar who used to write code for mobile phone Wi-Fi software. When he became unwell he believed strangers on the internet were stalking him. Unfortunately he was able to access our Wi-Fi and then hack one of the OT's IT account. Wrote a lot of unpleasant things on someone's Facebook before we worked out what was going on. IT had kittens. Since then we've had to remove Wi-Fi and use wired connections. We supervise the computer use directly the first few times someone uses them. OT and the speech and language therapists have a few games installed they use for cognitive assessments too."

"What happened to him afterwards? Were the police involved?"

"No, the social worker liaised with the police. That's not always the case. Mustard LSU have at least two patients with malicious communication convictions. Our man

had his access to the internet revoked until he stabilised on cariprazine. He's doing well now: went cruising to Vancouver last October."

"Sound like he's having a good time" responded Anna.

"Certainly, that's what he said in clinic last month. Speaking of a good time; let's go to Samphire ward and meet some patients. There's a dance therapy session on and it's 80s day. You two need to satisfactorily participate in order to pass this placement..."

Brave New World

Dr Sue Ruben

Dr Alice Smythe was slightly distracted as she logged into the nearest computer. It was the second meeting of the new group today. She had renamed it LIMP, (Lets IMplement the Proposal), to amuse her team, whose morale was very low, since the arrival of the new management team from Ohio. She was standing up, to fulfil the directive that whenever possible all interactions took place fully vertical. Desks had been removed and no personal space was permitted for unnecessary clutter like family photographs.

She realised that she was almost missing the last lot, who were replaced after the revelation that the finance director had embezzled the fund which provided funerals for the needy. This had caused a huge backlog in the mortuary, or as it was now known the End of Life Last Pathway Centre. Bodies had been doubled up in the fridges until a mass ceremony was held. Since the crematorium heated the local swimming pool, and prescribed exercise facility, the water that day was pleasantly warm for a change. "Every cloud has a cliché" she mused as she scanned her messages looking for one that might actually require her to do something.

Alice had been nominated to represent the Royal College of Psychiatrists, and was using personal development session to attend weekly meetings of this group. It had been rapidly convened after Parliament had passed a Bill which paved the way for "People of sound mind to make provision to allow assisted dying when there life became intolerable". As was usual since BREXIT, 20 years earlier, it followed a referendum, with no forward planning as the mood of the public had been misread. Feelings ran high. The Daily Mail talked of 'The Euthanasia Directive' and a group of enthusiastic environmentalists had coined the slogan "Cull a Granny and save the planet" The group were to sort out how the Law would operate in the real world, ensuring appropriate safeguards and a clear regulatory framework.

"It's for us to put the meat on the bones of this poorly worded legislation" declared the Chairperson, a recently retired Inspector of Prison Ships, at the first meeting.

As she made her way to Meeting room 2, in the Executive Suite, where seating and refreshments were still provided, Alice found herself thinking of her early career. There still was an NHS, and she had had youthful optimism that the combination of new technologies with the application of science would mean less suffering, better care and new effective drugs for her chosen area, dementia. She had once joined in loud enthusiastic clapping at a conference where a heavily bearded Professor had talked of his vision of the future. People would live, still healthy, youthful and hairy well into their second century, although the retirement age would have to rise perhaps to 102. She decided against doing the maths to work out how many more years of work that would give her now, if his prediction had been accurate.

Reality was not that rosy. She had come to believe that target driven care, based on outcomes that were measurable, but not necessarily meaningful, had encouraged the technological approach to dementia care. Cross infection rates had been reduced, violent incidents unheard of, and survival rates had risen. All since the introduction of robots, called MAIDS (Mechanical Assistants for Intervention Delivery Services). They had a humanoid appearance, were excellent time-keepers, with pre-programmed banal, soothing chatter, available in many languages. Centralised control centres, staffed by nurses and technicians, oversaw the projects, and detailed information from smart monitors was constantly available. The food, while having no discernible flavour, was nutritious, and being synthetic was suitable for all diets. Personal interactions with the subjects were rare. (The term subject replaced patient in 2023.) While cost effective and hygienic, these facilities, usually built on brown field sites were hard to staff. On a recent visit to one Alice sensed that even the MAIDS were depressed.

Public opinion had been mobilised after a documentary exposing the paucity of life endured by these incapacitated souls. There was a mass march on Westminster. "We demand to die with dignity not live to 102 looked after by R2D2" they chanted. A referendum was triggered, and the usual arguments ensued. The slippery slope scenario, the economic pros and cons, and of course the religious. Alice, after listening to the Moral Maze, noted that the Almighty was on both sides.

She reached meeting room 2, where a motley crew of experts were gathering. Many of the usually keen committee types had been reluctant to participate. "It's a poisoned chalice Alice" chortled her cynical chum. "Not going to get you an OBE." She had felt queasy, and disheartened yesterday when she heard two junior doctors whisper and giggle "There's Dr Death" as she passed them.

She sat down next to the portly veterinary surgeon and studied the agenda. They had 3 months to write a comprehensive report for the Department of Wellbeing. As she read through the agenda items, a realisation began to make itself felt. Here was her chance to help find a way where the shared yet unspoken belief that death

was a failure could be challenged. Surely, she thought a way can be found to allow people to actively facilitate an earlier death than the current defensive system allows. Alice dimly remembered that pneumonia used to be called 'the old man's friend'. Years ago resuscitation policy had seemed more humane, or was she just supporting medical paternalism? Perhaps she could use her skills in the Art of Medicine to make a difference to ordinary people in their struggle to better finish their extraordinary journey through life to whatever comes next. As she dunked a digestive into her coffee she felt her heart lighten.

Anosognosia

(Of Greek derivation: "a" meaning without, "nosos" meaning sickness, "gnosis" meaning knowledge. Literally "without knowledge of sickness.")

Dr Kevin Morgan

'It's 2016,' I answered.

There was a long pause as Dr Wright's gaze shifted from the screen to my face and settled there, his assessment now complete. He was pleasant enough, I thought, rather formal perhaps and business-like but seemed OK. He was of the suit-and-tie variety of Consultant and very young.

'It's actually 2036 Dr Morgan,' he said finally

'Of course it is, that's what I meant. 2036.', I said, laughing awkwardly. "You know, back in 2016 I was doing exactly the same job that you do now. My office wasn't as nice as this one though.' I smiled nervously, feeling uncomfortable. Shouldn't it be him that was nervous, I thought? I always had been when seeing medical colleagues – a demanding bunch that would always know more than I did. At least that was the fantasy. I looked down and rubbed unsuccessfully at a stain on my old green corduroy trousers.

A cold December rain was blowing against the window and darkness seemed to be gathering. Was it already so late? Inside all was bright and modern, with abstract prints on the wall and a single large screen and keypad on the desk. How very tidy it all seemed, everything ordered and fitting together perfectly. Not like the piles of patient notes, assorted request forms and old BNF's of my day! Fidgeting, I looked up at the member of staff sitting next to me who smiled encouragingly. She reached over to pick up a newspaper that had slipped to the floor and replaced it on my lap. Rolling it up, I gripped it with both hands.

'Look, I'm sorry, I really think I'm wasting your time,' I said, starting to feel irritated. 'In my day it would have been called simple age related cognitive

decline. Quite normal. Do you still have that concept nowadays or are we all at some stage or other of dementia?’

‘I’m just looking at your results,’ he said, frowning at the screen, ‘and it does very much look as if you have Alzheimer’s disease.’ He stopped and looked at me searchingly, letting his words do their work.

‘That’s impossible,’ I replied quickly, ‘after all, I should know, shouldn’t I? It is just...’

‘The results are quite clear, Dr Morgan,’ he interrupted, looking back at the screen. ‘On the memory tests you scored well below normal for your age – and were in fact in the moderate to severely impaired range. Amyloid imaging too was positive.’ He paused, then turning to me continued: ‘The fact that you are an intelligent and high functioning man has helped you adapt. You have found ways of adjusting and compensating that have helped you continue living an active life but these have, to be blunt, simply masked your problems. You...’

‘This is nonsense!’ I said, this time interrupting him. Shaking my head I looked out through the rivulets of rain to the gloomy and unfocussed world outside.

‘There is nothing wrong with me. How can there be? I can do everything I need to do and remember everything I need to remember. I feel fine – no, in fact I feel positively well! How can I have Alzheimer’s? Just a couple of years ago I was the one telling others they had Alzheimer’s!’

‘It was almost fifteen years ago that you retired,’ Dr Wright said quietly.

I sighed with frustration. What was going on here? Fear began rising deep within me and for a terrifying moment my hold on reality seemed to slip, an intense insecurity and choking emptiness threatening to overwhelm me.

‘But I am not ill!’ I exclaimed angrily and, instantly, the feeling was gone. ‘No test is perfect, even now. I am the best judge of this and I’m afraid you’ve got it wrong!’ My newspaper dropped once more to the floor and again the woman reached down and replaced it, this time avoiding my questioning gaze.

Dr Wright persevered:

‘We now have good drugs that go some way to reversing the condition,’ he said. ‘The outlook is much brighter than it was in your day.’

‘I’m sure it is – but I don’t have Alzheimer’s!’ I said, my voice rising.

There was silence.

Had psychiatry changed so much, I wondered, the messy uncertainty and endeavour to understand the mind of another replaced by hard, calculating science? I sighed heavily struck for the first time, in that familiar setting, by a profound disorientation.

Dr Wright, meanwhile, considered his patient. How extraordinary, he thought, that an old age psychiatrist that has spent his life looking for these signs in others could be so unable to see them in himself! Alzheimer's and anosognosia, it seemed, were no respecters of profession. He regarded his retired colleague, with his friendly but indignant gaze and stained trousers with a tender sympathy.

'Is there any chance, Dr Morgan, that you could be mistaken?' he ventured gently. 'As you know, sometimes it can be the person with the memory problems that finds it most difficult to recognise them.'

'No, I don't think so,' I replied.

'So there is a small chance? You're not 100% sure?'

"I am 100% sure, Dr Wright!"

There was no escaping my sense of certainty and yet something about our exchange made me warm a little to the probing Dr Wright. A glimmer of comradely connection stirred somewhere within. Relaxing a little I looked again closely at the Consultant that faced me, a look of interest and concern on his face. Somehow, he no longer seemed quite so young.

'Well, we're out of time for today,' he concluded, 'but perhaps you and your wife would come back and talk to me about this again?' he said, smiling.

'Yes I would like that,' I said and looked again at the woman beside me. Her eyes reddened and moist, she handed me my coat.

WINNER OF THE PHILLIP DAVIS PRIZE

'A Patient Lost in the Midst of Legal Confusion'

Summary, Dr Itunuayo Ayeni

Introduction:

A rapidly aging population is set to dramatically change the landscape of Old Age psychiatry as we know it. It is predicted that within the next 25-years the older adult population will markedly increase worldwide, (World Health Organization, 2011). This in turn will lead to an increase in age related conditions such as dementia. According to a study by Ferri et al. (2005), 4.6 million new cases of dementia will be diagnosed every year, which equates to approximately one new case every 7 seconds. This figure is expected to rise to an astonishing 81.1 million by 2040. In a publication by Prince et al. (2014), the number of dementia cases within the UK was estimated to be 850 000. It is estimated that over the next 11 years there will be a 40% increase in the amount of new cases, (Prince et al. 2014).

Mental and physical health have often been seen as two entirely distinct entities. However, old age medicine in particular operates contrary to this, suggesting a strong and overlapping relationship, (Anderson and Holmes 2005). A large proportion of patients admitted to acute medical wards often have an existing cognitive impairment that affects their ability and capacity to consent to admission. In these circumstances, where short medical intervention is required, treatment can often be provided using the best interest principles stated by the Mental Capacity Act 2005. As research has shown that severe cognitive impairment is associated with long in-patient medical stay (Sampson et al. 2009), clarification is needed as to which framework can be used for individuals with an existing diagnosis of dementia requiring treatment within an acute medical setting.

The Mental Health Act:

The Mental Health Act was initially introduced in 1983 and provided criteria for assessment and treatment of individuals presenting with a mental health disorder (Hamilton 1983). Additional changes were made in the 2007 amended version, with mental disorder being classified as 'any disorder or disability of the mind.' The Mental Capacity Act (MCA) 2005 was introduced to protect vulnerable individuals and those who lack capacity. According to the principles of best interest, anything that is done on behalf of an individual lacking capacity should be done in their best interest. As far as possible, individuals should be actively involved in the decision; the wishes of the individual should be taken into consideration. The Mental Capacity Act has the additional benefit of providing a framework for the treatment and/or restraint of individuals in order to prevent harm. Restraint can be defined as the use of force in order to prevent harm to the individual. It also involves restricting a person's liberty. If an individual's liberty is to be deprived, the Deprivation of Liberty Safeguards (DoLS) needs to be considered for the patient.

Deprivation of Liberty Safeguards:

Deprivation of Liberty Safeguards provides a lawful framework for individuals admitted to hospital or a care home, (Department of Health 2015). It was introduced in 2009 following the European Court of Human Rights ruling of the Bournemouth case (Department of Health, 2005; Equality and Human Rights Commission, 2016). The ruling stated that a legal framework was required to protect the right to liberty for people who lacked capacity. The Deprivation of Liberty Safeguards states clearly that the decision to deprive an individual of their liberty should only be made in the best interests of the patient. In 2014, the Cheshire West ruling challenged many of the existing views regarding the Deprivation of Liberty Safeguards, (Department of Health 2015). The Supreme Court decided that when an individual lacking capacity was under continuous or complete supervision and was not free to leave, this amounted to deprivation of liberty.

Case Presentation:

The difficulty in ascertaining which legal framework is most appropriate for use with elderly patients is demonstrated by the following case presentation. Patient X is a 93-year old lady admitted to an acute medical ward with a background of vascular dementia. Prior to her admission there had been a significant change in her presentation with increased agitation and challenging behaviours. She was receiving regular sedative medication and one to one nursing in order to manage her behavioural presentation. On arrival to the medical ward the patient remained confused and disorientated with no recollection of why she had been admitted. The patient was non-compliant with physical investigations including bloods and an ultrasound scan. Although she made no attempts to leave the ward, she did state on several occasions that she wanted to return home. An initial psychiatric assessment concluded that patient X was likely suffering with an acute confusional state. As the patient lacked capacity to make a decision regarding whether she should remain in hospital an urgent authorisation for Deprivation of Liberty Safeguards was made as this was deemed the least restrictive option. The patient had originally been brought in for investigation of a physical health problem that required an extended period of admission to hospital. The Deprivation of Liberty Safeguards was completed but declined on the basis that the patient had an underlying diagnosis of dementia that was felt to be impacting directly on her presentation on the ward. As a result, a recommendation was made that the patient required treatment under the Mental Health Act.

Wider clinical and practical implications:

This presentation is not an untypical case within liaison psychiatry, with patients often falling within this grey area of legal confusion. What often happens in these situations is that the patient becomes lost amongst a variety of factors. We begin to look at clinical cases as one with a commonality. We look at the patient as a set of criteria questions, and a bureaucratic approach can tend to overlook that we are also dealing with an individual who may also be a parent, spouse, sister and friend. The lack of clarity and conflicting views for patients can result in them being left in a state of limbo. This has long-term clinical and financial implications for us as medical practitioners.

A report by the Association of Directors of Adult Social Services (2014) showed a significant increase in the number of Deprivation of Liberty Safeguards applications following the Cheshire West ruling. With ever-increasing staffing pressures in the NHS, particularly within mental health services, valuable time spent focusing on legal complexities is time that could otherwise be dedicated to the patient. The average Deprivation of Liberty Safeguards Assessment has been estimated to cost approximately £1277 (Shah et al. 2011) and the average cost of the Mental Health Act is estimated to be similar. With increasing financial pressures, finding ways to reduce additional cost is crucial to health and social care and would enable valuable resources to be directed at more fundamental areas of need.

The concerns over the lack of clarity relating to use of the Deprivation of Liberty Safeguards has been recognized by the government, who have recently appointed the Law Commission to conduct a review looking at the DoLS framework, (Law Commission 2016). The review has already recognized that the current approach fails to meet the needs of some patients who lack capacity and fails to take into account the interface between the Mental Health Act and Deprivation of Liberty Safeguards. The ongoing review by the Law Commission aims to introduce a new scheme that addresses the issues raised by article 5 of the European Court of Human Rights as well as ensuring appropriate safeguards are in place for patients and relatives. It also aims to address the issues discussed within this essay, namely the interface between Deprivation of Liberty Safeguards and The Mental Health Act.

In 2001 The National Service Framework for Older People (NSFOP) was developed to address the inconsistencies in care for older adults, (Crome and Natarajan, 2004). The aim of the model was to focus on older adult care, primarily the treatment of dementia, in order to address the range of community and hospital based services. With an aging population, addressing such concerns has become even more critical than ever in terms of developing future service provision. One of the ways in which this could be provided would be through the provision of older adults psychiatry liaison services. These services act as a bridge between mental and physical health. At present, there are limited older age specific liaison services, (Anderson and Holmes, 2005). This means that there may be staff with

limited experience of managing older adults. In order for services to be clear as to how physical and psychiatric services may present within the elderly, specialist older adults services will be required for ongoing care of an increasing older adult population.

Conclusion:

There remains uncertainty in the use of Deprivation of Liberty Safeguards, particularly because of its overlap with the Mental Health Act. Old age psychiatry is a challenging and fascinating specialty with a strong overlap with physical health. The current lack of older adult specific liaison services, which are often the first point of call, will further exacerbate the problem and create a lack of provision for future services. It is clear that further work is required to address key areas of concern and this has been recognized by the review of the Deprivation of Liberty Safeguards. However, until this confusion is resolved our patients will continue to remain in a legal mist.

Recommendations:

1. Further clarity is required for the use of Deprivation of Liberty Safeguards for older adults.
2. The legal framework used for detention of older adults who lack capacity should be more patient-centred with more emphasis on clinical and ethical implications rather than framework. All clinical cases should be assessed on their own merit.
3. The overlap between mental and physical health is most prominent within the elderly population. All non-medical staff involved in direct assessments of older adults should have specific training within old age psychiatry.
4. All higher specialist-training posts within liaison psychiatry should have dedicated training in old age psychiatry.
5. Future provision will need to consider the need for increased older adult liaison and older adult primary care liaison services in order to meet future clinical demands.

References

1. Act, Mental Capacity. (2005) "Code of practice." Department for Constitutional Affairs. London: TSO.
2. Act, Mental Capacity. (2005). "Mental Capacity Act." London: Office of Public Sector Information.
3. Anderson D and Holmes J. (2005) "Liaison psychiatry for older people—an overlooked opportunity." *Age and ageing* 34, pp 205-207.
4. Association of director of Adult social services (2014). Joint letter on the impact of Supreme Court decision regarding deprivation of Liberty Safeguards. ADASS/ LGA, London.
5. Bournemouth case. Equality and Human Rights Commission (2016). <https://www.equalityhumanrights.com/en/what-are-human-rights/human-rights-stories/bournemouth-case> accessed on 29th October 2016.
6. Bournemouth consultation. Department of Health (2005). <http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/assetRoot/04/10/86/41/04108641.pdf> accessed on 29th October 2016.
7. Crome, P. and Natarajan, I., (2004). The national service framework for older people. *Drugs & aging*, 21(8), pp.499-510.
8. Department of Health Guidance: Response to the Supreme Court Judgment/ Deprivation of Liberty Safeguards (2015). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/485122/DH_Consolidated_Guidance.pdf accessed on 29th October 2016.
9. Ferri, Cleusa P., et al. (2005) "Global prevalence of dementia: a Delphi consensus study." *The lancet* 366: 2112-2117.
10. Hamilton, John R. "Mental Health Act (1983)." *British medical journal* (Clinical research ed): 1720.
11. Law Commission (2016). Mental Capacity and Deprivation of Liberty Interim Statement.
12. Prince, M., et al. (2014). "Dementia UK: update." Alzheimer's Society, London.
13. Mental Health Act (1983). Legislation.gov.uk. <http://www.legislation.gov.uk/ukpga/1983/20/contents> accessed 29th October 2016.
14. Mental Health Act (2007). Legislation.gov.uk. <http://www.legislation.gov.uk/ukpga/2007/12/contents> accessed 29th October 2016.
15. Shah, Ajit, et al. (2011). "Deprivation of liberty safeguards in England: implementation costs." *The British Journal of Psychiatry*: 232-238.
16. Sampson, E.L., Blanchard, M.R., Jones, L., Tookman, A. and King, M., (2009). Dementia in the acute hospital: prospective cohort study of prevalence and mortality. *The British Journal of Psychiatry*, 195(1), pp.61-66.
17. World Health Organization (2011). "Global health and aging." *Acedido março* 5.

WINNER OF THE MEDICAL STUDENT PRIZE

A Case Study: Principles of Capacity and Best Interests

Matthew Hastings

Principles of Capacity and Best Interests

Primum non nocere

The principle of *non-maleficence* was often judged to be the primary ethical consideration of medical practice, and while it is certainly still essential to avoid inflicting unnecessary injury on those patients you treat, this principle should be considered in the historical context of the proficiency of medicine. Historically, the doctor would have been unable to cure a multitude of common ailments and could not have been certain that any treatment offered would ultimately be useful or even safe for the patient; hence it was of vital importance to be reminded of the damaging potential an action may have on a patient. It is only relatively recently that the clinician is able to offer treatment which he knows has been scientifically proven to be effective and to better understand and be aware of the risks every prescribed treatment carries. In the age of modern medicine where the clinician is far better informed other principles begin to take precedence:

- *Autonomy*- ensuring that patients can make informed decisions for their own health care
- *Beneficence*- actively supporting those who require medical help
- *Justice*- ensuring fair and equal treatment¹

These principles are of specific importance when considering patients whose cognitive faculties are seriously impaired. Where they are so impaired as to prevent the person from making autonomous decisions they are said to be lacking mental capacity, and it is necessary to act in their best interest by following the principles of beneficence and non-maleficence². To avoid ambiguous management in such cases, and in accordance with the principle of *justice*, this is done in the UK by following relevant legal frameworks.

In Scotland people who have become unable to make autonomous choices are protected by the Adults with Incapacity (Scotland) Act 2000 (AWI)³ and in England and Wales by the Mental Capacity Act 2005 (MCA)⁴. These acts outline how such patients are supported in receiving healthcare, managing finances, and protecting their autonomy and human rights. The five principles of the MCA are demonstrated in box 1:

Box 1: The Five Statutory Principles of The Mental Capacity Act⁴

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

It is important to set legal standards for the treatment of those lacking mental capacity primarily as they are vulnerable adults who cannot necessarily look after their own interests and are potentially at risk of abuse, but also due to the increasing awareness that health and social workers have for the complications that diminished capacity can cause in the provision of care^{5,6}.

Mental incapacity is caused by a mental disturbance or cognitive impairment rendering them incapable⁷. In the AWI "incapable" is defined as an inability to:

- act on decisions
- make decisions
- communicate decisions
- understand decisions
- retain the memory of decisions⁸

The conditions which can lead to someone becoming incapable are varied, but cognitive decline is the symptom most often associated with dementia disorders, for which the biggest risk factor is increasing age⁹. We are currently living in a greying society in which the prevalence of age related conditions will increase; assuming current population trends remain unchanged it is estimated that the number of people in the UK with dementia will exceed 1 million by 2025 and over 2 million by 2051⁹. This means that potentially health services in the UK will see a growing frequency of incapable patients and it is the responsibility of practitioners to be aware how to best respect their autonomy and act in accordance with beneficence^{7,10}. This is especially true for psychiatric services where already approximately 29% of general adult in-patients are incapable of making treatment based decisions¹¹. However, bearing this in mind it is important to emphasise the first principle of the MCA, "*A person must be assumed to have capacity unless it is established that they lack capacity,*" likewise the assumption of capacity is focal to the AWI^{3,4}. Capacity is not indicated by a person's status as cognitively impaired, mentally unwell, or even old; rather it is a functional ability which must be demonstrated to be absent by proper assessment^{7,12}. Just

because a patient has a diagnosis of dementia should not mean that they are in any way incapable.

The following case will serve as an example to highlight how capacity is assessed, and some of the effects which diminished mental capacity can have on patient care.

Case Study

Mr W is a 74 year old gentleman previously known to the Psychiatry of Old Age Liaison Team (POALT) who was admitted to a medical ward in September 2016 for treatment of community acquired pneumonia. At this time his next of kin, his grandson, applied for power of attorney which necessitated a formal assessment of his capacity.

Past Medical History: Aortic Stenosis

Atrial Fibrillation and Flutter

Aortic Valve Replacement

Transient Ischaemic Accident

Regular Medication:

Atorvastatin 20mg nocte

Clopidogrel 75mg OD

Lansoprazole 15mg OD

Tamsulosin MR 400micrograms OD

Bisoprolol 1.25mg OD

Background History

Mr W was referred to the memory clinic in 2011 but cancelled the appointment. He was re-referred in 2012 after his GP noticed him behaving erratically during an appointment where he explained that he cancelled his first appointment as he was concerned he might have been detained. He cancelled this appointment too and then declined a home visit from the Older Peoples Community Mental Health Team (OPCMHT). Following this he had no further contact with mental health services until a hospital admission in December 2015.

Mr W was admitted to a medical ward in December 2015 due to worsening confusion at home, hallucinations, and paranoid delusions. He had recently started a course of Trimethoprim for a UTI and presented at this time with new shingles on the right side of his face. He was diagnosed with Delirium secondary to infection, assessed by the receiving physician as lacking capacity and was treated under the Adults with Incapacity Act.

At this time he was living in sheltered housing since the death of his wife in 2013, and it emerged that before this acute decline he was increasingly struggling to function properly on his own as he was forgetful and was not eating or drinking properly. Furthermore, on two occasions when in apparent good health Mr W presented to the police station across the road from his sheltered housing accommodation having become disorientated and unable to find his way home.

During this admission Mr W was observed at a nearby supermarket by an off duty member of staff who recognised him and supported his return to the hospital,

thereafter he was reviewed each morning by the POALT and a member of staff took him on a walk around the hospital grounds while he smoked a cigarette as per his usual routine at home. Following this intervention he no longer attempted to leave the hospital but did however continue to spend his days walking between in-patient wards, apparently out of boredom and a need to be meaningfully occupied. As the ward staff were often unaware of his location the consulting physician in charge of his care felt it would be safer for him to continue his convalescence at a care home.

He was transferred to a care home on the 24th December 2015 where he continually expressed concerns that he was being denied his liberty, felt like "a caged animal," and wanted to return to his flat in sheltered accommodation. Following an AWI Case Conference and reassessment of capacity it was decided that Mr W was fit to return to his own home with a suitable package of care and did so on the 5th February 2016.

In the months that followed Mr W became more and more dependent on his grandson, often calling in the middle of the night over trivial concerns unaware that he was doing so at unsociable hours. Similarly, it was also reported that whilst awake in the middle of the night he would often leave his flat to go for walks.

Power of Attorney

It was becoming clear that there were concerns regarding Mr W's state of mind. The concerns had been on-going for many years and it seemed to indicate a general decline. One potential way to safeguard a person's autonomy for after they have lost the necessary decision making abilities is to do so pre-emptively while capacity is intact. This can be regarding specific instructions as an advance directive, or by appointing one or more person whom you trust with the authority to make certain decisions on your behalf¹³. This is known as Power of Attorney. The appointed person should be able to consider the previously expressed views and wishes of the granter, and execute decisions on their behalf accordingly once the granter becomes incapable of doing so themselves⁸. Mr W's grandson was aware of the necessity to obtain these powers should his grandfather become incapable, as otherwise decision making regarding health and welfare would have to be taken by the respective professionals⁸. This would certainly take account of the family views but ultimate authority for medical care, for example, would lie with the doctor responsible for Mr W. Furthermore, once again Mr W's ability to live safely at home alone was under scrutiny. Aside from increasing social care needs, he was known to keep late hours, had a propensity for wandering and had become disorientated and lost at even a short distance from home. Additionally, it was unclear whether he had actually left the hospital at his latest admission, but it was known that on one occasion he had dismantled his ward alarm bracelet and had not been present. While this is a good demonstration of intact problem solving ability, it is also concerning that his safety, as a vulnerable adult, could be jeopardized. It was probable that due to his previous bad experience at the care home he would not make the decision himself to leave his own home.

Assessing Capacity

As capacity is the ability to appropriately follow through the decision making process it is reasonable that when assessing whether a person lacks capacity it is in relation to a specific decision¹⁴. In this scenario the particular decision being assessed was whether Mr W had capacity to appoint his grandson as his power of attorney; this was initially questioned by his solicitor in light of his erratic behaviour and fluctuant capacity over the last year. It is an important distinction that a patient may lack the capacity to make one decision but retain the ability with respect to another, for example while there is doubt over his ability to determine a power of attorney Mr W's capacity to accept antibiotic treatment for his chest infection was never questioned. Similarly, a patient may be incapable of making a decision at a certain time due to a mental impairment that would not be a problem at a different time.

Capacity assessment is a *two stage process*, the first stage considers whether a patient has an impairment or mental disturbance affecting their cognition, and if this criterion is fulfilled then the second stage considers whether the impairment is preventing that person from making a particular decision at the time it needs to be made.

A person is deemed to be unable to make a decision if they are unable to properly execute all four stages of the decision making process:

1. *understand information relevant to the decision*
2. *retain that information long enough to make the decision*
3. *use or weigh that information as part of the process at arriving at a decision*
4. *communicate a decision by talking, using sign language or any other means*

If a patient is unable to do any of the above criteria at the relevant time and as a result of the mental impairment previously identified then a lack of capacity can be demonstrated.¹⁴

"Do you want your grandson to have Power of Attorney?"

Stage 1 of Mental Capacity Assessment

At the time Mr W's capacity was assessed he did not have a formal diagnosis but he had demonstrated evidence of cognitive impairment having scored 22/30 on a Montreal Cognitive Assessment. Subsequently he would be given a diagnosis of mixed dementia.

Stage 2 of Mental Capacity Assessment

Understanding

It is not essential that Mr W be able to totally understand the minutia of the decision in question, simply that he can broadly comprehend the salient details relevant to appointing a power of attorney. In this case he was informed that this

role would involve legally granting his grandson the ability to make decisions on his behalf regarding finances, medical care, and where he would live whenever he was in a position to not make them himself. By checking his understanding of the information it became clear that he had initially interpreted this to mean that he was handing his estate to his grandson at a time before his death, and while he trusts him to make those decisions after he is departed he did not seem comfortable to allow him to do so while he is alive. This seemed to indicate a general understanding of the nature of a financial power of attorney but the preoccupation with money made it difficult to assess whether he had understood the other details relevant to this decision.

Retention

It is necessary to retain information in order to employ it in making a decision. Mr W had been provided with a leaflet prior to the assessment as well as having been verbally provided with all the relevant information needed to make the decision earlier in the day, although it became clear that he was not able to remember this. However, as a person need only retain the information long enough to make the decision in question it is not necessary to test retention over any long period of time. It may be that the patient does have a problem retaining information but may still be able to reach a meaningful decision in a short time even if they eventually forget. Retention of information was a significant problem for Mr W who was prompted several times regarding the decision he was supposed to be making but could not successfully retain the information.

Judgement

Can the patient use the available information, identify how the various issues relate to each other, and reach a conclusion based on a weighted judgement of the pros and cons? Furthermore even if the patient does reach a decision it is important to consider how they made it. For example it is possible for a patient to understand individual components of an argument but, due to a mental impairment, be unable to see the bigger picture or perhaps reach a decision without due regard of the relevant information. In this case Mr W stated that he trusted his grandson, an indication that he had correctly concluded that trust was a necessary element in making this decision and needed to be taken into account. Ultimately, he could not make a decision and seemed to consider both refusing his grandson and accepting at other times; suggesting he could understand that there were consequences for both responses. While his inability to make a decision could be the result of impaired cognition it is also important to remember that even with full mental capacity it is a part of normal human behaviour to struggle over important decisions.

Communication

Mr W was able to express his thoughts and concerns easily.

Ultimately, it was concluded that Mr W no longer had capacity to make this decision as a result of the cognitive impairment associated with advancing dementia.

At the time of his first admission to hospital his lack of capacity to decide treatment and residence had primarily been the result of delirium. When he had recovered from this acute problem and had his capacity reassessed in the following month he was empirically found to be capable of making these decisions. However, it is still very likely that even at this time he was suffering from dementia given the long history of disorientation, memory problems, and familial concern that preceded the delirium whilst in good health since 2011. Despite a likely underlying cognitive impairment he was able to give due consideration to the risks and benefits that may be associated with living alone, and could make the decision to return home.

The fact that he did not have capacity at this latest assessment for a similarly complex decision is an indication that he had experienced further cognitive impairment in the previous nine months as a result of the advancing course of his dementia. Mr W was not thought to be delirious at this time as, although he had been admitted with a chest infection, his behaviour and faculties, objectively, were largely as they had been. Therefore, as his responsible clinicians had discounted delirium, it is unlikely that he would be able to regain this capacity at any point in the future.

Guardianship

It is predictable that his mental functions will continue to decline and he will eventually become increasingly incapable with age. This is of course the reason his grandson had attempted to gain the power as it is necessary that someone make care decisions in the best interests of Mr W. In Scotland, in cases where the granter does not have capacity to appoint the powers, and the appointment cannot be postponed, then guardianship can legally be granted by a sheriff^{8, 15}. A similar process exists in England and Wales where the court appointed decision maker is known as Deputy². This can entitle a guardian to all the same privileges as power of attorney, but with the disadvantage that the process is more convoluted and can take months to be approved by the court, and potentially at a personal expense to the applier where legal aid is unavailable⁸. It is naturally necessary that such cases would involve more checks and balances to safeguard the interests of adults with incapacity, and indeed in the years following guardianship being granted cases are regularly reviewed¹⁵.

With powers of attorney unattainable then the next step for the grandson would be to apply for a guardianship to assume responsibility for the decisions Mr W cannot make. In the months awaiting approval of this by the court Mr W was moved to a locked old age psychiatric ward to continue his pneumonia treatment and investigation of his dementia. Here relevant decisions are made by the old age psychiatry team with respect to his best interests⁸.

Best Interests

The fourth of the statutory principles of the MCA states:

“an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests¹².”

This is similarly true for the AWI which outlines the five principles a decision maker must follow in these circumstances which are comparable to the concept of “best interest,” these are shown in Box 2:

Box 2: AWI Principles of Decision Making for the Incapable⁸

Principle 1 – benefit

Any action or decision taken must benefit the person and only be taken when that benefit cannot reasonably be achieved without it.

Principle 2 - least restrictive option

Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

Principle 3 - take account of the wishes of the person

In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the person, as far as this may be ascertained.

Principle 4 - consultation with relevant others

Take account of the views of others with an interest in the person's welfare.

Principle 5 - encourage the person to use existing skills and develop new skills

These principles are applicable regardless of who the decision maker is or how serious the decision is perceived to be¹². However, exceptions to the rule occur when wishes expressed in advance are carried out which may not have been in the patients best interest, but is respectful of their autonomy.

Ultimately, Mr W's transfer to the old age psychiatry department for his pneumonia convalescence is an interim measure, as it would be unfair and unnecessary for him to remain there indefinitely. Working out what is in his best interest with regard to his residence needs to take account of the guiding principles.

Cardinally, this is a decision which Mr W has a right to make for himself and his incapacity to do so cannot be assumed without evidence. However, this will require formal capacity assessment as it is the intention of the grandson in pursuing guardianship rights to consider whether residential care is in the best interests of Mr W.

“Where is it in the best interests of Mr W to live?”

Benefit

Mr W is an elderly man with serious medical needs that periodically need to be addressed. Additionally, he requires significant social care to maintain a functional standard of living. With respect to these concerns his physical health would certainly benefit from moving into a residential care home.

However, it is conceivable that his mental health could suffer from such a move; he paints a charming picture of his life in sheltered housing, and it would distress

him to leave it. Primarily, he is most concerned not to have to leave the friends and socialising routines he has made in the years following his wife's death. In this respect it would be beneficial to remain at his current home. However, it is reasonable to believe he could achieve an adequate social life at a residential home.

Least restrictive option

Specifically, this principle relates to what is less restrictive of a patient's liberty rather than deciding what is literally the least restrictive course of action¹². In this case, given Mr W's entrenched habit of going for walks, and reported incidences of wandering at night and getting lost, it will be necessary to restrict his freedom in some way. It is not safe for him to be able to do this unchecked, and he has already demonstrated an ability to circumvent certain limitations when he dismantled his alarm bracelet.

With his current location being a locked ward it must be considered that by comparison a residential home is certainly less restrictive.

Wishes of the person

Mr W has been quite clear in expressing where he would like to live. He does not believe that he lacks capacity to manage his money, his wellbeing, or to take decisions about his residence. He does not wish to go into a care home and would like to go home whenever he is discharged. However, he does not appear to fully appreciate what the risks associated with him continuing to live independently might be, nor does he understand the reasons why people are concerned. This would tend to indicate that he does not have the capacity to make this decision, although that is not a reason to take no account of his wishes.

Consulting relevant others

The most significant other party to this decision, and possibly the person who will make it, is his grandson. Mr W has no other living family, aside from the grandson's own wife and children, and they have a very close relationship since Mr W was largely responsible for his grandson's upbringing. However, despite an extensive social care package it is a daily requirement that the grandson, or his wife, look after Mr W in some way. This has been manageable whilst the grandson's wife did not work, but she has expressed an intention to take up employment. The family feel that Mr W's needs would be best met in residential care, especially as they would become increasingly unable to provide the additional assistance his care currently involves.

The consultant physician responsible for his medical management had been particularly troubled by Mr W's inclination to leave the ward, and had involved the POALT with a view to transferring him to a safer environment. In fact, Mr W was agreeable to the move to a psychiatric ward and found it to be a more stimulating environment than a busy medical ward. In this setting the multidisciplinary team responsible for his care also have an obligation to protect his best interests. In this regard there was a general consensus that this would best be served by a more rigid care environment, especially considering the likelihood of further decline.

Encourage skills

Given that Mr W had very poor memory retention it is unlikely that he could be encouraged to learn new skills that might better serve him to live alone. He had a rigid routine, deviation from which often resulted in confusion.

Conclusion

In balance of the five principles examined it is likely that it is in Mr W's best interests to move into a care home. Naturally, if he is capable of deciding where he should live then it would not be necessary to defer to what is in his best interest. In this case by remaining at home he would be exercising his right to make an unwise decision as per the third principle of the MCA and his fundamental right to self-determination¹⁶.

If deemed incapable it is not that a patient has forfeited their autonomy, merely that it can no longer be determined what exactly their autonomous decision would have been. When decisions cannot be made autonomously it is only fair that the situation be judged objectively, without prejudice, and with respect to the *best interest*.

By examining the values which put together the concept of *the best interest* it can be seen that they are further expressions of the remaining principles of medical ethics.

- *Beneficence*, the best interests involve doing what is right for the patient in given circumstances
- *Non-maleficence*, to understand what are the best interests are you must identify what the subjective and objective concerns are and avoid harming the patient
- *Justice*, the principles to formulate a patient's best interest are set in law, and in such a way to prevent decisions being affected by any bias' resulting from the variety of human values.

Considering that these principles are applied whenever autonomy cannot, would suggest that autonomy does take precedence. Perhaps the primary petition of medical ethics should no longer be "first do no harm," rather as moral standards have evolved it should become "first they decide."

References:

1. Gillon R. Medical ethics: four principles plus attention to scope. *British Medical Journal*. 1994 309 (184)
2. Series L, Arstein-Kerslake A, Gooding P, Flynn E. The Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000 and the Convention on the Rights of Persons with Disabilities: The Basics. *Mental Capacity Law Discussion Paper*. Available from: http://www.39essex.com/docs/newsletters/crpd_discussion_paper_series_et_al.pdf [Accessed 6th December 2016]
3. Adults with Incapacity (Scotland) Act 2000 asp 4.

4. Mental Capacity Act 2005 (c.9) London: HMSO Available from:
<http://www.legislation.gov.uk/ukpga/2005/9/contents> [Accessed 6th December 2016]
5. Chan TC, Luk JK, Liu A, Chiu PK, Chan FH, Chu LW. Financial abuse in a mentally incapacitated old man. *Hong Kong Medical Journal*. 2009 Jun; 15(3):213-6.
6. Manthorpe J, Samsi K, Rapaport J. Dementia nurses' experience of the Mental Capacity Act 2005: a follow-up study. *Dementia*. 2014 Jan; 13(1): 131-43.
7. Nicholson TRJ, Cutter W, Hotopf M. Assessing mental capacity: the Mental Capacity Act. *British medical journal*. 2008; 336:322.
8. The Scottish Government. Adults with Incapacity (Scotland) Act 2000. A short guide to the Act. Available from:
<http://www.gov.scot/Resource/Doc/217194/0058194.pdf> [Accessed 6th December 2016]
9. Prince M, Knapp M, Guerchet M, McCrone P, Prina M, Comas-Herrera A, Wittenberg R, Adelaja B, Hu B, King D, Rehill A and Salimkumar D. *Dementia UK: update. 2nd ed.* Alzheimer's Society; Nov 2014.
10. Raymont V, Bingley W, Buchanan A, David AS, Hayward P, Wessely S, et al. Prevalence of mental incapacity in medical in-patients and associated risk factors: cross sectional study. *Lancet*. 2004; 364: 1421-7.
11. Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M. Mental capacity in psychiatric patients: Systematic review. *The British Journal of Psychiatry*. 2007 Oct; 191: 291-7.
12. Department of constitutional affairs. *What are the statutory principles and how should they be applied?* Mental capacity act 2005. Code of practice. 1st ed. Norwich: The Stationery Office; 2007.
13. Bronner K, Pernecky R, McCabe R, Kurz A, Hamann J. Which medical and social decision topics are important after early diagnosis of Alzheimer's Disease from the perspectives of people with Alzheimer's Disease, spouses and professionals? *BMC Research Notes*. 2016 Mar; 9:149.
14. Department of constitutional affairs. *How does the act define a person's capacity to make a decision and how should capacity be assessed?* Mental capacity act 2005. Code of practice. 1st ed. Norwich: The Stationery Office; 2007.
15. Mental Welfare Commission for Scotland. *Welfare Guardianship*. Available from: <http://www.mwscot.org.uk/the-law/adults-with-incapacity-act/welfare-guardianship/> [Accessed 6th December 2016]
16. Howe H. Ethical aspects of evaluating a patient's mental capacity. *Psychiatry*. 2008; 6(7): 15-23.

FEATURES

Health and Care of Older People in England 2017

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Age UK's report entitled 'Briefing: Health and Care of Older People in England 2017' aims to use 'the most authoritative data available', most from official sources, to determine how well our current health and care system is working for older people. Whilst the report is unashamedly heavy on facts and figures it qualifies this by saying '...never forget that behind them are millions of 'real' older people'. It manages to elucidate evidence for clinicians to put their daily work into some wider perspective. This article outlines salient points from an important and highly topical report.

The health and care needs of our ageing population

Adequate health service provision is especially important as we grow older due to our increased need, with six out of seven people in their early eighties having a diagnosed long term health condition. Access to social care is equally as essential considering over one third in their late eighties will struggle to complete five or more activities of daily living without assistance. The over 85 population has increased by nearly a third in the last ten years, and this aging population is thought to be one of the factors most responsible for our increasing health and care burden. The number in this age category is predicted to double by 2036, the report suggests we will therefore clearly need to expand health and care provision for this group, identifying which services should be increased and to what extent.

The state of social care

The growth in the older population has resulted in an increased demand for social care, and to cater for the expected population in 2020/21 the report suggests we would need to increase current spending by at least £1.65 billion. However, between 2010/11 and 2015/16 there was a £160 million cut in spending on social care, leaving just short of 1.2 million aged over 65 without necessary assistance with ADLs in 2016, about 18 percent more than the previous year. The report further noted that nearly 1 in 8 older people currently have at least one need unmet, and that an estimated extra £4.8 billion a year would be needed to ensure every older person in this group has access to social care (increasing to £5.75 billion by 2020/21). Despite this, overall local government spending on social care is estimated to actually fall by 8.3 percent between 2015/16 and 2019/20.

Carers and the care market

In 2015, there were over 9 million carers in England (and interestingly over two million carers being aged 65 and over; 417,000 of these being aged 80 and over) but although the overall number of carers has been rising, the actual percentage of the population providing care has not substantially increased. 1 in 5 people over 65 provide care, emphasising that many carers are older people themselves, and it is important to remember that around two thirds of these older carers will also have a health condition or disability. The contribution by informal carers was valued at a staggering £132 billion in 2014/15, and any small reduction in this contribution would have a huge impact on demand for formal care. The report opines that this all points towards informal care provision by families and communities as 'reaching the practical limits of care they are able to provide in the context of a rapidly ageing population'.

The state of healthcare

The report puts the current NHS financial state into recent historical context. The annual NHS budget has risen from £91 billion to £117.2 billion over the last 10 years. However, it has not been steadily rising, and actually decreased in 2010/11 with a slow rate of yearly increase since. Investment across different sectors has been uneven, for example between 2009/10 and 2012/13, spending on hospital services increased by 6.2 percent to £45.78 billion but funding for primary care GP services fell by about 3 per cent to £8.14 billion. For the same period, the report observed funding for mental health grew by 'just' 2.5 percent to £9.1 billion. By 2015/16, the deficit in NHS hospitals was £2.5 billion, which has rapidly increased from £109 million in 2013/14 despite increases in funding. In light of this growing deficit hospitals are trying to make cuts and so far in 2016/17 have saved £1.2 billion. A large proportion of this saving, about £900 million estimated for this year, was through controls on agency staff spending. The overall effect of this is that the UK now spends less per head on health services than the average for OECD countries; in 2014 this figure was £3,935, compared with £5,411 in Germany and £9,522 in Norway.

Despite a growing demand the report notes that since 2010/11 there has been a relatively small increase in the size of the NHS workforce. The biggest increase has been amongst doctors, especially those working in hospitals and community health services. However, GP numbers fell by 3.4 percent between 2010 and 2015, despite demand increasing steadily over the last 20 years. The report provided interesting data on the increasing demand for GP services. It noted that the number of consultations rose by 38.3 per cent to 300 million between 1995 and 2008, meaning the estimated number of consultations for an average GP practice increased from 21,100 to 34,200. Estimates for GP consultations for 2013 reached 340 million. In terms of the older person, a Kings Fund report found that between 2010/11 and 2014/15 the proportion of contacts with the over 85 population grew by 16 per cent compared to just four per cent for those aged 18 to 64.

The impact on older people

An increasing number of older people are being seen in A&E departments (very topical given the recent winter pressures on A&E making media headlines on a regular basis), with the number of patients aged over 60 increasing by 20.7 percent between 2009/10 and 2014/15. The total number of hospital admissions is also on the rise, with 65 percent of these for older people. In addition, the number of outpatient appointments for people aged over 60 has significantly increased by a third to over 36 million in recent years (the report noting that 'once again' this increase is far greater than the increase in overall numbers of people in this age group).

The length of hospital stay is longer for older people, with those in the over 75 age category staying an extra 4.1 days on average than the general population. The number of days lost to delayed discharge from hospital has been rising as evidenced by waits for home care to be provided having increased by 181 per cent to nearly 36,000 delayed days between 2010 and 2016. This is coupled with a concomitant increase in delays for transfer to residential placements increasing by 40 per cent. Such issues are sadly now most likely a routine experience for most clinicians working with older adults. Importantly, the report noted the total number of people waiting has not risen nearly so fast, indicating waiting times for each individual are increasing rather than an increased demand for these services. Interestingly around the same time this Age UK report was released, the Royal Society of Medicine (2017) released a report concluding that failures in the health and social care system linked to disinvestment were likely to have been the main cause of a substantial increase in mortality (largely in the older population) in England and Wales in 2015.

Fit for the future?

This report concludes that England's current health and care system is nowhere near right for our aging population, and this unfortunately is having negative consequences for many. More and more older people are not having their care needs met, yet funding for social care is falling and there is difficulty recruiting staff to work in the care sector. Insufficient social care is resulting in delayed discharges from hospital, ultimately having a negative impact on anyone needing a hospital bed. Until now, the report notes the Government has just about been able to sustain social care services through increases in Council Tax, suggesting 'families must do more' and NHS cash transfers, but considering the financial stress the NHS is under the latter will not be possible for much longer.

Government policy aims to join together and improve access to health and care services for older people, enabling them to be independent for longer and prevent unnecessary hospital admissions. Age UK agrees that this is the right way forward, but questions whether there is sufficient funding to achieve this. The Sustainability and Transformation Plans (STPs) have been created to help local health and care systems develop to meet changing needs. However, the response to this has been largely negative due to views that they plan to make cuts, for example in hospitals, rather than redistributing funds to better serve the changing population.

Our over-85 population, the most frequent users of health and care services, is predicted to rapidly grow over the next two decades. The report suggests that so far the Government has been failing to provide adequate resources to cater for growing demand, but going forward changes to services need to be made quickly before things spiral out of control. Following the EU referendum, public interest in how this country is being run is at a high, and this is therefore an ideal time to debate how best to care for our growing older population.

References

Age UK (2017) *Briefing: Health and Care of Older People in England 2017*
[http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The Health and Care of Older People in England 2016.pdf?dtrk=true](http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true)

Royal Society of Medicine (2017) *New analysis links 30,000 excess deaths in 2015 to cuts in health and social care.*
<https://www.rsm.ac.uk/about-us/media-information/2017-media-releases/new-analysis-links-30000-excess-deaths-in-2015-to-cuts-in-health-and-social-care.aspx>

Are the service users on our frail functional ward frail and functional?

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Background

Many UK services are “ageless” with the only specialist “old age” wards being dementia wards. Hertfordshire Partnership University NHS Foundation Trust,(HPFT) used to have mixed old age wards with functional older patients and people with dementia. We have set up a new 16 bedded ward for older people with functional mental illness. This covers the Hertfordshire population of around 1.1 million, and 191 000 over age 65 (1). Of these, 5300 are predicted to have severe depression (1).

The Royal College of Psychiatrists believes older people have specialist needs and that to ignore these needs is discrimination rather than non-discrimination (2). One reason for the belief that older people have specialist needs is the high

prevalence of “overlap” patients who cannot be easily defined as purely organic or purely with functional illnesses.

Aims and objectives

- 1) Are our service users frail? – We counted Long Term Health Conditions (LTCs), and recorded abilities in mobility, vision and hearing.
- 2) Are our service users functional? – Do they score above the cut-offs on cognitive testing?

Methodology

The study was carried out by gathering the patient details who were admitted to Wren ward between 06.08.2014 to 30.01.2015. There were total 19 patients admitted during this period. We collected the following data: Date of Admission, MMSE (Mini Mental State Examination) (3), ACE-III (Addenbrooke’s Cognitive Examination III) (4) scores, Diagnosis, Age, Mobility status, Sensory disabilities, Long Term Condition count and originating community team.

A long term condition (LTC) is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies. The latest data from the Quality and Outcomes Framework (QOF) and the 2009 General Lifestyle Survey suggest that around 15million people (30 per cent of the population) in England have a long term condition (5). There are 15 domains: Hypertension, Asthma, Diabetes, Coronary Heart Disease, Chronic Kidney Disease, Hypothyroidism, Stroke or Transient Ischaemic Attacks, Chronic Obstructive Pulmonary Disease, Cancer, Atrial Fibrillation, Depression and Mental Health. In this audit mental health problems and depression were excluded and rest of the 13 domains were used as physical health count.

One patient had a known mild dementia prior to admission and was admitted to our ward due to risk of absconding. Four more patients were admitted with functional diagnoses but changed by us to an organic diagnosis following in-patient assessment.

Findings

Cognition

Of the 19 patients admitted, 12 were assessed with the ACE-III, 16 with the MMSE and 7 had no structured cognitive assessment. Of the 7 who were not tested, 5 refused and in 2 cases the treating team recorded “cognition grossly intact”.

Figure 1a

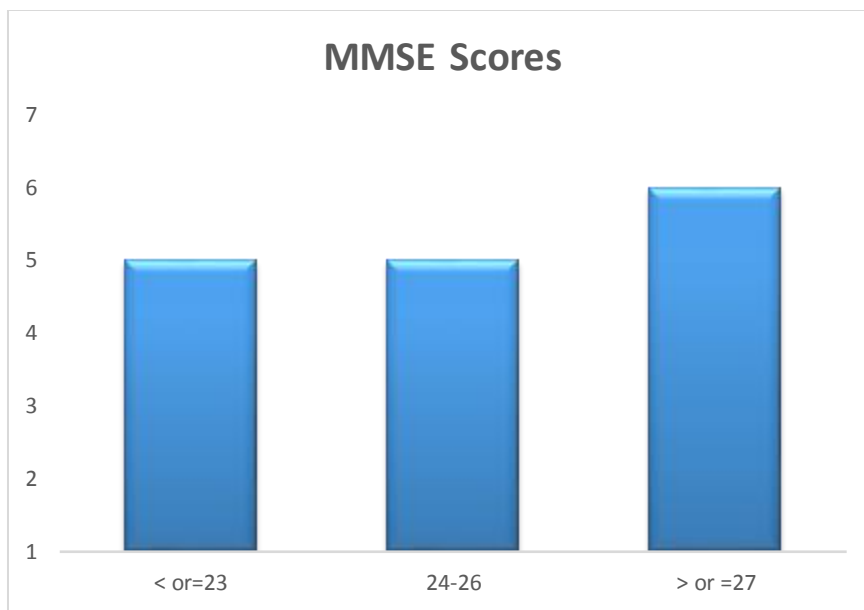
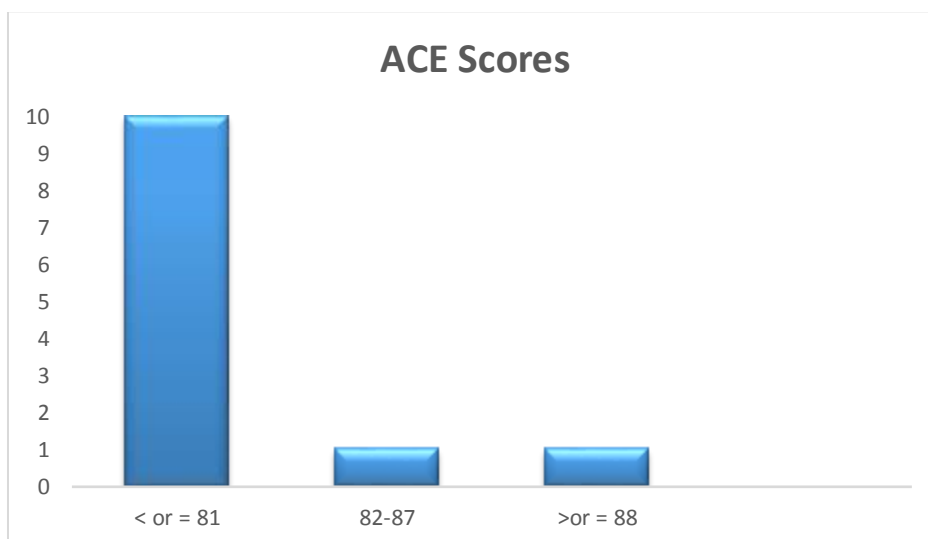


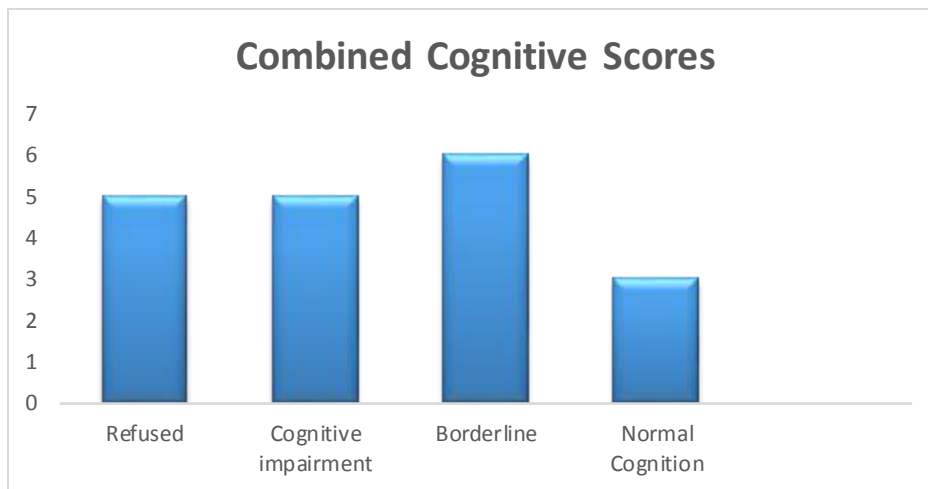
Figure 1b



Combined cognitive tests

In order to combine our two cognitive tests we took scores of 24 – 26 on the MMSE and 82 to 87 on the ACE as “Borderline”. Patients with one test pass and the other fail were included in this category. Patients with one test borderline were also treated as borderline for the combined figures (in particular many of the people who scored above 26 on MMSE did not score above 87 on ACE-III). Below this we recorded “cognitive impairment” and above, “normal cognition”. Only one patient was recorded as “normal cognition” on testing. In the figure below we have added the two other patients who did not have structured testing but were recorded as “cognition grossly intact”.

Figure 2



Frailty measures

Of the 19 patients, 3 had no long term condition, 16 had between 1 and 4 and no-one had more than 4 LTCs.

On testing mobility there were 17 patients who were mobile independently, 1 patient chair bound and 1 used walking aid.

Table 1 shows the data for patients who were admitted with an LTC count of 0, mobile and no sensory deficit. This also included the people with a primary dementia diagnosis.

Table 1

Age	LTC 0 and mobile and sensory deficit 0 ("not frail")	LTC>0 or sensory deficit or not mobile ("frail")
<65	1	4
66-69	1	1
70-74	0	3
75-79	2	1
80+	0	6
Total	4	15

Conclusion

Conventionally, two main groups of older people with mental health problems have been identified depending on diagnosis: those who have an 'organic' brain disorder such as dementia; and older people with so-called 'functional' disorders, most commonly affective disorders, and also people with schizophrenia and other

psychoses. This categorisation has largely remained despite its limitations, as the two groups can have very different needs.

Having separate in-patient beds for functional and organic disorders has been consistently regarded as good practice (6, 7). People with severe depression, for example, may find that sharing their living space with people with behavioural problems can make them feel worse. The effect on people with dementia of sharing a ward with people with severe depression may also be unhelpful. The type of supervision needed for the two groups may be quite different (8). Our trust constructed a new unit in 2014 and now provides separate in-patient wards for functional and organic disorders.

Cognitive Scores

Roughly 50% of our patients who were tested scored either side of the traditional MMSE cut-off of 23/24. Out of 12 patients tested with the ACE-III, only one scored above the higher cut-off and another one above the lower cut off. 10 of the 12 had an ACE score which would suggest dementia.

5 of our patients were diagnosed with dementia by discharge, but in only one of these was this diagnosis established before admission. This evidences the common experience that an individual's clinical presentation can change over time, we often see more organic illness build up in someone with functional illness in old age. It also emphasises the need for a full in-patient assessment to clarify the diagnosis of some patient.

While the separation of the "frail functional" patients from people with an overt dementia has been good for care of both groups, these findings perhaps emphasise the specialist nature of Old Age Psychiatry. Any attempt to provide only dementia or "all age" functional services will be doomed to miss this important group with "functional" illness but evidence of significant cognitive impairment which does not amount to frank dementia.

Frailty

In order to test if our ward is correctly being used for frail patients we combined a long term condition count with information about mobility and sensory deficits. We found that a majority of patients fitted our criteria for frailty but a significant minority did not.

Summary:

In summary our findings were that a majority of our functional ward patients had at least borderline cognitive impairment. Some of these had a dementia diagnosis, but many did not. Planning of dementia and functional mental health services needs to cater for the large number of elderly people who fall in the borderline between these two theoretical groups. A majority of people admitted to our ward met our frailty criteria.

References

1. Projecting Older People Population Information (POPPI) [online] Oxford and Bath: Institute of Public care. [Accessed December 2014]. Available at: <<http://www.poppi.org.uk/>>.
2. Warner, J (2014) Wither old age psychiatry? *International Psychogeriatrics, International Psychogeriatric Association*, pp.1-4.
3. Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**(3), pp.189-198.
4. Hsieh, S., Schubert, S., Hoon, C., Mioshi, E and Hodges, J.R. (2013). "Validation of the Addenbrooke's Cognitive Examination III in frontotemporal dementia and Alzheimer's disease." *Dementia and Geriatric Cognitive Disorders*, **36** (3-4), pp. 242-50.
5. Department of Health (2012) Long Term Conditions Compendium of Information: Third edition. Leeds: England.
6. Royal College of Psychiatrists (2006) Raising the Standard: Specialist Services for Older People with Mental Illness. Royal College of Psychiatrists.
7. Audit Commission (2002) Forget Me Not 2002: Developing Mental Health Services for Older People in England.
8. Audit Commission (2000) Forget Me Not: Mental Health Services for Older People. Audit Commission Publications.

Physical Restraints and Asphyxial Deaths

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Physical restraints remain widely used in the care of older people despite concerns about their safety and appropriateness. Estimates of physical restraint prevalence vary greatly between (and within) countries. This predominantly reflects differences in tradition and practice, but comparison of studies is often complicated by the use of different definitions and inclusion criteria, particularly with regard to whether bedrails are regarded as restraints.

A group of international experts recently agreed on the following definition: 'Physical restraint is defined as any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to his/her body

by the use of any method, attached or adjacent to a person's body that he/she cannot control or remove easily' [1]. The intention of physical restraint usage was not regarded as relevant given that 'the consequences of physical restraint use remain the same'.

While acknowledging that 'the intention isn't to restrain but to prevent falls' has too often been abused as a rationale for restraint, there are disadvantages to focussing on the overall prevalence rate for physical restraint use rather than on the particular devices used and the indications for their use. Firstly, recent work has clarified those clinical situations where bedrail use seems appropriate, such as for bed bound patients without cognitive impairment or with markedly reduced alertness, or inappropriate, such as for those with agitation or who can transfer from bed independently [2]. The same argument could be made for the use, for example, of special chairs for those whose postural instability will not otherwise allow them to sit safely. Secondly, different restraints restrict individual freedom to different degrees with, for example, direct contact restraints such as straps being particularly restrictive.

Recent evidence also suggests that different restraints also differ in the risk of death by asphyxiation - the most horrific complication of physical restraint. In a study of Australian nursing home resident deaths reported to the Coroner over a 13-year period, five deaths directly attributable to restraints were identified [3]. All five residents had poor mobility and four had dementia. Two residents died from neck compression from a lap belt after slipping down in their chair. Three residents were asphyxiated following falls from bed and entrapment in bedrails (one) or bed side netting (two).

It could be argued that, considering the approximately 160,000 nursing home residents in Australia, 5 deaths in 13 years means that such deaths are thankfully rare. It is important, however, to consider that the denominator for assessing risk with a particular restraint will depend on the frequency with which that restraint is used. While recent Australian data are not available, bedrails are used for 20-70% of nursing home residents and other devices, including fixed tables and lap-belts for chairs and abdominal and limb belts for beds, are used in 3-10% of residents in Europe and North America [4]. A prevalence of bedrail/ bedside netting use of 20-70% in Australia would equate to one death per 139,200 to 485,000 person-years for those restrained in this way, and a prevalence of 3-20% for other restraints would equate to one death per 31,200 to 208,000 person-years.

Other studies support a worrying risk of death from trays and belts. A 1992 Minnesota study concluded that vest, tray and belt restraints caused a minimum of one out of every 2,000 nursing home deaths, with almost 60% of such deaths occurring in chairs [5]. In a more recent series, 22 deaths caused by physical restraint from belts, 16 of them in nursing homes, were identified from 27,353

autopsies over 13 years in a Munich institute [6]. Most deaths were blamed on failure to apply abdominal straps in bed, with or without bedrails, correctly. Given that the catchment area for the Institute has about 7.5 million people, with about 66,000 nursing home residents, and accepting a 3-10% prevalence of tray and belt restraints for nursing home residents, this suggests a very alarming risk of death from such restraints of the order of 1 per 1,600 - 5,400 person-years.

Why might there be such differences in the risk of death from non-bedrail restraints between Australia and Bavaria? Selection of residents for restraint may play a role: the greatest risk for harm from restraints may be with those who are most agitated. Abdominal straps may be a particularly dangerous restraint. Differences in autopsy rates, especially for nursing home deaths, would significantly affect detection of restraint-related deaths. Finally, deaths due to restraints are often underreported and may even be deliberately concealed [5], and more such deaths might be missed in Australia.

There is a need for better data about the frequency and type of physical restraints in different countries, for national registries of deaths that might be due to restraints in nursing homes and for more vigorous investigation of unexpected or suspicious deaths occurring in a nursing home.

Another response to these findings, sometimes seen in the recommendations of coroners following restraint deaths, is less welcome: an emphasis on the better design of restraints or on improvement of staff training in how to restrain. (It is sad to note that one of many companies manufacturing a variety of restraints bears the name of Pinel who, with Pussin and others, started freeing the mentally ill from chains more than 200 years ago). The major concerns regarding physical restraints relate more to the potential for causing psychological distress and discomfort than to the rare disasters that can occur. Large multi-component intervention studies have found that the frequency of restraint use can be cut dramatically without significant increase in psychoactive drug use or in falls-related injuries [12,16,17], and this should be the priority.

References

1. Bleijlevens MH, Wagner LM, Capezuti E, Hamers JP. Physical restraints: consensus of a research definition using a modified Delphi technique. *J Am Geriatr Soc* 2016; 64:2307-10.
2. O'Keeffe ST. Bedrails rise again? *Age Ageing* 2013; 42:426-7.
3. Bellenger E, Ibrahim JE, Bugeja L, Kennedy B. Physical restraint deaths in a 13-year national cohort of nursing home residents. *Age Ageing* 2017; doi: 10.1093/ageing/afw246
4. Feng Z, Hirdes JP, Smith TF, et al. Use of physical restraints and antipsychotic medications in nursing homes: A cross-national study. *Int J Geriatr Psych* 2009; 24:1110-8.

5. Miles SH, Irvine P. Deaths caused by physical restraints. *Gerontologist* 1992; 32:762-6.
6. Berzlanovich AM, Schöpfer J, Keil W. Deaths due to physical restraint. *Dtsch Arztebl Int.* 2012; 109:27-32.
7. Harris JC. Pinel orders the chains removed from the insane at Bicêtre. *Arch Gen Psych* 2003; 60: 442-442.
8. Köpke S, Mühlhauser I, Gerlach A, et al. Effect of a guideline-based multicomponent intervention on use of physical restraints in nursing homes: a randomized controlled trial. *JAMA* 2012; 307:2177-84.

The use of group therapy in older adults: An overview of three diverse therapies in St Patrick's University Hospital

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One in five people over 65 rated themselves as having three or more depressive symptoms in the Health survey for England 2005, the most recent British health survey looking at mental health in older adults⁽¹⁾. Woods and Roth found that a '*..substantial number of older people with depression do not recover with the standard treatments, and relapse is a major issue*'⁽²⁾. There is a theory that personality disorders, particularly in the A and C clusters can often be significant contributors to depression and may lead to poor outcomes, a factor that is not readily treatable with medication⁽³⁾⁽⁴⁾⁽⁵⁾. In 2009 a report by Agronin found that '*A limited number of outcome studies have found that various forms of group therapy in late life are generally efficacious for depression...and compare favourably with individual psychotherapy*'⁽⁶⁾. Of course, there are many barriers to group therapies in later life. As we age, hearing, sight and cognition can become an issue. There is also the cultural barrier of older people not wanting to voice their difficulties in a group setting and a greater stigma around mental health issues as compared to younger generations. So, how do we get around these obstacles and why should we try?

Group therapy for older adults can offer several advantages including the opportunity for social contact with peers, sharing age-related concerns with others, and a chance to give and receive feedback. It also gives individuals an opportunity to be altruistic and supportive of their peers, which is important for self-esteem and a sense of belonging. St Patrick's Mental Health Service (SPMHS) is an independent not-for-profit private facility in the Republic of Ireland. More than 40% of admissions are of patients over the age of 65. Along with the aforementioned therapeutic benefits, group therapy is also an efficient method of service provision. In SPMHS we have three diverse groups designed specifically

for those over 65: the Evergreen programme, Sage program of psychology skills, and 'Living life to the full' which is based on self help CBT classes. In this article I will be discussing these therapies and what they offer the older person.

During the inpatient journey at SPMHS there is a well-established tradition of psycho-education. This was the impetus for starting the Evergreen programme. The Evergreen programme is a psycho-educational group that was developed in 2003 ⁽⁷⁾ and is hosted for inpatients at SPMHS. One of its main strengths lies in the fact that it is facilitated by various members of the old age multidisciplinary team including the consultant, clinical nurse specialist, ward nursing staff, psychologist, pharmacist, social worker occupational therapist and pet therapist with the Irish therapy dogs network. This gives the programme a broad base with a holistic ethos. The Evergreen programme aims to promote the positive mental health of inpatients aged 65 and over. By emphasising the themes of independence and recovery, a focus is created upon resilience and regeneration, rather than illness and disability. The programme aims to de-stigmatise clinical conditions such as depression, anxiety and memory disorders as well as to challenge stereotypes of later life. Therapeutic nihilism in the past has led to the idea that illness and despair are natural parts of later life. During Evergreen sessions, we aim to remind people that this can be an enriching phase of life with its own joys and challenges. The term 'Evergreen' itself was chosen to symbolise strength, longevity and wellness over adversity.

The Evergreen programme takes place in the group room on the old age ward thus maximising patient involvement. Early participation in the programme is encouraged. There is a total of thirteen groups each week which explore various domains of mental health including self-care, changes and transitions in role and life and improving physical well being. These sessions are limited to 30-40 minutes each. Practical facilities such as earphones with a sound amplifier are provided to those who need it. Patients are encouraged to give anonymous feedback in a letterbox on the ward and a monthly focus group is hosted by the chair of the Hospital's Consumer Council. Feedback is discussed by the team at a quarterly review meeting. Groups are well attended which we interpret as either positive affirmation, or effective coercion by our nursing colleagues!

Sage is a psychotherapeutic group provided by two clinical psychologists who have a particular interest in old age, along with an assistant psychologist. It is available to both inpatients and outpatients over 65 although younger patients may also avail of the programme. Sage is aptly named as its aim is to help patients move towards the *"...profound wisdom that comes with age"*. The underpinning model is adapted from Thomas Lynch's ⁽⁸⁾ novel approach of Radically Open Dialectical Behaviour Therapy (RO-DBT) for recurrent depression. It highlights the role of emotional over control and its impact on social behaviours in the development and maintenance of a range of mental health issues. Participants are taught eight skills over eight weeks and then repeat these for a further eight weeks to consolidate

the information. Unlike dialectical behavioural therapy which aims to move patients into 'wise-mind', RO-DBT aims towards 'flexible-mind' which involves the relaxation of rigid methods of self control, increasing intimacy and self-disclosure, activating the social safety system and increasing self enquiry to learn from novel experiences. RO-DBT is used in the general adult population but further adaptations have been made in applying it to older adults in an Irish context. These include more introductory materials on the role of psychological factors in mental health issues, increased emphasis on sensitivity to values around privacy and avoidance of references to the programme as a 'class' due to past adverse educational experiences. The psychologists involved have described the valuable ingredient of group cohesion, a factor that Thomas Lynch has termed "the tribe". This occurs between group participants during the therapy with group validation and support proving to be vital components of this treatment.

'Living life to the full' is a cognitive behavioural therapy group which the old age team provide to outpatients over 65. It is designed by Professor Chris Williams, Professor of Psychosocial medicine at the University of Glasgow ⁽¹⁰⁾. It involves weekly classes lasting an hour and a half each for six weeks. This is facilitated by the same consultant and clinical nurse specialist each week, both of whom are known to the participants. Traditional aspects of cognitive behavioural therapy including the interaction between thoughts, feelings, actions and physical sensations are taught. A short video recapping the information given is shown at the end of each session. Each session combines a lecturing style with open discussion and patient participation. Patients are encouraged to think, reflect upon and share their experiences in order to incorporate the skills learned into everyday life, although they are also reassured in advance that no personal matters need to be disclosed to the group. Participants are given booklets and worksheets at each session to facilitate reflection and practice in their own time.

In conclusion, there are many potential obstacles to group therapy in older adults, including organic deficits and cultural values around privacy. Self-stigmatisation and a lack of emotional awareness can also prove to be challenging. However, it is possible to adapt group treatments accordingly. Group therapy can be an enriching experience for those over 65 with social contact, validation and the teaching of new skills being core components. Although a greater evidence base is needed, as is the formalising of referral criteria and outcome measures for each of the three group interventions, anecdotal reports are largely positive. The development of group therapies for older people in the future is an important measure given the rapidly expanding older population and the potential benefits.

Bibliography:

1. Craig R, Mindell J. *Health survey for England 2005: the health of older people.*: Information Centre. London : 2007.

2. Woods R, Roth A. What works for whom? A critical review of psychotherapy research (second edition). [book auth.] Fonagy P (eds) Roth A. *Effectiveness of psychological interventions with older people*. New York : Guilford Press, 2005.
3. T Lynch et al. *Treatment of older adults with co-morbid personality disorder and depression: A dialectical behavior therapy approach*. International Journal Geriatric Psychiatry, 2007, Vol. 2.
4. J.-P. Schuster, Hoertel N, Le Strat Y, Manetti A, Limosin F. *Personality disorders in older adults: Findings from the national epidemiologic survey on alcohol and related conditions*. American Association for Geriatric Psychiatry, 2012. 1064-7481.
5. More JQ, Lynch TR. *A preliminary investigation of self-reported personality disorders in late life: prevalence, predictors of depressive severity, and clinical correlates*. Aging and Mental Health, 2004, Vol. 8.
6. M, Agronin. *Group therapy in older adults*. Current Psychiatric Report, 2009, Vols. 27-32. 11.
7. Lyons D. *An Agenda for Positive Aging: Lessons from Ireland*. American Psychological Association, 2004, Vol. 59. 978-1-62948-714-4.
8. Lynch T. R., Hempel R. J., & Dunkley C. *Radically Open-Dialectical Behavior Therapy for Disorders of Over-Control: Signaling Matters*. American journal of psychotherapy, 2015, Vol. 2:69
9. T Lynch et al. *Radically open-dialectical behavior therapy for adult anorexia nervosa: feasibility and outcomes from an inpatient program*. 2013, BMC Psychiatry, Vol. 13, p. 293.
10. C Williams. *Living life to the full*. Media innovations, 2008.

We are pathologising old age

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The points of reference of normality and health have been placed firmly in young adulthood. Old age has lost the value it once had. When life was more stable than it is now and technology did not change the way people lived each new generation, older people acted as the community's reservoirs of wisdom. Patriarchal and matriarchal societies in the relatively recent past listened to the opinion of their elders in times of crisis. Whether this social prestige would have been enough to compensate for the losses often experienced in old age is a different argument, of course. We still have sporadic examples of gerontocracy, like the Pope, or the

American president, but the former is the head of a traditional and unique gerontocracy and the latter is an exception to this and many other rules.

From a cultural point of view, old age is not so much rejected as it is denied. Old people are rarely seen in cinema and TV dramas, and when they are shown, they tend to be portrayed in negative roles (1). Alternatively, they may be depicted in benign but infantilising roles, often pretending to be young and portrayed as frisky, disinhibited and generally comic. Given that most films belong either to the romance or to the action genres, one can forgive script writers for not including many old people in their stories. To put it brutally, the loss of sexual attractiveness and physical vigour that comes with age has erased old people from popular culture. Old has become abnormal and therefore, in a sense, pathological.

We, old age psychiatrists, know better, of course. We know that there is a dignity in growing old well and that it shouldn't be necessary to pretend to be young to be valuable. And yet, we also unwittingly contribute to the marginalisation of old age by pathologising one of its inherent attributes. We accept oldness, but not forgetfulness. The British Medical Journal has been arguing for some time that our profession over-medicalises life in general (2), but in old age we seem to over-medicalise cognitive issues in particular. No doctor would regard a diminution of physical strength, or a wrinkly skin, as pathological processes in old people, and yet the relative loss of mental agility that tends to be associated with old age is often given a name - Mild Cognitive Impairment- and an ICD-10 diagnostic code. This is despite the fact that MCI has no useful value in predicting dementia. MCI is a risk factor for dementia, but most people with MCI do not go on to develop the disorder (3). And there is no evidence that it is frequently associated with the essential characteristics of a medical disorder, such as suffering or distress, other than that resulting from the worry of receiving a pre-dementia diagnosis, ironically.

Any loss of mental acuity is arguably a bad thing, but so is any loss of physical strength, skin suppleness, fertility, or sexual attractiveness. So why do we single out cognition as the one area of decline that deserves an ICD-10 code?

We reside in our brains, so any mental decline, however mild or natural, embodies an entire process that ends with death. Devoid of the positive social attributes that she once held, and unable to manage new technologies, the slightly forgetful old person is now marginalised and labelled as pathological.

Celebrating old age may be a challenging task, but we should at least accept it for what it is, warts and all. Denying old age by pretending to be young is undignified and futile. Denying the attributes of old age by declaring them abnormal is also futile. Old age is natural and potentially beautiful. An early death is the only way to avoid it, so it is also desirable, even if it brings with it a wrinkly skin and a little forgetfulness.

References

1. Vasil L, Wass H. Portrayal of the elderly in the media: A literature review and implications for educational gerontologists. *Educational Gerontology* 1993, 19:71-85. <http://dx.doi.org/10.1080/0360127930190107>
2. BMJ. Too much medicine. <http://www.bmj.com/too-much-medicine>
3. Matthews FE, Stephan BC, McKeith IG, Bond J, Brayne C, Medical Research Council Cognitive Function and Ageing Study: Two-year progression from mild cognitive impairment to dementia: To what extent do different definitions agree? *Journal of the American Geriatrics Society* 2008, 56:1424-1433.

EVIDENCE

Exciting times for Older persons mental health: Conference update.

Dr Anitha Howard.

The Faculty of Old Age Psychiatrists Conference Update, Bristol, March 22 to 24 2017, **#oapsych2017**.
@RCPsychOldAge

How do you move a large magnet into a small room? How do we make depression in Older people more understandable to the general public? How can we raise the profile of older person's mental health and how can old age psychiatrists develop integrated care?

These were some of the questions were raised on the first day of the Faculty's conference this year and, Dr Amanda Thompsell's speech ,on the exciting times older person's mental health are currently in, was great start to the day. A theme, echoed in Alistair Burn's speech which highlighted the need to make depression in older people more relatable to the people because it is under detected and undertreated.

Professor John O'Brien updated the audience on the new research initiatives in older persons' mental health including Biomedical Research centres and Dementia Platforms and also managed to fit in receiving the lifetime achievement award as well. Dr Helen McCormack, discussed the new report from the college on Integrated care for Older Adults while Dr Karen Franks described an example of an Integrated service with Gateshead Care Home Initiative.

The afternoon had workshops ranging from Young Onset Dementia to Social media with Dr Krishnan's bid to increase the number of the followers on Twitter for the Old Age Faculty (**@RCPsychOldAge**). Thursday ended with an informal Q and A sessions with members of the executive committee and a Bollywood themed conference dinner.

Highlights from Friday included Dr Rob Howard delivering the results of the ATLAS trial and, yes, antipsychotics are beneficial in the treatment of late onset schizophrenia like psychosis. Other highlights included Dr Julian Hughes updates on value based practice and how this could affect consent in the future. The importance of recognising Autism in Older People was reinforced as well as Carer's and Patient's view on End of Life care in dementia.

As always, the posters and new research competition covered a range of interesting topics and were of the highest quality- a fitting end to the conference *And how do you fit a large magnet into a room? - You break down a wall, of course.*



And the winners are,

Professor John O'Brien, The life time achievement award

Dr Kathy Liu, Old Age Psychiatrist Essay Prize 2016.

Dr George Crowther, Poster Prize award.

Dr Itunuayo Ayeni, Philip Davies Prize award.

Matthew Hastings, Medical Student Essay Prize.

Dr Jay Amin, Mohsen Naguib New Research Prize.

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

Ayesha Bangash, trainee editor

If we knew what we were doing it would not be called research, would it?

Albert Einstein

This update has been produced to apprise readers of what is happening in the world of psychogeriatric research. Papers discussed below have been published within the last 3 months.

Delirium superimposed on dementia: phenomenological differences between patients with and without behavioural and psychological symptoms of dementia in a specialized delirium unit

Abengana J, Chong MS, Tay L. Delirium superimposed on dementia: phenomenological differences between patients with and without behavioural and psychological symptoms of dementia in a specialized delirium unit. *Int Psychogeriatr* 2017, 29:3, 485–495.

A 2 year prospective cohort study of patients admitted to a specialized delirium unit sought to examine differences in delirium presentation and outcomes between DSD (delirium superimposed on dementia) patients with and without pre-existing behavioural and psychological symptoms of dementia (BPSD). It was seen that pre-existing BPSD significantly influenced the delirium course and delayed its recovery. This study is considered to be the first to explore the impact of BPSD on the presentation, progression and outcome of DSD.

Treatment preferences for depression in the elderly

Luck-Sikorski C, Stein J, Heilmann K, Maier W, Kaduszkiewicz H, Scherer M et al. Treatment preferences for depression in the elderly. *Int Psychogeriatr* 2017, 29:3, 389–398.

German depressed and non-depressed patients recruited from primary care practices in 4 cities underwent face-to-face interviews to determine their treatment options for depression. Medication, psychotherapy, talking to friends/family and exercise were the preferred options however the depressed elderly showed difficulty in choosing treatment options. This study is considered to be the first to report support for various treatment options in patients aged 75 years and older.

Meta-analysis of randomized, double-blind, placebo-controlled trials of melatonin in Alzheimer's disease

Wang Y-Y, Zheng, Y, Ng CH, Ungvari GS, Wei W, Xiang Y-T. Meta-analysis of randomized, double-blind, placebo-controlled trials of melatonin in Alzheimer's disease. *Int J Geriatr Psychiatry* 2017; 32(1):50-57

This meta-analysis was carried out on 7 randomized controlled trials up to 24 weeks duration. Patients receiving melatonin treatment showed prolonged total sleep time at night ($n = 305$; SMD: 0.26, 95% CI: 0.01 to 0.51, $I^2 = 9\%$, $p = 0.04$). This meta-analysis is considered to be the first to assess the efficacy of melatonin alone for Alzheimer's disease and also the first study examining the respective effects of melatonin on total sleep time at night and daytime.

Prevalence of mental disorders in elderly people: the European MentDis_ICF65+ study.

Andreas S, Schulz H, Volkert J et al. Prevalence of mental disorders in elderly people: the European MentDis_ICF65+ study. *BJPsych* 2017;210:125-131.

This cross-sectional study estimated the current, 12-month and lifetime prevalence rates of mental disorders in different European and associated countries. The most prevalent disorders were anxiety disorders followed by affective and substance-related disorders. This study is considered to be the first to examine prevalence rates of a variety of mental disorders; previous studies on the prevalence of mental illnesses in older adults have mostly focused on depression and dementia.

Depressive symptoms in early- and late-onset older bipolar patients compared with younger ones

Garcia-Lopez A, Ezquiaga E, De Dios E, Agud JL. Depressive symptoms in early- and late-onset older bipolar patients compared with younger ones. *Int J Geriatr Psychiatry* 2017; 32 (2): 201-207.

There is paucity of research on geriatric bipolar disorder including the differences between late and early onset bipolar disorder. This prospective study studied the clinical and outcome differences between older bipolar patients with early onset (EO) and late onset (LO) of the illness and between younger and EO older patients with a bipolar disorder under long-term treatment in an outpatient clinical setting.. It was seen that older patients suffered significantly from more frequent depressive symptoms than younger ones. LO older patients were predominantly bipolar II. As bipolar illness progressed, depressive symptomatology became more frequent and manic episodes were less severe.

Cochrane Corner

Dr Jenny McCleery, Consultant old age psychiatrist, Oxford Health NHS Foundation Trust, and Joint Co-ordinating Editor, Cochrane Dementia and Cognitive Improvement Group
Dr Ciaran Abbey, Consultant old age psychiatrist, Oxford Health NHS Foundation Trust

Welcome to Cochrane Corner where we will endeavour in each issue to examine Cochrane systematic reviews relevant to our patient group and look at what is coming up in the future.

Cochrane is made up of 37,000 people in 130 countries contributing expertise and time to try to provide the best evidence to inform decisions on the use of healthcare interventions and diagnostic tests. There are more than 50 Cochrane review groups, including five covering mental health related topics: Dementia and Cognitive Improvement (<http://dementia.cochrane.org/>), Common Mental Disorders(<http://cmd.cochrane.org/>), Schizophrenia(<http://schizophrenia.cochrane.org/>), Drugs and Alcohol (<http://cda.cochrane.org/>) and Developmental, Psychosocial and Learning Problems (<http://dplp.cochrane.org/>). This Corner will have an emphasis on reviews from the Dementia Group, but will be alert to any reviews from the other groups which are particularly important to older patients.

Pharmacotherapies for sleep disturbances in dementia

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009178.pub3/full>

Psychiatrists are often asked to advise on drug treatment for sleep disturbance in patients with dementia, but are well aware that hypnotic and sedative drugs have potential to cause harm in this context. This recently updated review is remarkable largely for the dearth of evidence to inform treatment decisions in this context. In order to be relevant to clinical practice, the authors looked for trials including patients with any subtype of dementia who were presenting with a significant sleep problem at baseline. They found only 6 RCTs covering three drugs: melatonin (222 participants, four studies, but only two yielded data on the primary sleep outcomes suitable for meta-analysis), trazodone (30 participants, one study), and ramelteon (74 participants, one study, no peer-reviewed publication, only limited information available on the sponsor's website). The included patients all had dementia due to Alzheimer's disease, mainly moderate to severe.

Cochrane reviews use GRADE methods to assess the quality of evidence (1). For each outcome, the overall evidence may be considered high, moderate, low or very low quality, reflecting risk of bias in the included studies, degree of consistency between studies, degree of precision of effect estimates, whether studies address the review question directly, and the likelihood of publication bias. In this case, all of the evidence was of low quality, primarily due to imprecision. The review found no evidence that melatonin at doses up to 10mg, or the melatonin receptor agonist ramelteon, had any important effect on sleep.

Trazodone 50mg at night did have a beneficial effect on some sleep outcomes, but as noted this was in a single very small trial and replication is needed. The included trials did not report any serious harms from the drugs used, but small RCTs are a weak basis for conclusions about harms.

This review may not have a major effect on practice, but it serves an important purpose in making clear to prescribers that they are in a largely evidence-free zone when it comes to the efficacy of commonly used drugs in this patient group, and – by highlighting an evidence gap around a common clinical question – may have an influence on the research agenda. We await with interest a companion review, Non-pharmacological interventions for sleep disturbances in people with dementia, which should be published later this year.

Interventions for preventing delirium in hospitalised non-ICU patients

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005563.pub3/full>

A fascinating recent study by Davis and colleagues (2) has strengthened the evidence for believing that delirium in people with dementia-related neuropathology accelerates cognitive decline beyond that expected, reinforcing the importance of trying to prevent delirium as far as possible. This review, which was published in March 2016, assesses 22 different interventions and is too complex to describe in detail here. The largest number of studies examined multi-component, non-pharmacological interventions which were found to be effective in reducing the incidence of delirium when compared to usual care (RR 0.69, 95% CI 0.59 to 0.81; seven studies; 1950 participants; moderate-quality evidence). Unfortunately, however, there was only low quality evidence from one study of 50 participants who had pre-existing dementia and in this subgroup the effect of the intervention was uncertain (RR 0.90, 95% CI 0.59 to 1.36). Clearly, this needs to be studied further, as do a variety of other pharmacological and anaesthetic interventions for which results were inconclusive.

An older review from 2014 of delirium prevention interventions in long-term care settings was much smaller, finding only two trials to include (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009537.pub2/full>).

There was very low quality evidence from one small trial that a hydration management intervention had no effect on the incidence of delirium, but moderate quality evidence from a larger trial that use of a computerised medication management system led to a large reduction in delirium incidence over 12 months (HR 0.42, CI 0.34 to 0.51; one study, 3538 participants), although it was not shown to affect hospital admission rates, mortality or falls. The study took place in the US and the intervention depended on a computerised medication management system across nursing homes which may not be possible to replicate easily in the UK. One of the authors of the review is working to develop and test an educational intervention to prevent delirium in UK care homes (3).

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Many of the groups have Twitter accounts which can help you keep up to date. The Dementia and Cognitive Improvement Group's account is @CochraneDCIG. Follow us to find out more or keep in touch through our website, <http://dementia.cochrane.org/>. Please let us know what you would like to see in future Cochrane Corners.

- (1) Guyatt G, Oxman AD, Akl EA, Kunz R, Vist G, Brozek J, et al. GRADE guidelines: 1. Introduction - GRADE evidence profiles and summary of findings tables. *Journal of Clinical Epidemiology* 2011;64:383-94.
- (2) Davis D, Muniz-Terrera G, Keage H, Stephan B, Fleming J, Ince P, et al. Association of Delirium With Cognitive Decline in Late Life: A Neuropathologic Study of 3 Population-Based Cohort Studies. *JAMA Psychiatry*. 2017;74(3):244-251.
- (3) Siddiqi N, Cheater F, Collinson M, Farrin A, Forster A George D, et al. The PiTSTOP study: a feasibility cluster randomized trial of delirium prevention in care homes for older people. *Age Ageing* (2016) 45 (5): 652-661

CASE REPORT

From independence to flying ducks: a case of rapid physical and cognitive decline

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In Psychiatry for Older People, a patient who presents with confusion and low mood will usually prompt a workup for delirium and depression. We recently assessed a relatively young patient (whom we have given a pseudonym of Betty) who had an unusual presentation of marked rapid decline in both physical and cognitive function.

First presentation

Betty was a fit 64 year old with an unremarkable past medical history. She was admitted to hospital with three months of progressive weakness and weight loss. Examination revealed significant bilateral leg muscle wasting with reduced power. Over the same three months, her mood had become low, with loss of energy, motivation, poor sleep and anhedonia. Her loss of appetite had resulted in weight loss of three stone. She hid food in her bag and around the house, and neglected housework and finances.

Prior to these three months, Betty was functioning at a high level. She was driving, independently mobile, self-caring and looking after her disabled son.

Initial diagnosis

Betty was initially reviewed by a psychiatrist for working age adults and the diagnosis was depression. Sertraline 50mg was started. Addenbrooke's Cognitive Examination (ACE)-III revealed a score of 55/100, with global cognitive impairment.

Betty's hospital admission spanned three and a half months whilst investigations for her neurological symptoms took place. Blood tests and a computerised tomography (CT) scan of the chest, abdomen and pelvis were unremarkable. The possibility of malignancy was ruled out. No organic explanation was found for her weakness and muscle wasting.

New symptoms

Betty developed visual hallucinations of seeing small people and cats. Later, this included seeing objects in her hands, ducks flying around the room, and her husband when he was not physically present. She was orientated on admission, but soon lost awareness of time, place or person. She thought that she was in a shopping centre, a garden or just returned from a trip to Scotland. Whilst always remaining pleasant, she was confused and frequently confabulated. A diagnosis of delirium was made, with a urinary tract infection being the likely cause. Her symptoms of hallucinations and confusion did not resolve after the infection was treated.

Betty struggled to engage in physical rehabilitation, often refusing outright when encouraged by the physiotherapists and occupational therapists. She lacked interest in self-care. She was struggling to meet her nutritional requirements. She spent most of her time in bed.

Further advice

As it was unusual for a relatively young person to have rapid cognitive decline, Betty was referred to the neurology team and, as she had turned 65 years old, our Mental Health Assessment and Liaison Team for older people (1).

Sertraline was increased over the months to 100mg and subsequently to 150mg. Mirtazapine 15mg was added while the Sertraline dose was being increased.

Differential Diagnoses

The neurologist felt that Betty had an acute confusional state accompanied by low mood. He suggested to treat any infection, correct nutrition and hydration, and to undertake further investigations including electroencephalography (EEG) and a magnetic resonance imaging (MRI) scan of the head. He also suggested lumbar puncture to obtain cerebrospinal fluid (CSF) for various tests including analysis for Creutzfeldt-Jakob Disease (CJD).

Betty's CSF was sent to the National CJD Research and Surveillance Unit in Edinburgh for analysis (2).

The diagnosis, hospital discharge and progress

Betty's CSF was negative for CJD. EEG was reported to show diffuse, modest slowing, pointing to a diagnosis of longstanding change, more consistent with a chronic cortical pathology such as vascular dementia rather than a neurodegenerative cause.

CT and MRI head scans showed vascular changes of symmetrical deep cortical white matter ischaemia. These may have been more than expected for the age of Betty but were in keeping with small vessel disease.

Betty was diagnosed to have vascular dementia by the medical team and discharged to a care home as a temporary measure, with follow up by the neurologist and Community Mental Health Team. She remained bed bound and frail at the time of hospital discharge, though her mood was much improved on Sertraline 150mg and Mirtazapine 15mg. Betty had the insight that she was physically declining, though was cautiously optimistic about her care home placement. The plan was to re-evaluate her progress there to see whether her physical health would improve adequately for her to eventually go home.

Betty was reviewed in the neurology clinic one month after discharge. The neurologist felt that there was a dramatic improvement in her mood and did not think she had dementia, as she was very able to interact intellectually. Betty's husband felt that Betty was back to her normal self. Physically, Betty had improved to the point of being almost ready to go home. Betty is due a repeat cognitive test by the Community Mental Health Team.

The final diagnosis

Betty's cognitive decline was due to depression which improved on the combination of antidepressants. The confusion and hallucinations were consistent with delirium which was caused by a urinary tract infection. The delirium further affected Betty's mental state. The infection was treated by antibiotics. Betty's decline in her physical function was likely to be caused by a combination of depression (resulting in poor hydration and nutrition) and infection. The recovery of her cognitive abilities over the months is not consistent with dementia.

Discussion

Betty presented a diagnostic challenge for us. She had depression, an infection and neurological symptoms which were not explained by depression or infection. It was unusual that depression and a urinary tract infection caused such major

decline in the physical function of someone who is only 65 years old who was previously fit and independent. The working diagnosis was CJD for a long time, as she showed a rapid decline in mobility, cognition, slurred speech, hallucinations, depression, anxiety, withdrawal, ataxia, loss of appetite and memory loss which were all consistent with the diagnosis of CJD.

CJD is a rare but important differential diagnosis as it has a poor prognosis and is incurable. CJD was first described by two German physicians; Hans Gerhard Creutzfeldt and Alfons Maria Jakob in the 1920s (3). Rare and fatal, it is the most common form of human prion disease. As there is no cure, patients are given symptomatic relief.

The incidence of CJD is 1 per million worldwide (4) and there are four subtypes: sporadic (85% of cases), familial (10-15%), variant (1%), and iatrogenic (1%) (5).

In sporadic CJD, progression is usually rapid, with pronounced neurological symptoms of dementia, myoclonus and ataxia (6). Prognosis is very limited, ranging from a few weeks to months. Variant CJD has a slower progression (1 to 2 years). Symptoms tend to be more psychiatric and can include anxiety, depression, agitation and social withdrawal (6). Neurological symptoms tend to appear later.

NICE recommendations for suspected CJD are CSF and EEG (1); the latter will show periodic sharp-wave complexes (3). Whilst pathological diagnosis remains the gold standard, MRI has high diagnostic utility. It shows hyper-intensity, described as the cortical ribbon sign (3).

In Betty's case, the low ACE-III score and the EEG findings probably led to medical team making the diagnosis of vascular dementia. In the context of delirium or depression, it is important to treat these conditions fully first before considering a diagnosis of dementia or doing a cognitive examination. If cognitive examination has been carried out before a patient has become euthymic (in this case), then the findings should be interpreted in context with caution, and a repeat ACE-III should be carried out again when the patient becomes euthymic and is no longer delirious.

What made Betty improve was the correct medication (antidepressants and antibiotics), nursing care and time for her to rehabilitate with regular physiotherapy and occupational therapy input. We were very pleased that Betty made a remarkable recovery and the diagnosis was not CJD which has a very poor prognosis.

We appreciated the opportunity to be involved in Betty's care and thanked her for her consent for this case report.

References

1. National Institute for Health and Clinical Excellence (NICE) (2016). *Clinical Knowledge Summaries Dementia*, NICE [www]. Available: <https://cks.nice.org.uk/dementia> [Accessed 01/03/17].

2. The National CJD Research & Surveillance Unit (NCJDRSU) (2017). *CSF Laboratory*, The University of Edinburgh [www]. Available: <http://www.cjd.ed.ac.uk/csf-laboratory> [Accessed 01/03/17].
3. Abdulmassih, R., Min, Z. (2016). An ominous radiographic feature: cortical ribbon sign. *Internal and Emergency Medicine*, 11(2): pp 281–283.
4. Ali, R., Baborie, A., Lerner, A.J., White, R. (2013). Psychiatric Presentation of Sporadic Creutzfeldt-Jakob Disease: A Challenge to Current Diagnostic Criteria. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 25(4): pp 335-338.
5. Johnson, R.T. (2005). Prion diseases. *The Lancet Neurology*, 4(10): pp 635-642.
6. Wadsworth, J.D.F., Hill, A.F., Beck, J.A., Collinge, J. (2003). Molecular and clinical classification of human prion disease. *British Medical Bulletin*, 66(1): pp 241-254.

TIPS FOR WRITING

Writing for the Old Age Psychiatrist

Helen McCormack, Sharmi Bhattacharya , Anitha Howard, Editors.

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