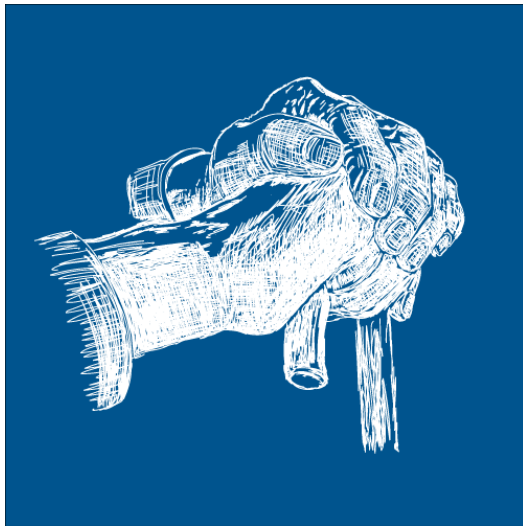




The Old Age Psychiatrist

Issue 80, May 2021

Old Age Psychiatry Faculty
Newsletter



The Old Age Psychiatrist

Issue 80, May
2021

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Update from the Editorial Team

by

Sharmi Bhattacharyya

Editor, The Old Age Psychiatrist, Royal College of Psychiatrists

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Hello from the Editorial team and hope you are looking after yourselves and keeping safe and well. Hopefully by the time you read this newsletter some restrictions would have eased and some 'normality' will ensue. We hope the articles in the newsletter will provide some food for thought and as always highlight the great work Old Age Psychiatrists do.

Sadly we lost two stalwarts in Old Age Psychiatry in the last year - Brice Pitt and Klaus Bergman – the tributes not only highlight their contributions to Old Age Psychiatry but also their varied interests and achievements.

The Chair's report makes an interesting update. The virtual Faculty conference on 25th, 26th March 2021 was a huge success.

Dr Amanda Thompsell, the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement and Prof Alistair Burns provide a joint update on Older people's mental health and Dementia. Please also read the article by Dr Thomas ST6 trainee on the NHSfutures platform and contribute.

This edition also has two very thought provoking interviews which highlight and celebrate achievements by Old Age Psychiatrists. Thank you to our trainee Editor Dr Nicole Edwards for interviewing Baroness Murphy who was awarded the Lifetime Achievement Award from Royal College of Psychiatrists and Prof Wendy Burns who was awarded CBE in the New Year's Honours. We are proud as a Faculty.

The essay completion was a huge success – thank you to Nicole for coordinating and to our three judges Prof Dave Jolley, Dr Josie Jenkinson and Dr Grace Ofori-Attah for taking the time to read the submissions. The title this year was **Old Age Psychiatry in the Time of Corona... And Beyond?....** The top three essays are published in this edition. The Medical Student essay prize also makes a fascinating read.

This edition contains also contains our usual updates such as Cochrane corner and research update. Read about the new training resources developed by the Faculty based on HEE core competencies and what to do if you have a European patient who does not have settled status

We are also advertising for our next [trainee Editor](#) as Nicole finishes her term in August 2021. Please also see link if you are interested in joining an [old age liaison psychiatry](#) network

As usual we round off with a film review by Dr Howard – note the sensitive and accurate portrayal of dementia in this film which may not always be the case.

The next newsletter is September 2021 so the last date for submission of articles is 30th June 2021.

As always let us know what you think of the newsletter, and feel free to email me on drsharmib@gmail.com with ideas, suggestions and of course articles for the future newsletter.



The Old Age Psychiatrist



We are looking for a new Trainee Editor for The Old Age Psychiatrist, the official newsletter of RCPsych's Old Age Faculty! The post would begin in September 2021. The closing date for applications is **31st May 2021**.

If you are an enthusiastic, creative and organised trainee with an interest in Old Age Psychiatry, and you are looking for a new and exciting opportunity to develop leadership and publication skills, please consider applying.

Contact our editor, Dr Sharmi Bhattacharyya, at drsharmib@gmail.com or current Trainee Editor Dr Nicole Edwards, at nicole.edwards@cntw.nhs.uk for more information.

View from the Chair

Dr M S Krishnan (Krish)



Dear colleague

Hope you all have had a good start of 2021 and keeping safe.

I am again delighted to share another successful event by our faculty, our annual faculty conference. We had nearly 800 delegates registered for the conference and over 500 people watched the live events and many continue to watch the sessions. Thanks to our Academic Secretary Mohan and his team from the exec who put together a really good program.

This is the first time we had chairs from other countries interacting with us (USA, Canada, Australia & New Zealand). We also had a session by our EAGP colleagues.

We received a message from one of our senior and eminent faculty member 'Congratulations to you all!! Brilliant conference! I have been attending these conferences since they began and this is the best ever!' – A clear validation for the success and I also wish to thank our CALC team.

However we did miss face to face networking opportunities with our members, trainees and new consultants. We hope that in 2022 we will meet in person.

I am thankful for all our members who are continuing to provide clinical leadership in supporting our vulnerable older adults who are suffering with lockdown and isolation. The services are gradually picking up pace and there is increasing need for supporting our older adults with Mental Health problems.

We had our recent faculty executive committee meeting this month remotely on 3 March. We started planning our faculty strategic objectives.

We had a very helpful discussion from the groups who looked at the following points:

- Service models: CMHF and Integration, ageless services
- Strengthening our voice: how the Faculty can influence the College, the public and other organisations

- Workforce planning: New curriculum, recruitment, retention
- New treatments: Challenges with Aducanumab, how the Faculty can support new service models and treatment pathways.

As a clinician I wondered about few things that the faculty could give a steer on for our members. One of my concerns is about consistent lack of access to images from neuroimaging as part of diagnostic work up (PACS etc). When we carried out a poll at the conference this was confirmed. I also worry about lack of consistency in diagnosis and follow up pathways for vascular dementia diagnosis. This is something we as faculty should look at.

We also carried out a poll at the Conference on Community mental health transformation. It was worrying to learn that only 15% were aware of the local ICS/STP plans for older adults.

You may recall we did a webinar last year. The proposals have been received and funding to start from June. We are putting together a follow up webinar on 26 April. Join us if you can.

The faculty has also been involved in the MHA White Paper consultation and developed new resources for teaching and training based on HEE core competencies.

Faculty Social Media presence

The Faculty twitter page @RcpsychOldAge has now reached 2282 followers. Until recently we were the second largest followed faculty on Twitter. Hope you will continue to support and grow our social media presence. We had excellent twitter presence raising the profile of our faculty during the recent #OAPsych2021 you can search the hashtag for threads of conversation.

This edition is once again filled with so many articles including the prize winning medical student and newsletter competition essays.

The quality of the essay competition entries was really good and the judges struggled to select one single winning essay. Thanks to EAGP who is celebrating their silver Jubilee Year for kindly awarding prizes for 6 more essays.

There is a personal perspective from Dr Don Williams who was our faculty Academic secretary many years ago and has raised awareness on Football and Dementia.

We have moving tributes to Brice Pitt and Klaus Bergman. This edition also features interviews from Prof Wendy Burn and Baroness Elaine Murphy.

We recently passed one year since the first lockdown. Staff well-being has never been given priority until this pandemic. Please look after yourself and support colleagues around you.

With lockdown easing off and following the roadmap from the government I hope that you are able to meet with friends and family safely over the spring into summer.

Krish

Chair of the Faculty of Old Age Psychiatry
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Older People's Mental Health and Dementia – update for Newsletter

Dr Amanda Thompsell, National Specialty Advisor, Older People's Mental Health

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Professor Alistair Burns, National Clinical Director for Dementia

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As Spring blooms and vaccine numbers are rising we are starting to look forward again. But we should not forget the disproportionate impact that COVID has had and is having on older people with mental health needs.

The extent of this is being highlighted in an upcoming report by Age UK. Age UK published in September 2020 the results of a survey which highlighted the detrimental impact COVID was having on older adults' mental health. The new report contains the results of repeating a similar survey (but on a much larger scale) in January 2020. At the time of writing this report is not yet published but we understand that this will show that the impact of COVID on the mental health of older adults is even greater than it was seen to be in September.

We do therefore need to make sure that the mental health of older adults receives special consideration. But as we do this we need also to guard ourselves from spreading negative attitudes and the stereotypes that may add to the problem. Whenever older adults are mentioned in relation to COVID, it is nearly always as a vulnerable group. We know that exposure to and internalisation of negative representations of old age can exacerbate psychiatric conditions such as increasing depressive symptomatology among older adults.

As we now look forward the most important change on our horizon is the Community Mental Health Transformation (CMHT). This is moving apace. The proposals for each ICS/STP area have been agreed with the National Team and if you don't know what the vision is for older adults' mental health in your local area please ask to see it. There is an immediate £121 million earmarked for CMHT in this coming year. It is vital that part of this money is used to address the mental health needs of older adults as is fair based on current provision and

demographics locally. Unless someone speaks up locally for older adults they could lose out, so we urge you all to get involved in the debate on how to use this money in your area. If you want information on your local demographics it is worth looking <https://fingertips.phe.org.uk/>

Each ICS /STP as part of their CMHT plans will by now have decided which two of the three specialist community pathways ("personality disorders", rehabilitation and eating disorders) they want to make a start with this year. We have clear guidance from NHSE &I that each of these specialist community pathways must provide for older adults. There is now no excuse for maintaining the tyranny of low expectations for older people in these areas.

We take this opportunity to commend again the "Futures" web page at <https://future.nhs.uk> and in particular its older adults mental health section. Please use this to share your best practice examples or ask questions and do make use of the resources this offers (such as link to useful guide produced by Rethink on the steps needed to transform community mental health services).

Finally as will be described in more detail in an article in this newsletter the Faculty (with help from Faculty members) has produced a range of power point presentations on older adults' mental health accessible on <https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/training-packs>. Whilst these presentations are not intended to cover every aspect of HEE's core competencies framework in older adults' mental health; we hope that these will save you time when you are developing your own training to address your local knowledge gaps.

We want to end with some good news that the positive practice guide for older people for IAPT has been updated and is due to be launched very soon which should increase the focus on psychological therapies for older adults. Importantly, the IAPT manual states: *"A person's involvement with secondary mental health care services should not lead to automatic exclusion from IAPT services."* So yes, we can refer to IAPT if we feel it would be useful.

Dementia

There have been a couple of developments over the last few months that we think are important. We have unfortunately continued to see the dementia diagnosis rate decline, and this reflects a number of issues including the continued disruption to memory clinic services because of the pandemic but also a slowing down in the number of referrals from Primary Care.

We know from the dementia diagnosis rate information that there are about 40,000 less people on the dementia register than were before and that will partly reflect the slowing down in services. At the same time, we have seen a slight increase in the level of antipsychotic prescribing – perhaps inevitable around the early stages of the pandemic when there was a lot of disruption in care homes. There is wealth of information specifically on the PHE Dementia Profile <https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>.

We have updated our Dementia Wellbeing Pathway to include some additional advice <https://www.england.nhs.uk/publication/dementia-wellbeing-in-the-covid-19-pandemic/> and many thanks to the College for publishing our piece on vaccination (<https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/dementia-uk---useful-tips-on-the-covid-19-vaccine-for-people-with-dementia---december-2020>).

We have continued to highlight the increased death rate and level of antipsychotic prescribing ([https://www.thelancet.com/journals/laneur/article/PIIS1474-4422\(20\)30370-7/fulltext](https://www.thelancet.com/journals/laneur/article/PIIS1474-4422(20)30370-7/fulltext)) and in some ways can see that because dementia is the commonest cause of death in England and Wales, the rates follow and in some ways are a barometer of the various lockdowns.

We have begun discussions about a Disease Modifying Treatment pathway and thanks to the many colleagues from the college who were involved in discussions about this. Taking this forward depends on the regulatory view of these medicines from the American and European agencies and ultimately, NICE. However, if they are able to be introduced it will mean a significant shift in the way memory clinics are organised.

Lockdown continues to scupper the photo competition but hopefully we will be back on track soon. If you want to contact us with any suggestions /queries about anything we have written (or specifically about CMHTs), please do so....
amanda.thompsell@nhs.net or Alistair.Burns@manchester.ac.uk

Brice Pitt has left the stage...

by

Dr Mark Ardern

Consultant Old Age Psychiatrist, 1984 -2008

St Charles Hospital London W10

The history of our specialty began tentatively. Its development followed that of Geriatric Medicine a generation earlier. Individual consultants with limited resources, but passionate intent, gradually hacked away at the undergrowth, creating paths for others to follow.



Brice Pitt was one of those pioneers. Having initially wanted to train as an actor, he nevertheless followed his father into Medicine. He qualified at Guys, took up a career in Psychiatry and in 1966 became the country's first Consultant Psychogeriatrician. The service he developed in east London was also at the forefront, being one that required all referred over 65-year-olds to receive their assessment at home. By 1974 Brice had written what I believe to have been the first book on the subject: "Psychogeriatrics – an Introduction to the Psychiatry of Old Age". In 1980, together with Geriatrician Christopher Silver, he published a study demonstrating the benefits of joint admission beds.

Elsewhere other services were advancing. Some, like in Nottingham, became fully integrated with Geriatric Medicine. Others remained embedded within Psychiatry. Necessity being the mother of invention, these early services were almost always spearheaded by tenacious and visionary consultants. Their dynamism spawned new generations of psychiatrists persuaded of the attraction of work with the elderly. My own mentor in this regard was Roy Simons who led an effective service in Aylesbury largely focused on home visits, a day hospital and a highly organised programme of respite care.

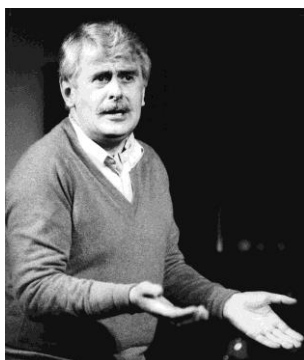
By the mid 1980s Old Age Psychiatry was gaining traction. In 1973 Brice and others formed a special interest group at the College. Five years later it had

grown into a Section. By 1989 this would lead to Old Age Psychiatry being recognised by the government as a Specialty. In 1985 in Paddington and North Kensington a new service had opened on the site of the then District General Hospital, St Charles. By any measure this was a lavishly resourced affair. Part-funded by the closure of two psychiatric hospitals in Surrey, a comprehensive age-related service, enthusiastically supported by local Geriatricians and management, became a marriage of Medicine and Mental Health for the Elderly.

Moreover, at St Charles agreement was achieved on the establishment of an academic department. At the national level Tom Arie had been appointed as Professor of Health Care of the Elderly in Nottingham in 1977, then Elaine Murphy the first Professor of Old Age Psychiatry at Guys in 1983. Locally the planned second whole-time equivalent Consultant post was split into those of Chair and Senior Lecturer.

It was 1986 when the post of Professor at St Mary's was advertised. Although Brice Pitt offered a proven record of service creation, teaching and writing, some of us worried that his CV might be insufficiently "research" orientated to satisfy the Medical School. However, at his appointments committee Brice comfortably demonstrated his achievements and aspirations. On arrival Brice readily juggled that balance of academic and clinical work, supporting the joint department and multidisciplinary outreach. After all he had been advocating both for 20 years.

Each Friday morning Brice arranged a teaching session which brought psychiatrists and physicians together. Enthralling his audience of junior doctors



and multidisciplinary team, Brice was not an academic happy in an office. Time was spent scurrying around the catchment area on home visits, either on his moped or bus and perhaps with a wide-eyed medical student in tow. Brice showed how teaching and clinical work are best undertaken together and in a way which can be *fun*. Such teaching was often skillfully interspersed with mischief.

One occasion he described his visit to a man with Diogenes Syndrome. During the slide show of an appallingly squalid interior, he tantalised by feigning a glimpse of his daughter's bedroom! One Christmas, Brice (looking the part of Santa himself) organised a case conference on the diagnosis and management

of Ebenezer Scrooge. Few resented the 8.30am starts to these Friday breakfast treats.

Within a few years gravitational forces eventually lost St Charles its A&E department. This inevitably led to move of the Geriatricians' acute beds two miles away to the St Mary's site. Psychiatric admission beds were now marooned in a potential backwater and liaison work regressed to a more formal and less efficient process. Two steps forward and one back...

For me as a newly appointed Consultant, Brice's vast clinical and service experience was an inspiration. We counted ourselves fortunate to have such a thriving department with Brice as its figurehead. Then one day in 1993 a catastrophe happened. Mohsen Naguib, Senior Lecturer and organiser of the rotational training scheme, died suddenly aged 43. Brice left the news in a message on my home phone, devastated. It left a chasm in our department.

Retiring from his post as Chair in 1995, Brice continued one day a week at the memory clinic he had set up at the Hammersmith Hospital. In a published interview with Elaine Murphy, he described his retirement plans, one of which was to continue acting. Unsurprisingly he was a keen amateur actor, director and playwright. Forty years of association with the Tower Theatre in Islington continued until his death, with regular appearances on stage until around 2008.

Brice's extensive writings included in 1968 the first community study of postpartum depression. His style was lyrical and often quite personal; for example, at age 56, "Making the Most of Middle Age". In 1993 "Down with Gloom" was a self-help book on depression with cartoon illustrations by Mel Calman.

After Brice left St Charles we kept in occasional touch. There would be a phone call out of the blue to catch up, reminisce and sometimes to hear his complaints that he never expected to live so long! To many people he was a father figure. He reminded me of the actor Peter Ustinov, especially in his role as Hercule Poirot. But, despite being the showman, Brice remained benevolent, supportive and caring. He was especially kind to patients and staff. And in return he was undoubtedly loved.

Brice died of complications from COVID-19 on the 16th of January 2021. He was 89 years of age. He leaves behind a wife, children and grandchildren. To Psychiatry his legacy lives on.



"Yes, of course Doctor. We'll certainly be able to see her at home in the next couple of days..." (Actually, depicting Brice from a 1984 production of "The Happiest Days of Your Life").

Previous photos are: 1) from his final onstage role in "The Mysteries" in 2008, and 2) from a 1984 production of "Sleuth".

All images reproduced with the kind permission of the Tower Theatre, London.

Klaus Bergmann- a tribute

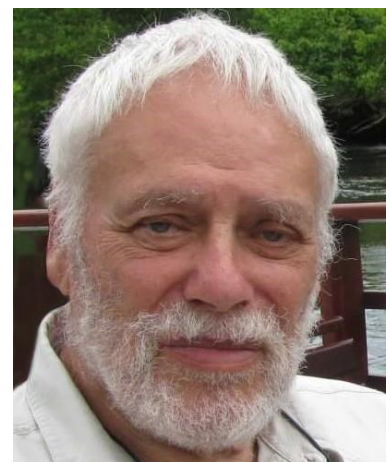
By

Dr Marisa Silverman

Consultant Psychiatrist (retired) South London and Maudsley NHS Foundation Trust

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Klaus Bergmann died on 5th December 2020 a few days short of his 90th birthday. He was one of the generation of pioneer psychiatrists who established the speciality of Old Age Psychiatry in Britain. He will be remembered for his contributions in the field of community research and also as an outstanding clinical teacher and clinician. In preparing this memoir I have quoted directly from the oral contribution made by Klaus to a witness seminar



Klaus was born in Dresden in 1930 to a Jewish family. His parents were able to escape to Palestine and then to Britain where he was educated, later studying medicine at Sheffield University where he was a keen rugby player and met his wife Marie. After National Service in the RAMC, he returned to Sheffield to train in psychiatry under Professor Erwin Stengel and then moved to Newcastle to undertake research into the prevalence of mental disorders in older people living in the community. He joined Martin Roth's team, working with David Kay, Bernard Tomlinson and Garry Blessed.

"I learned many lessons from the elderly people I met on the survey. The most important was that the majority of my respondents were normal, coped well and led useful lives more often supporting their younger families than requiring their support and that malfunctions were mainly the result of physical or psychiatric ill health. My wish to continue working with older people gelled and I entered the field without psychiatric hospital experience but also without the therapeutic nihilism so often engendered by such experience."

Klaus then moved to Sussex into a busy, under resourced NHS Consultant post before returning to a senior role in Newcastle. In 1978, following the retirement of Felix Post, he joined the Maudsley and Bethlem Royal Hospitals remaining there alongside Professor Raymond Levy , Robin Jacoby and other colleagues until his retirement after twenty five years.

I joined them in 1978 as Senior Registrar and later also worked alongside them as a consultant colleague. I remember well my first encounter with Klaus, who arrived in leather coat, jumped on the chairs to open windows and then sat down to take snuff leading to an enormous sneeze. He was a tall, well built man, bearded and with a taste for colourful ties, He would be a fount of anecdotes, puns, dirty limericks and jokes, yet with patients, he was respectful and sensitive.

Klaus was an excellent clinician who developed expertise in the treatment of the complex patients that were referred to the unit, particularly those with refractory depression. He was willing to take difficult decisions but also tried to enable patients to remain at home if possible despite occasional resistance from concerned authorities.

Klaus had researched and written on neurosis in older adults, based on the extended community sample in Newcastle. His clinical teaching emphasised the importance of careful physical health and mental state assessment and consideration of the role of personality, past experience and changing family dynamics. He brought wisdom, acumen and humour into his work.

Always down to earth, he was interested in the education and previous interests and habits of his patients. Klaus related to me a home visit to a particularly dilapidated Camberwell flat, the home of a frail, elderly single Irishman whose grimy condition and apparent lack of food was causing concern to well meaning social care workers. However, Klaus found an ample supply of onions and potatoes under the kitchen table and engaged in a conversation about the Irish rugby team which convinced him of the absence of substantial cognitive impairment. I was reminded of this visit when re-reading his contribution to the Guthrie witness seminar.

Klaus had commented positively on a visit he had made to the pioneering unit at Crichton Royal Hospital,

"... the thing that impressed me most. It was to see the chronic and mainly demented old ladies sitting in a circle peeling potatoes and talking to each other instead of the useless occupational therapy that they usually have to do and they were thoroughly socialised and doing something they'd done all their lives and I thought, really this was something that impressed me enormously. It may be too small to impress you from my impression, but I was very, very taken by it."

Klaus enjoyed life and had many interests. He loved opera, particularly Mozart, and was also a Friend and frequent visitor to the Tate Gallery and Royal Academy. He enjoyed fell walking and camping with his family when younger and, after retirement, he travelled widely with Marie. He was staunchly committed to the NHS, and when in Newcastle had been a Labour Councillor. Typically, he joked about this, maintaining that he had been promised before selection that it was a guaranteed unwinnable seat. Klaus developed an election slogan about a local housing estate, 'It is time for change on The Grange', but he was then horrified, as a busy fulltime consultant, to be returned with a majority.

He was very sociable and enjoyed meeting up with the "Old Farts", a group of retired Old Age Psychiatrists which met regularly for a convivial lunch, until Covid stopped social contacts.

Klaus greatly influenced my own practice and work with trainees during my later professional career. "Don't complain now - just see the patient and complain later".

We will miss him greatly.

References

Clare Hilton (Faculty Member and Historian in Residence to our College) 2008
The Guthrie Trust Witness Seminar on the Development of Old Age Psychiatry from the 1960s until 1989

Annual Essay Competition

by

Dr Nicole Edwards,

CT3, Trainee Editor of The Old Age Psychiatrist

The title of this year's essay competition was "Old Age Psychiatry in the Time of Corona... And Beyond?" We asked entrants to think about the impact of the COVID-19 pandemic on the specialty, the clinicians working within it, and, of course, the patients. We had a great response and the standard of entries was very high – so much so that we had a joint first place, a runner-up, and six additional highly commended essays! Thank you to everyone who took the time to submit an entry; they were all very enjoyable to read.

We would like to thank the European Association of Geriatric Psychiatry for their generous award of £250 which went towards funding additional prizes for these highly commended essays. This was done in honour of their Silver Jubilee so these one off prizes are named the EAGP Silver Jubilee Prizes. The entrants receiving this highly commended award are:

Dr Ayana Hazu CT2, *Tavistock and Portman NHS Foundation Trust*

Dr Ayesha Bangash *Consultant Psychiatrist, Southwest Yorkshire Partnership NHS Foundation Trust*

Dr Eleni-Maria Liaka CT1, *Central and Northwest London NHS Foundation Trust*

Dr Jennifer Parker *Specialty Doctor, Avon & Wiltshire Partnership Mental Health Trust*

Dr Oli Sparasci CT3, *Greater Manchester Mental Health Trust*

Mrs Rosemary Stubbs, *Service User*

We would also like to extend a huge thank you to our three wonderful judges who gave up their time to read through every entry and pick a winner. They approached their task with great enthusiasm, thoughtfulness, and diligence. Our judges were; **Professor David Jolley**, Consultant Psychiatrist and Honorary Reader at the Personal Social Services Research Unit at the University of Manchester, **Dr Josie Jenkinson**, Consultant Psychiatrist for Older Adults Liaison and Vice Chair of the Old Age Faculty, and finally, **Dr Grace Ofori-Attah**, Consultant in Addiction Psychiatry and professional screenwriter recognised by the BBC New Talent Hotlist and BAFTA.

Another exciting development that occurred over the course of the competition was the invitation to include the essays in the College's archives. As part of the College response to COVID-19, writings and recordings of College members' experiences during the pandemic are being collected, and it was thought that the essay entries will be of particular importance given the impact on the care of older adults. The entrants are currently being contacted to seek their permission before screening for deposition into the archives.

Below are the full essays from our joint winners, Dr Clare Wadlow and Dr Sharon Holland, and our runner-up, Dr Stephanie Vincent.

Essay competition joint winner

Old Age Psychiatry in the Time of Corona...And Beyond?

by

Dr Clare Wadlow,

Consultant Old Age Psychiatrist, Enfield, North London

It's a Friday lunchtime in early December 2049 and I'm surrounded by colleagues, no – friends, and good food. Time has warped and now here I am at my retirement party. As I ignore the recent warnings from my GP about my creeping waistline and a family history of diabetes, and load my paper plate with chocolate cake someone asks me a question. I pretend not to hear them in order to buy myself some more time, what was that dear? I turn to look at Jane, the new trainee who asks the good questions and has the sparkle in her eyes: I was just wondering, what was the most challenging part of your career? She asks me. The hubbub in the room dies down a little and people look up from their treat-laden plates.

The year 2021. I say. The younger folks look a little confused, they furrow their brows, the older folks nod knowingly. But I thought COVID hit in 2020? said Jane.

2020 was tough, I agreed. I had only been a consultant for 4 years. Suddenly, there was a lot that wasn't known. It was frightening at first, everything was changing, new words, new rules. We couldn't see our patients or families, clinics stopped and admitting people to psychiatry wards was to put them at risk. At the lowest points, we were taping bags of normal saline to the tops of wardrobes and teaching OTs how to use oxygen concentrators. Remember when our CMHT manager Stephen ended up serving dinners and I had to try to work a hoist as so many staff were off sick? The tumble weed swept down the usually busy admission ward corridors. People died, older adults and not such older adults. Colleagues got really sick. But by early 2021 we knew a bit more, vaccines were finding their way into everyone's arms and the sun started to shine. Boris got carried away with optimistic promises and the world started to heal.

So why was it so difficult then?

Well what came next was the part that every psychiatrist knew was just around the corner, the thing that hadn't really been counted or considered, and the health burden that didn't seem to be on any government's weighing scales. Mental health crises. People had been bereaved, trapped under oxygen masks in ITU, made redundant, kept away from school and day centres, missing family and friends. We found our community patients frightened, forever changed. They didn't want to see people, to go outside anymore, it didn't feel safe. Our dementia patients had absorbed the anxiety and their carers had collapsed exhausted under the even more persistent strain of care without respite. The care homes were traumatised, elderly residents felt abandoned inside without visitors. People who had felt trapped and isolated, who were for a time trapped and isolated became understandably depressed. People became manic for the first time, psychotic again. There were queues at the memory clinic for people who had missed appointments when clinics closed or who had the delayed gift of COVID delirium.

But I must stop here, there's something else to say. The other thing we learnt was there was all this fighting spirit. This gratitude for conversations with colleagues and the newfound value of a workplace you could leave home to bring in freshly baked muffins and the latest comical lockdown video to share. Then I started to notice that my patients were asking if I were ok, if the team was coping. We started to actually innovate. The NHS engine reignited and big old cogs creaked into action. Suddenly virtual meetings were easy, useful even. Protocols and resources got dragged into the 21st century. Even older adults found themselves on video calls and U3A zoom calls. Pointlessly long meetings that had been there forever became shorter. We became nostalgic for home visits and when re-instated, they became even more of a privilege and thoroughly enjoyed!

Things continued to change, well you all know – you've been living in the new world now for decades. So many of the positives you see around you blossomed from the bud of an idea squeezed out of us in the tense wake of COVID19. It became very clear that old age psychiatrists couldn't sit in clinics or just point patients with dementia elsewhere after their scans. We had to be available to everyone, to join with our GP and geriatrician colleagues through virtual ward rounds and community networked and multidisciplinary hubs that actually got the job done. We had to help protect vulnerable brains and champion dementia

prevention and challenge loneliness to walk the plank. We had to wrestle back managerial decision-making and role model our way into appealing to the best trainees. All the while rebuilding our own lives and caring for our friends, families, colleagues and patients.

You'll be sure I still have that Old Age Consultant COVID-crisis WhatsApp group on hand for swapping pics of large glasses of wine, frustrations about where to get the second dose of Pfizer and a glowing nostalgia for a time before surgical masks. Though to be honest, mainly now its photos of the others on tropical beaches or hiking up distant mountains – all in the name of demonstrating how I should be enjoying my retirement, and I can't wait to join them. I think we earned it.

Essay competition joint winner

Old Age Psychiatry in the Time of Corona...And Beyond?

by

Dr Sharon Holland,

ST6 Dual Adult and Old Age Psychiatry

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

"How did you go bankrupt?"

"Two ways. Gradually, then suddenly."

— **Ernest Hemingway**, *The Sun Also Rises*

The same can be said for the pandemic of COVID-19. It began with Wuhan whispers of a novel deadly virus ravaging through the community with unsettling speed and severity. This was initially dismissed, by those of us safely lounging in Europe, as an over-hyped flu that would soon die out and be forgotten. However, when it eventually hit our shores in early 2020, it proved itself every bit as contagious and lethal as promised and the eventual lockdown measures were life-changing.

While the virus and its consequent lockdown restrictions had a wide-ranging impact across society and across medicine, Old Age Psychiatry has found itself in a unique position. Obviously, our patients were disproportionately affected in terms of risk, curtailment of health services, and the socially isolating effect of shielding. However, there was also another angle to the experience which has struck me more and more as time has gone on and I am hopeful it can positively influence our perspectives, and the care we provide, into the future.

We, as a general population, were inadvertently provided with a glimpse into what it might be like to grow old in today's world. While there are plentiful positives to growing old, many of which are under-valued in today's society, there are also the inevitable downsides. Reduced mobility, social isolation, a

sometimes-failing memory or confusion, and an ever-present shadow of illness and death, are a few of the biggest cons to the pros of becoming wise and chronically incredulous. COVID-19 has bizarrely provided us with an insight to the challenges of this journey, and the resilience the older members of our society must draw from on a daily basis.

Suddenly, we were no longer able to move about our worlds with the same ease and freedom we usually enjoyed. A trip to Sainsbury's became a stressful affair with a disinfectant station at the door, and two metre markings scattered throughout the aisle floors. Many of us were no longer permitted to have our friends over for drinks or chats or general sanity checks. Our worlds became smaller and smaller until we grew sick of the sight of our living room walls and craved the sight of loved ones in person. It mimicked the chronic social isolation, boredom, and loneliness of older people. And it was not pleasant.

The experience of confusion can be one to which people may find it difficult to relate. Similar to psychosis, it is a completely pathological state rather than the exaggeration of a well-known emotion such as sadness or fear. However, I believe we were all subject to a variety of confusion, particularly during the early stages of the pandemic. This included the now oft-satirised murmurings of politicians telling us to stay home but go to work and only meet in groups of six, unless they are part of your bubble and it is the 25th of December. It also included the disorientation and complete upheaval of routine with everything from sudden unemployment to unwanted furloughs to working from home to working in equipment we had only ever previously seen in unnerving Hollywood movies about plagues. We began to forget what the bottom halves of our colleagues' and friends' faces looked like. There really is no such thing as pleasantly confused.

Our own mortality and that of our peers became something we found ourselves thinking about more often. This would previously only occur if an isolated 'tragic' event happened, whereas now it has become a very real and regular pause for thought. Images of young, 'healthy', 'no underlying conditions' people dying have saturated many of our newsfeeds and psyches. I suspect we often underestimate the chronic strain that this awareness of one's own vincibility can have on older people. And it is not pleasant.

Having considered all these miserable musings however, it is important to note that some of the most uplifting and life-affirming memories of the pandemic have also been provided by our older citizens. Captain Sir Tom pacing his garden with his trusty walker ahead of his 100th birthday, so that NHS workers might be granted free biscuits and somewhere nice to collapse, was as welcome as the sensation of removing an FFP3 mask. With all the fortitude that only a World War veteran can authentically imbue, he became an icon of strength for the nation, before ultimately succumbing to the virus himself. Captain Sir Tom's new acquaintance, the Queen, in her 94th year, managed to squeeze emotions out of even the most hardened anti-monarchists when she reassured us that we would meet again, exactly when we needed to hear it most.

I will not forget the frail of body but strong of heart over-85s who emerged from their months and months of shielding in order to receive some of the first doses of vaccines. They looked tired, and pale, and squinted in the daylight, but they were smiling, bolstered by their families and a determination of spirit that the rest of us needed to see. Watching them brave the snow and ice, the risk of a hip fracture, and the deafening frenzy of anti-vaxxers, to come and get their vaccines, filled my cynical heart back up to an acceptable level.

In short, the pandemic has given us a small experience of some of the daily challenges our patients face without the prospect of an end in sight. It has shown us how demoralising it can be and it has also shown us what we can do to help. It has hopefully instilled in us a new empathy towards our patients and the difficulties they negotiate, even in viral peace-time. Most of all, COVID-19 has managed to remind us that we are tasked with caring for one of the most resilient and stoic population groups, and how lucky are we.

Essay competition Runner Up

Older adult psychiatry and the COVID-19 pandemic

by

Dr Stephanie Vincent

CT2, South London and Maudsley NHS Trust

Diary excerpts from a psychiatry trainee working in the pandemic:

27/03/2020

We've just entered a national lockdown due to the COVID-19 pandemic, something we'd never heard about before 2019, but it's all we hear about now. Early research has highlighted the increased mortality related to COVID-19 in the older adult population.¹ I am concerned, for my older adult patients and my grandparents.

25/05/2020

Seeing pictures on social media today from when I worked in New Zealand, I'm reminded of the Te Whare Tapa Wha holistic model of wellbeing, which describes 4 elements of wellbeing representing the 4 walls of a house: spiritual, family/social supports, physical health and mental health; the model says a weakness in one of the walls, impacts the overall wellbeing of a person.^{2,3} I think the COVID-19 pandemic has shaken all these elements for older adults: places of worship are closed, they cannot see loved ones, routine operations are cancelled, and they (like everyone) are more isolated.

24/10/2020

I've been reading about medical ethics for my MRCPsych exam. It's easy to see why governments have taken drastic measures in the pandemic for the greater good, to protect the older adult population, as per Bentham's utilitarian theory discussed in Dimmock and Fisher's book.⁴

I was doodling whilst watching the news and my mind wandered to some of the practical and psychological impacts my older adult patients face in the pandemic, whilst also looking for the positives.

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14/11/2020

Working as a doctor during the pandemic, it has been humbling to see the goodwill, hard work and care that prevails in the NHS. The staff have shown great flexibility, embraced working differently, whilst managing both their own personal circumstances and their professional careers. As medical professionals, we have been challenged to adapt in every aspect of the CanMED roles⁵: maintaining professionalism despite high pressure; learning academically about neuropsychiatric symptoms of COVID-19 as a presentation/complication; communicating with colleagues virtually; advocating for service-users; signposting them to appropriate services; leading in medical scenarios when they become unwell with COVID-19 symptoms and collaborating with relatives when visiting has been suspended.

25/11/2020

Most of our service-users are missing their families, the healthcare assistant on the ward has worked hard facilitating video calls and it's fantastic to see their faces light up. Maybe we should continue these after the pandemic, since research has shown social support is a positive factor in mental health wellbeing.⁶

12/12/2020

With staff wearing masks permanently, it's difficult for service-users to recognise us; I think they find it disorientating.

26/01/2021

As we enter a new year, one word felt particularly pertinent to the older adult population in 2020, LOSS: loss of freedom, loved ones, support and normality. The Kubler-Ross grief cycle details the rollercoaster of emotions related to grief, i.e. denial, anger, depression, bargaining and then acceptance.⁷ Service-users, their families, NHS staff and the wider population have forged their own journeys through the cycle: some are in the early stages, others between stages and others out the other side.

28/01/2021

For some patients, the pandemic seemed to be the sole trigger for their presentations, and for many others a contributing factor, exclaiming 'well, the pandemic hasn't helped!'

01/02/2021

The government vaccine schedule is underway. Hopefully, a period of recovery and healing follows. Looking back to the Te Whare Tapa Wha model, developed by Mason Drurie, drawing on other elements of the model for strength and exploring each element in turn can help during difficult times.³ Perhaps exploring how we help our service-users strengthen their 'walls' could be beneficial, to empower them and their relatives to develop plans to help themselves. A JAMA article concluded that some studies show greater resilience from the psychological effects of the pandemic in older adults, but some may have fewer coping mechanisms, whether through lack of technology, limited social support or restricted mobility (limiting exercise); health professionals should evaluate their resources and plan to lessen the deficits.⁸

15/02/2021

An article in the latest RCPsych Insight I read this weekend talked about working digitally during the pandemic, something practically the whole population has adapted to. The article highlighted the challenges of telephone/video assessments and the lack of non-verbal cues; difficulties in forming rapport;

limited camera views to assess appearance and behaviour but some positives were the removal of stresses when travelling to the clinic, which could ultimately help with engagement.⁹ The article highlighted that it is important not to assume older adults cannot use technology, but equally it is important not to exclude those who cannot.⁹ A flexible approach to patient choice is important; situations vary, and we must engage with all who need help.

I caught up on the RCPsych 'Lessons from the pandemic' webinar today¹⁰, it included:

- Anecdotal accounts of how older adult mental health services in Wales have adapted.
- Reports on delirium as a key presentation for COVID-19 in older adults.
- Observations that many are having their first presentations to mental health services and many have stress-induced presentations.
- The importance of using a hybrid model for conducting assessments, of embracing the opportunity to upskill older adults in the use of technology, to not assume they are unwilling, to remain patient-centric and ask the service-users what they want.
- The amount of conflicting information on how to access health care services during the pandemic can be disorientating even for those without mental health difficulties. Simplifying information would be helpful.

I was heartened to see Dewa and Kilkenny's response to a BMJ article¹¹, they suggested that "the awareness of COVID-19's universal threat to our wellbeing has connected people in a new way worldwide. Despite the COVID-19 pandemic's devastating effects, going forward, this pandemic could dramatically reduce mental health stigma leading to increased mental health help-seeking globally; talking about our mental health will become a new norm"^(p.2). I hope their prediction is correct as an advocate for reducing stigma in mental health, but services should start planning for an increase in demand.

References available on request

Medical Student Essay Prize

Later life with substance-abusing children: exploring victimisation, addiction, and bereavement in the case of Ms E.

By

Sarah Chitson

Year 4 medical student, King's College London

I was based with the older adult community mental health team when we went to visit Ms E, an elderly retired lady living on her own in a council flat. She had been referred from talking therapies as she had expressed to her therapist that she felt suicidal, was considering taking an overdose, and could not identify any protective factors which might stop her from ending her life. She was also experiencing low mood, low energy, and a lack of interest in reading magazines or knitting, which had been her main interests.

Ms E was friendly and likeable, and appeared well kempt in her sparsely-furnished but tidy surroundings. She was very forthcoming when talking about her mental health and was able to name a number of factors which contributed to her low mood and suicidal ideas.

Introduction

The World Health Organisation (WHO) reports approximately 800,000 deaths due to suicide each year. The highest suicide rates in every continent on the globe are amongst older adults; in high income countries, one fifth of all completed suicides occur in those aged 60 or over. In addition, studies of older adults have found that a significant minority have active suicidal ideas and plans (defined as thoughts of taking one's own life), with one study finding that 11% of those in residential care homes for the elderly had experienced active suicidal ideas within the past year. It is therefore critical to take note of low mood and suicidal ideas in older adults, understand the causes, and prevent suicide where possible. Although the factors which cause someone to attempt suicide vary from person to person and in different cultural contexts, having a common

mental disorder (anxiety or depression) or being a woman who has experienced violence are both known to increase the risk of suicide in multiple global contexts.

Substance abuse is also a highly prevalent problem with far-reaching impacts. Approximately 100 million people worldwide are addicted to substances, and the number of people impacted by a family member's addiction is likely to be even higher, although family members of substance abusers are not well-documented in the literature. Affected family members often suffer in silence, despite an increased risk of mental health problems – in a recent cross-sectional study, family members of substance abusers had almost double the incidence of mental health disorders compared to those without a substance-abusing family member.

This essay will explore the case of Ms E, an older adult with active suicidal ideas and symptoms of depression who was the mother of two substance-abusing adult children. The essay will use current literature to help understand some of the issues which contributed to Ms E's poor mental health, as well as the impacts on her family and implications for the healthcare system.

Bereavement and abuse

The trigger for Ms E's suicidal thoughts had been the death of her son several months ago from a terminal illness. He had lived with her until his death and they had a dysfunctional relationship; he was an alcoholic and had abused her, including threatening to kill her at knifepoint on several occasions. Over the past few years of living together, Ms E had found herself trying to get out of the house as much as possible to escape her son, and had asked the council if she could move accommodation, a request which was refused. His violence had been a cause of her depression and suicidal feelings in the past, but now that he had passed away, she found herself missing him and wishing they had had a better relationship when he was alive.

Bereavement and grief are a natural part of life, in particular for older adults who are more likely to have experienced bereavement from their closest family and friends. However, this does not make older adults immune to psychiatric disorders when grieving; in contrast, a recent meta-analysis indicated that

elderly people may have more difficulties when processing grief. This may be because older adults generally have worse physical and mental health to start with, which reduces their ability to cope with the changes and stress associated with bereavement. In addition, many older adults have less social contact than their younger peers – for example, because they do not leave home to go to work each day, or because of reduced mobility preventing them from going out – and this may make it more difficult to cope with grief. Being the parent of substance abusing children, as well as being a victim of abuse, can further ostracise a person from their social network, which may have put Ms E at further risk of mental disorders both before and during the grieving process. It is important that healthcare professionals are able to understand some of the risk factors for a patient's grieving process to be interrupted or prolonged, so that further support can be provided for those who are struggling.

Interestingly, family members of a person struggling with addiction already experience significant feelings of loss, even before the person dies; they may grieve the loss of good quality relationships with their addicted family member and feel let down by them. For Ms E, this was certainly the case, and she experienced even more regret at her fractured relationship with her son once he had passed away. Her hopes for a better relationship with him, despite being hurt by him, have been echoed in other studies of family members affected by addiction.

As in the case of Ms E, abuse is commonly perpetrated by those abusing substances, and elderly people may be particularly vulnerable to abuse due to physical health conditions and cognitive decline. A number of studies have suggested that the prevalence of elder abuse, including physical, psychological, and sexual abuse, is in the region of 10% of all adults aged over 60. It is sometimes assumed that elder abuse occurs when the elderly person is dependent on the abuser, however, research generally shows the relationship to be the other way around, especially if the perpetrator uses substances or has a mental health condition – for example, the perpetrator may depend on the victim for finances or housing. This suggests that elderly people living with a substance-abusing adult child are at particular risk of abuse. Other risk factors for elder abuse include the victim being isolated or having functional impairments, low income, and sharing their home with other adults.

Unsurprisingly, the experiences of violence and other aspects of abuse have a lasting impact on victims of abuse. A large retrospective cohort study conducted in the UK recently found that women who survived intimate partner violence in the general population were almost three times as likely to develop a mental illness. Perhaps some of this risk links to a lack of timely intervention by mental health services in the UK; one reason could be the under-identification of abuse victims, noted in the same study, which stops victims from receiving the necessary support to recover. A large study conducted by WHO has also shown that women who experience violence, either from an intimate partner or a non-partner, are also at increased risk of suicide attempts – again highlighting the importance of intervention for this group.

In addition, elder abuse has consequences for the wider healthcare system. Older adults who have been abused have an increased rate of hospitalisation, even after adjusting for medical comorbidities, cognitive and functional impairment. This suggests that preventing elder abuse and intervening in existing cases may help the physical health of victims, which could alleviate the burden on hospitals and potentially be economically favourable to the healthcare system as a whole.

It is therefore important that elder abuse is identified so that its harms can be prevented. In the UK, guidelines recommend opportunistic enquiry in health and social care settings to screen for abuse so that action can be taken if it is present. During the COVID-19 pandemic, elder abuse may have become more prevalent due to increased stress and isolation, but opportunities for the identification of abuse are likely to have dropped, due to reduced face-to-face appointments. It is therefore paramount that healthcare professionals prioritise screening for abuse during the pandemic to ensure abuse is identified. Current UK guidelines also recommend that multi-agency partnership takes place to prevent and mitigate the effects of abuse, including with housing services – this was sadly lacking in the case of Ms E, as the ability to move out of her flat and away from her son could have had a positive effect on ending the abuse.

Theft and estrangement stemming from addiction

Ms E had also been a victim of theft. She was a woman of modest means, but had carefully saved up to pay for her son's memorial plaque after his death. This money was stolen from Ms E by her daughter, described by Ms E as 'a drug

addict'. As well as the obvious stress of losing such an important sum of money during a period of grief, this had understandably broken down the relationship between Ms E and her daughter – her daughter had subsequently moved out of the flat, adding to Ms E's sense of loneliness and hopelessness. Later, a family friend also stole some valuables from the flat. These thefts together had a negative impact on her mood and caused her to worry considerably, although she stated that she did not want the crimes investigated. She reassured us that she did not keep cash in her flat anymore, and did not feel that someone could take advantage of her financially.

There are financial costs to being a family member of a substance abuser. This commonly includes having money and property stolen, as in Ms E's case, as well as financially supporting the person's addiction, and losing their own employment and income due to the behaviour of the substance-abusing person. A recent Swedish study found that half of all parents of substance-abusing children had been victims of theft or burglary by their children, and over half of those had experienced theft on more than five occasions. In the UK, the financial cost to affected family members of substance abusers has been estimated at £2.5 billion per year by the Drugs Policy Commission. Older adults are at higher risk of theft by a child with an addiction, but also being taken advantage of financially in other ways, including scams or financial abuse. The individuals most at risk of financial abuse are those with dementia or reduced cognitive function, as these victims are less able to manage their finances and make wise decisions regarding money. However, even those with very subtle cognitive changes which remain below the diagnostic threshold may be more susceptible to scams. Other risk factors for financial abuse in the elderly include being female, single or widowed, and living alone. Furthermore, once a crime has been committed it is much more difficult for a retired elderly individual to recover financially from the damage, as they cannot replace lost savings easily by working.

Sadly, the psychological effects of financial crime can cause a cycle of victimisation which is difficult to escape. Clinical depression and other mental disorders put an older adult at risk of financial abuse, and financial abuse in turn worsens mental health, increasing the risk of further crime. An elderly person who has been a victim of financial abuse may feel embarrassed, lose confidence in their ability to live independently, experience self-blame and may become

further socially isolated. All of these factors may increase their vulnerability to further victimisation, and may stop elderly victims from reporting crime too. This cycle of victimisation, as well as Ms E's depressive symptoms following bereavement, may explain why Ms E was a victim of theft twice within a short space of time.

There are also other psychological impacts borne by the ageing parents of substance-abusing children. Few studies have been conducted regarding these impacts, however, qualitative research has recently been published in South Africa addressing the effect on mothers specifically. Through a series of interviews, Groenewald *et al.* found that mothers often bore a particular feeling of responsibility for their children's health and wellbeing, perhaps more so than other family members, and consequently their child's addiction caused them high levels of stress. They often blamed themselves for their child's substance abuse, or felt judgement from others, and this led to feelings of hopelessness, anxiety, depression, and anger. Family relationships were also frequently fractured due to the addict's destructive behaviours, and this could cause other siblings to leave home and marriages to break down, increasing loneliness and social isolation for the mother. Many of these elements can be seen in the story of Ms E, and contributed considerably to her poor mental health.

Cognitive decline, memory loss, and delusions of crime

Ms E had good cognition, easily answering the brief cognitive screening questions we asked, although she told us she had noticed some decreased concentration and increased forgetfulness recently, parallel to her low mood. She was judged to have capacity with regards to managing her finances and was independent in her activities of daily living.

In the case of Ms E, she was not judged to have any cognitive deficit, so we were able to work on the assumption that the thefts committed against her were real. We were also able to view her past medical records which showed that her son's abuse towards her was certainly real, and she had attended counselling for this some years ago whilst the abuse was still ongoing. However, when I presented this case to a psychiatrist in the older age psychiatry team who was not familiar with Ms E, the first response I received was the question: '*Did the thefts really happen?*' In the context of older adult psychiatry, I have realised

that it is important to consider whether reports of crime, particularly theft, are genuine.

Some older adults with dementia develop delusions of crimes committed against them when there has been no crime. It is thought that delusions occur most commonly in Lewy Body dementia; an estimated 60% of Lewy Body dementia patients have delusional beliefs. However, in Alzheimer's disease over a third of patients are also thought to experience some delusions. Of the delusions seen in dementia, the most common is where patients believe someone is stealing their property, and this experience can be extremely distressing. Patients may suspect that their caregivers are the perpetrators, leading to fraught relationships with carers – especially difficult if the main caregivers are family members.

Different reasons have been suggested for delusions in dementia. One theory is that the loss of cholinergic neurones upsets the dynamic balance between the cholinergic and dopaminergic systems in the brain, leading to a relative hyperdopaminergic state. A less biological explanation may be that a forgetful person with failing vision and hearing subconsciously blames their inability to find things on a third party rather than on their failing memory, to protect their self-esteem. In addition, a patient may have more difficulty locating belongings after moving home. Mental health issues may also play a role in the development of delusions; a Japanese study found that negative affect was closely related to delusions of theft or intruders, even after controlling for the effects of cognitive function and functional impairments.

Whilst it is currently impossible to reverse dementia, there are ways to manage delusions of theft. One aspect is educating and reassuring family members on whom the patient is casting suspicion; this can help to reduce family members' distress at being accused of stealing. Orientating the patient as much as possible with hearing and vision aids may also stop them from losing belongings, thus preventing their mistaken claims of theft. From a biological perspective, reducing polypharmacy may help to reduce disorientation and aid memory – a number of drugs used in older patients are thought to have anticholinergic effects on cognition which can interact with memory and orientation. A scoring system was developed several years ago by a group of clinicians at the Maudsley to better classify these drugs and enable clinicians to switch or withdraw these

medications. Since then, an online tool called Medichec has been created incorporating the scoring system, and I saw this tool in practice during my older adult psychiatry placement to try and reduce cognitive impairment from polypharmacy. However, it is vital that clinicians outside the field of psychiatry are also engaged in reducing anticholinergic medications if such tools are to have an impact.

Despite the possibility of delusions when an elderly patient claims there has been theft, it is crucial that clinicians avoid diagnostic overshadowing and have a low threshold for suspecting that a real crime has taken place, since older adults can be vulnerable to crime and financial abuse. This was the case with Ms E, who it seems had genuinely been a victim of crime when we visited her in her home, and was treated as such.

Loneliness and loss during a pandemic

Loneliness played a part in Ms E's presentation, and the national lockdown due to the COVID-19 pandemic was significant in increasing her loneliness, in addition to the estrangement from her daughter who had stolen the money. She had one son with whom she had a good relationship, and she felt she could confide in him about her suicidal thoughts, although stated that he was not a protective factor for her. He was very worried about her but was not always able to visit.

Mental health problems, including those caused by victimisation and bereavement, are likely to be worsened by increased loneliness and social isolation. Over the past year, physical distancing rules have been put in place to reduce the effects of the COVID-19 pandemic, leading to a decline in in-person social contact from March 2020 in the UK. Elderly individuals were more likely than the general population to be 'shielding' – avoiding all contact with others to reduce their risk of death from COVID-19. The shift away from in-person contact increased the prevalence on loneliness which in turn has had a negative impact on mental health; in the general UK population, a large online study found that the prevalence of self-reported depressive symptoms was found to have almost doubled from normal levels during the nationwide lockdown. The relationship between loneliness and depression during the pandemic has also been observed to be bi-directional, as those who met clinical criteria for depression also felt loneliness more acutely. Protective factors against loneliness during COVID-19

include higher levels of social support, being married or co-habiting or living with other adults. The lack of these protective factors in the case of Ms E, who lived alone and became estranged from family over the past months, may have contributed to making her experience of the pandemic an especially lonely one.

Despite Ms E having a good relationship with her youngest son, who did not use substances, the pandemic meant that they were not able to see each other regularly. This was difficult for both Ms E and for her son, who worried considerably about her mental health. Depression can be a stressor for the whole family, causing increased anxiety and depression in relatives, and family members may worry that the patient could harm themselves or others. During the pandemic, the inability to physically check on Ms E likely made her son even more worried about her suicidal ideas.

In addition, it is likely that Ms E and her son's experiences of bereavement were altered due to COVID-19 restrictions. One recent study examined how parents coped with the loss of a child to cancer during COVID-19 restrictions. It found that there were a mixture of positive and negative aspects to bereavement during the pandemic: there was more space and time to grieve, but parents found the loss of routine difficult. Being trapped in a home which held memories of the deceased child was also challenging, and physical distancing from support services added to the isolation of the grieving process. Whilst the circumstances of the deaths in this study were different to the case of Ms E, it is likely that many of the same factors influenced her experience of bereavement and grieving during this unusual pandemic period. In addition, the numbers of funeral attendees were restricted, and relatives were sometimes not allowed to visit a loved one in their final days, which may have further interrupted the normal course of grief. Since interruptions to grieving can cause an increased risk of mental disorders and suicide, it is important for healthcare professionals to consider how a person's grief may have been impacted by the circumstances of the pandemic and provide additional support. For example, some relatives may wish to see a photograph of the decedent if they are unable to be by the bedside, or to attend a virtual memorial service if they are not able to attend in person – elderly people could be supported by healthcare professionals to access this if they struggle with technology. Some will also need referrals to psychotherapy or further social support, which may be via telephone or the internet whilst the pandemic is ongoing.

Conclusion and personal reflections

Being the parent of substance-abusing children is not a mental disorder in its own right, but it can create a melting pot of multiple vulnerabilities – financial abuse and financial insecurity, domestic violence, difficult bereavement, social isolation, and complex family relationships – all of which predispose an elderly person to mental disorders. For Ms E, these vulnerabilities, with the COVID-19 pandemic overlaid, were enough for her to consider suicide. Through this essay I have aimed to show the broad variety of risk factors, many tied together by substance abuse, which contributed to the development of Ms E's depression and suicidal ideas. I have also touched on the topics of delusions and COVID-19 which are relevant to her case.

Before meeting Ms E, I had given very little thought to the parents of substance abusing adults, and how it might impact them socially, financially, and psychologically. This was my first time being involved in the care of someone so affected by substance abuse, and I was surprised by how almost no part of her life was left untouched in some way by her children's addictions. Through reading about the issues related to her case, I have begun to understand the broad impact of addiction, and the many ways in which health services can both support and let down these complex families. I also saw under-researched and poorly understood the 'condition' of being a parent of a substance abuser is. More broadly, I have realised how interconnected an older adult's life is with their family, something I am sure I will take forward into my remaining hospital placements and my career.

Ms E also demonstrates the potential vulnerability for abuse in an older adult. Through considering her case, I have been reminded of how important it is to assess risk and vulnerability opportunistically in any healthcare setting, which would allow for greater safeguarding for older adults like Ms E. In my future practice, I hope to advocate for substance abusing patients and their families to ensure they receive high quality care, and to take safeguarding seriously in the older adult.

References: Available on request

Interview with Baroness Elaine Murphy

Dr Nicole Edwards,

CT3, Trainee Editor of The Old Age Psychiatrist



I was extremely honoured (and nervous) to be asked by the editors of the newsletter to interview Baroness Elaine Murphy for May's edition. Baroness Murphy is a hugely important figure in Psychiatry and her career has varied from being the first Professor of Old Age Psychiatry in the UK to her current role as an independent politician in the House of Lords. In November 2020 she was awarded the Royal College of Psychiatrists Lifetime Achievement Award.

Dr Nicole Edwards (NE): Your award from the Royal College is clearly an amazing achievement, could you begin by telling us what your reaction was to it?

Baroness Murphy (BM): I was actually quite staggered because I've always felt rather guilty that I didn't do enough for the College over the years. I have sort of "zoomed" in and out of Psychiatry and into politics and history. I've always been interested in mental health and service development, but I haven't always done things directly for the college and I was sort of surprised to be honoured in that way, but it's such a fantastic honour. I'm very thrilled. Then one's colleagues contributing to the YouTube video... it's like having an obituary before you die, but who gets to do that very often! It was really thrilling.

NE: What do you think your most important achievements are, looking back over your career?

BM: You tend to look at your career as ever onwards and upwards and then perhaps you reach a plateau. But actually for me when I look back over what I've really felt I've contributed, it was back in the 80s. That's a long time ago,

but it was when I was interested in improving the services which were so appalling for people with dementia and depression and any disorders experienced by older people. They were misunderstood, not talked about, written off... people were being consigned to the back wards of the old asylums. It was around that time as well that the Alzheimer's Society was beginning to take off, and there was a group of us who were trying really hard to raise the profile of the specialty, raise the profile of the problems that people with dementia experience and the significant difference of depression in older age. We were doing a huge amount then to develop services. It was a very exciting time.

I think the biggest thing I did was to work with my friend Nori Graham when the government began introducing the Poll Tax introduction. The junior minister responsible for making the Poll Tax acceptable at the time was David Hunt, (now Lord Hunt of Wirral) and Nori said "why don't we see if we can get exceptions in the Poll Tax for people with severe mental illness and in particular older people with dementia?" We approached David Hunt, who turned out to have a family member with dementia at the time, and he managed to get these changes into the Poll Tax regulations and they have continued into today's Council Tax. That was something that I can point to that Nori Graham and I did. Despite other changes in the Mental Health and Mental Capacity Acts where I made some contributions, I would say the changes to the Poll Tax and service development at that time was my proudest moment.

NE: Is there anything that you would say to your younger self when you were starting out in training, and is there any general advice you have for people starting in Psychiatry

BM: I would say, do a few other things first. I did some Geriatric Medicine when I was a senior registrar and I did a little bit of Neurology as well, but I wish I'd done more general medicine. I would say to people generally that the more experiences you can get in medicine or in social care, then the better. It helps enormously, especially if you want to work with older people obviously. In my training I was very much able to choose my own training scheme and I was able to move from one place to another where I fancied. Now people are funnelled down quite rigid training programmes, which I'm not entirely sure is a good

idea, and if people have opportunities to move into different areas that's a better idea. To do much more, and to move sideways more, rather than up that ladder towards being a consultant. One is going to be a consultant for a very long time. So that's what I'd tell my younger self; don't be in a hurry and take every opportunity that comes along.

NE: I understand you were the first Professor of Old Age Psychiatry in the UK. Could you tell us a bit about how this came about?

BM: It's a strange thing really, because there were people who were in fact doing this work already. For example Professor Tom Arie – he was a professor over a department of both Old Age Medicine and Old Age Psychiatry but he was a psychiatrist by training, so really he was the first. But I suppose in terms of titles, mine was the first. At Guys' Hospital the Professor of Psychiatry then, Jim Watson, had a vision that he wanted to create this post and persuaded the NHS to fund it in perpetuity, which was brilliant. I was extremely fortunate to be appointed and very young at the time – too young perhaps! I was looking for a senior lecturer post, but he said to apply for the Chair and I did.

NE: Moving away slightly from Psychiatry, I wondered if I could ask about the book you published recently about the history of your home in Norfolk?

BM: I became interested in history and started a PhD with Roy Porter, who was the most fantastic PhD supervisor – he showed me what it meant to be a PhD supervisor. I wanted to know what people like me, who had administered mental health services in centuries past, how were they thinking about the problems of people with mental health and how to devise services? Then when I was spending more time in Norfolk, since I lived in a very ancient house, I thought wouldn't it be fun to see if I could get to know more periods of history that I'd left out during my PhD, which was focussed on the 18th and 19th centuries. I knew that doing a house history, if you really get into it, you would have to learn everything about the Medieval period right up to the 20th century. And I enjoyed it. So I got asked to do other house histories... I've just finished the history of Wingfield Castle, which is a late 14th Century castle nearby. I've just sent it to

the publishers so I'm in a hiatus now – I'm not sure what my next project will be!

NE: Thinking about the future of Old Age Psychiatry, are there any areas you think are most important?

BM: There is much better understanding of the problems of older people in general hospitals, and they get much better liaison services. There is better general understanding, and it could be better still. And also in Social Care, the understanding has improved from in the past when Social Care wouldn't deal with people with dementia. The understanding outside of the specialty is much better, so I think we've come a long way. The big things moving forward have got to be diagnosis and treatment of dementia and a better understanding of the nature of neurodegenerative disease is needed. We need to know how to treat these more complex types of dementia, and we don't. So there is still a lot to do and massive mountains to climb.

Interview with Professor Wendy Burn, CBE

Dr Nicole Edwards,

CT3, Trainee Editor of The Old Age Psychiatrist

I was fortunate enough to be given the opportunity to interview Professor Burn via Teams in February 2021. We discussed her recent CBE, her past achievements and thoughts on working clinically during the COVID-19 pandemic.



Dr Nicole Edwards (NE): One of the things which prompted us to suggest this interview was the amazing achievement of you being awarded a CBE in this year's New Year honours list. What was your reaction? How did it happen?

Professor Wendy Burn (WB): Total, total surprise. This email just popped up and I nearly fell out of my chair in astonishment! It's not often in life that something happens that's wonderful but totally unexpected – when you pass an exam, or get a job, you're sort of hoping it will happen aren't you, but for something so wonderful to just fall out of the sky was incredible. It was a really proud moment. It was also quite funny because when you open the email it asks you if you're going to accept it, which obviously I was, but it also says you can appeal if you think your honour wasn't high enough!

NE: And in non-COVID times, I suppose it would have involved going to Buckingham palace...?

WB: Hopefully this will still happen, yes. Once the pandemic is over they will have a backlog, but hopefully it still will happen. The other thing to say about the CBE is that I think I was given it because mental health has become so important – I don't think it was just for me. Mental health has always been in a bit of a second place to physical health, but things are improving and parity of

esteem is enshrined in law now, but there is still a bit of a way to go in reality. But that's another reason that I was so pleased, because it was a nod in the direction of mental health and its importance.

NE: What are you most proud of throughout your career? Are there any key moments that stand out to you, like being President of the college?

WB: I don't think there have been key moments, it's been more of a gradual flow. I started out as a consultant in 1990, and I'd been working just a few weeks and someone came up to me and said 'You're the new consultant, that means you're the College Tutor!'. There was no advertisement or interview for the post, I just became the College Tutor. That was the beginning, and it kind of went on from there... opportunities came along and I took them. I wasn't always successful – I applied for roles I didn't get, it wasn't smooth all the way.

One of the best things, though, was setting up the Yorkshire School of Psychiatry and I was the first Head, so that was a really proud moment. But it's been a gradual progression really. You look from the top and you don't really know quite how you got there. It was never the plan!

NE: Do you have any advice to your younger self, or to anyone starting out in training?

WB: I think I'd say don't have specific aspirations – someone once came up to me at the college and said they wanted to be President, how could they get there? It's actually very difficult to set your sights on a specific goal; opportunities will come your way, so take them where they come and see where that leads you. Also you don't have to do these things to be happy either! I'm sure if I hadn't done any of these things and just worked as a clinician I still would have been happy. That's the good thing about psychiatry, it's such a wonderful career. I've gone back to doing two days a week clinically now and it's so nice to go back and re-engage with the patients. I'm actually back working in the same patch that I started working in in 1990. Everything is different except the patients! A lot of it is video conferencing, wrestling with the computer or doing it over the phone, but the patients are just the same and just as wonderful. There was a worry that when I started perhaps it was this generation that was so tough after all they had been through, but actually I think it's all older people, they're just wonderful. They're brave and lovely to work with.

NE: Yes, and at the moment older people are dealing with a lot... With you working clinically throughout the pandemic, have you had any particular reflections for this group of people that you've noticed?

WB: I think it's been hard, yes. There's a difference between depression and misery, isn't there? A lot of the people I've seen with dementia I've found to be unhappy rather than having developed depression. Of the people that do suffer from depression, however, things have got worse because a lot of the day centres and community activities that helped keep them well all went. The team I work in have been brilliant, though, and we have still been doing face to face visits. Most of my patients have been vaccinated now, which is good, and it looks like there might be an end in sight. I was actually in the Novavax vaccine trial, and I told a number of my patients about this. They were all so positive about it and keen that vaccines were coming along.

NE: Moving on from COVID, I know that you're very active on Twitter and I wondered what you think the pros and cons of it are.

WB: It's really good for linking you in with people. It teaches you a lot, for example patients on Twitter expressing that they are not happy with the care they've received. The work that I did on antidepressants and withdrawal from them, a lot of that was driven by the people on Twitter talking about the terrible time they had with it. There is a downside to Twitter, with certain people being unkind and nasty... but you just have to block and mute those people. But the pandemic is a lonely time, so twitter provides a bit of a social life and human contact.

NE: What should the priorities be for Old Age Psychiatry moving forward?

WB: You'll probably know of my interest in Neuroscience, and I co-chair the Gatsby Wellcome Neuroscience project. There is a lot coming out of this in terms of dementia diagnosis and treatments. We may end up having to do lumbar punctures and IV treatments, we don't know when these things are coming but they are on their way.

NE: Was there anything else you wanted to tell us about?

WB: I've got two children and they are what I'm most proud of from my life. They've brought the most joy to me. So just to say that as a woman you can

have a career and a family. I had a lot of support, but it should never feel like a choice between career and family.

NE: And finally.... what is your favourite recipe for the time of year?

WB: Rhubarb crumble. It's got to be forced rhubarb grown in Yorkshire, though. I'll send you the recipe for the newsletter – it's the best rhubarb crumble recipe in the world.

Best ever Rhubarb Crumble

Original recipe by Katie Stewart

Serves 4

700 gm -1Kg Yorkshire early forced rhubarb

50 gm caster sugar

For crumble:

175gm SR flour

100gm butter (cold from fridge)

100gm demerara sugar

Wash and trim rhubarb. Cut stalks into 2 cm pieces. Put in saucepan with sugar and poach gently until soft, about 15 mins.

Put rhubarb into 1 litre shallow dish.

Sift flour into basin. Rub in butter. Add sugar and rub in again.

Or put crumble ingredients into food processor and mix until consistency is like breadcrumbs.

Bake for 30min at 180 degrees or until topping golden brown and crisp.

FutureNHS Collaboration Platform: A creative space to drive innovation

By

Dr Catrin Thomas,

ST4 in Old Age Psychiatry, Betsi Cadwaladr University Health Board.

What is it?

The FutureNHS Collaboration Platform was set up in partnership by NHS England and NHS Improvement in 2016. It's a digital platform that is open to anyone working across the health and social care sector. It promotes online sharing, learning and networking. It aims to improve collaborative working across different organisations, to develop innovative ways of working and to deliver high quality integrated health and social care services within our communities.

Although originally set up in 2016, the platform seems even more applicable in today's world. Since the start of the pandemic, we've all had to adapt our ways of working and, for better or worse, some of these are here to stay for the foreseeable future. The opportunities to network and share new ideas and practices with colleagues, working across the UK and beyond, are even fewer now that conferences and courses are being held virtually. FutureNHS is a platform that provides a creative space for these discussions and networking to occur, all from the comfort of your own home.

How does it work?

The platform is made up of different 'workspaces' which are self-contained areas dedicated to a particular topic or project. Each workspace has its own manager, whose role it is to look after the running of the workspace and manage its membership. You will need to request to join the workspaces that are relevant to your areas of practice and interest, such as the 'NHS England and NHS

Improvement National Adult and Older Adult Mental Health Programme' or the 'National Dementia Programme'.

Within these individual workspaces there are numerous different features such as forums and blogs. Forums are a great space for users to ask questions, share their ideas and celebrate local successes. They are a good way of building up professional relationships and developing joint working across borders. It's an interactive space where a user can post a query or problem and other users, from across different organisations, can reply giving their suggestions or detailing how they have overcome similar problems themselves.

For the workspaces you've joined, you'll receive weekly emails summarising the recent activities in those workspaces. This is a useful way to scan new activities and follow evolving discussions.

Endless opportunities: how can we make the most of the platform?

I was recently introduced to the FutureNHS Collaboration Platform and after becoming familiar with its functions, I was excited by its wide-ranging potential. Below, I've outlined a handful of my own ideas about how this platform could be utilised and I'm sure, you will be able to expand on this list.

Firstly, the platform is a great way to share resources, latest research articles and guidelines. Users can also advertise upcoming courses, conferences, webinars and podcasts. It can be used by different agencies as a way to circulate and gather feedback about developing frameworks, guidelines and future visions.

Multidisciplinary working is always at the heart of Older Persons Mental Health (OPMH) services. One of the biggest benefits of the platform is that it's open to a variety of professionals working across the health and social care sectors. Therefore, it's a great space to have meaningful and interactive discussions about important topics, such as the role of co-production in OPMH teams or what peer support services for older people look like across different parts of the UK. By having these insightful discussions and sharing our understanding, we can expand and improve our own local services.

OPMH services are also used to collaborating with others across a wide range of health and social care settings. Through the use of forums, we could expand our current relationships and increase the dialogue between different organisations, including social care, and different NHS trusts. This would allow users to learn from other members and discuss ideas, such as how to overcome certain barriers we might face when trying to implement new ways of working.

Users are able to showcase their successful quality improvement projects or share how they have implemented local service changes through the use of blogs. These can then be discussed with users from different organisations and across the integrated care systems and primary care networks and will hopefully, inspire and encourage others to implement similar changes in their own organisations.

It's very important that the views of OPMH services are included in the community mental health transformation framework. This platform is an ideal space to have these important discussions and ensure that our opinions and the voices of our communities are heard.

Lastly, as a group, I believe that we are great at adapting to new ways of working and this has never been highlighted more than over the last year. Certainly, we all had to quickly navigate our way through this new technological world with reduced face to face contact and increased virtual assessments. The FutureNHS Collaboration Platform is a great way of sharing our learning and enables us to work together to further enhance patient centred care for older people during this difficult time.

So, what are you waiting for?

I encourage you all to sign up to the FutureNHS Collaboration Platform today. To sign up, just head to www.future.nhs.uk and register. Looking forward, after Easter there will be different discussion topics on the forum every week. Of course, you don't have to wait until then, you can start your own forum discussions or blogs any time. See you all there!

New Resources for teaching and training

by

Dr Kapila Sachdev, MBBS, MRCPsych Consultant Old Age Psychiatrist,
East London Foundation Trust

The Royal College of Psychiatrists' Faculty of Old Age Psychiatry has published a set of training packs, which have been developed to help improve awareness of older people's mental health in line with HEE's [Older People's Mental Health Competency Framework](#).

The presentations have been prepared to cover the 3 tiers of competency levels described in line with the Competency Framework:

- **Tier 1** – Applicable to those that require general awareness and knowledge of older people's mental health needs, and knowledge of actions to support this population. This tier encompasses all those working in health, social care, voluntary sector family members and other services who have contact with older people with or without mental health needs.
- **Tier 2** – Applicable to health and social care staff and others who regularly work with older people and older people with mental health needs but who would seek support from others for complex management or decision-making.
- **Tier 3** – Applicable to Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for older people and older people with mental health needs.

Whilst these presentations are not intended to cover every aspect of the Core Competencies Framework in Older People's Mental Health, we hope that these will save time when colleagues are developing their own training modules to meet the needs for each tier. With this aim in mind we have included no design features on the slides. We have also not developed them with older adults or referred to any local support groups.

We would encourage those who use the slides to add to the presentations and personalise them to make best use of them, using their own design templates and adapting/adding relevant information including case studies.

Finally we would like to thank all the contributors who shared their presentations with us to help us to deliver this project.

LINK HERE: <https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/training-packs>

Why do psychiatrists need to know about the European Settlement Scheme deadline on 30th June 2021?

by

Dr Sally Gilmour

Speciality Doctor Old Age Psychiatry Pennine Care

Volunteer advisor to the charity *Settled*¹

Following the 2016 European Referendum three cases demonstrate European Elderly Patients and Adults of all ages with Mental Health conditions can face difficulties applying to the European Settlement Scheme EUSS with the deadline of 30th June 2021.

A 75-year old Portuguese gentleman diagnosed with early Alzheimers dementia. During the cognitive assessment, he did not understand 'Brexit' and did not believe he would have any problems staying in this country after living here 50 years.

An 80-year old Romanian lady with Alzheimers dementia with hallucinations, delusions and reduced mental capacity for decisions. She needed carer support and psychotropic medication to stay alone at home. Asking her daughter if she needed to help her mother apply for settled status, she said her mother had lived here so long that there would not be any problems.

A Danish lady age 68; a diagnosis of hoarding disorder; her possessions 4-5 feet high, a narrow path between collections of antiques and cardboard boxes, her large Danish flag hung over a window. Knowing her Danish passport had expired and without British passport she was not aware about settled status, had no family support, her documents were 'probably under the clutter'. Her social worker was advised to contact the charity 'settled' to support her application.

'There are at least 47,000 EU nationals aged over 65 in the UK (approximately a third of all EU nationals of this age group) who have not yet made an application to EUSS.' Age UK September 2020²

Before 30th June 2021, Europeans who do not already have British citizenship and have lived in the United Kingdom for less than five years before 31st December 2020 need to apply for pre-settled status; Europeans who have lived in the United Kingdom for longer than 5 years need to apply for settled status, which needs to be renewed every five years online. They need to apply if they're a family member of an EU, EEA or Swiss citizen, even if the family member does not need to apply.

Charities such as *Settled* have expressed concerns as to whether people will be entitled to NHS care and prescriptions as well as social care at home and funded care home places, mortgages, employment and banking products if they miss the deadline for the European Settlement Scheme. The Home Office has said that it has trained its caseworkers to exercise discretion in the applicant's favour where appropriate⁴.

Citizens of the following countries are affected:

Austria, Belgium, Bulgaria, Croatia, Republic of Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland*, Italy, Latvia, Lichtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and Switzerland.

* You do not need to apply if you have Irish citizenship. *Settled 2020*¹

How can I help as a Psychiatrist?

Psychiatrists should consider when European Settled Status EUSS may be relevant to our European patients especially with mental health conditions with associated reduced mental capacity or motivation and physical health conditions; who may not have the ability and awareness to apply for Settled Status or perhaps have lost relevant paperwork.

Family members and carers may assume their relative has been in the United Kingdom for so long that they do not need to apply and also be unaware of the settled status deadline. We must also consider those in controlling domestic or employment relationships.

Psychiatry Functional conditions which could be relevant are Schizophrenia, Depression, Hoarding, Bipolar disorder, Alcohol and Substance misuse in addition to Organic conditions especially Dementia, Delirium, Mild cognitive Impairment and Learning Disabilities .Our patients may also have relevant physical health conditions such as stroke, brain injury and other diagnosis.

If you are a Psychiatrist caring for a European Citizen who doesn't have the ability to make a decision and you are concerned that this person will not be able to:

- understand all the information needed to make the application
- complete a form and send specific documents (either online or by post) to prove their identity and their residence in the UK to the Home Office

Then it is important to advise that an application is enabled via their next of kin, power of attorney or social worker.

Please discuss settled status with your European patients with sensitivity. Advice is available by phone or online from the Home Office³, from advice organisations such as Settled¹, Age UK² as well as Citizens Advice⁵.

There are links to help at the end of this article including a pdf advice leaflet and consent form which considers those with reduced mental capacity which I created with the Settled charity and lawyer Chris Desira¹.

Useful links

1 Elderly support and Mental Health patient's information pdf and consent form including for those who lack mental capacity

<https://settled.org.uk/help/settled-status-advice-for-the-elderly-severe-health-conditiond-and-carers/>

For specific advice email advice@settled.org.uk

2 Age UK support EU settled status application www.ageuk.org.uk

3 Home Office EU Settlement Scheme Resolution Centre

Telephone: Monday to Friday (excluding bank holidays), 8am to 8pm; Saturday and Sunday, 9:30am to 4:30pm. Inside the UK 0300 123 7379 Outside the UK +44 (0) 20 3080 0010 Online form:

4 Parliamentary Question to the Secretary of State for the Home Office regarding those with dementia and EU settled status

<https://questions-statements.parliament.uk/written-questions/detail/2019-10-28/6360>

5 Citizens Advice www.citizensadvice.org.uk

6 Free Settled Status legal advice can be sort from Here for Good network of immigration lawyers

<https://www.hereforgoodlaw.org/advisory>

Are you interested in joining an old age liaison psychiatry network?

by

Josie Jenkinson, Vice Chair

Consultant Psychiatrist for Older People, Psychiatric Liaison Service
Ashford and St Peters.

Old age liaison psychiatry is a growing area of liaison practice. The Faculties of Old Age Psychiatry and Liaison Psychiatry are working together to develop a network of clinicians interested in/already practicing in this area. We plan to be as inclusive as possible so colleagues from all of our nations (and beyond!) are most welcome!

We hope to set up an initial meeting/event toward the end of 2021/beginning of 2022.

If you would like to be added to our contact list please contact Dr Annabel Price (Old Age Faculty vice chair) at josie.jenkinson@sabp.nhs.uk. Your contact details will be confidential and not shared elsewhere.

The Experience of Dementia

Jane Garner FRCPsych. Founder member and former secretary of the Older Adults Section of the Association for Psychoanalytic Psychotherapy in the NHS. janegarner5097@gmail.com

Sandra Evans FRCPsych. Former chair of the Older Adults Section of the Association for Psychoanalytic Psychotherapy in the NHS. sandra.evans8@nhs.net

Sigmund Freud's ideas are now widespread in societal notions and in common parlance yet a discussion of his contribution to psychological theory and health continues to arouse controversy. He was a neurologist who believed that over time, neurology and psychology would come together. Criticisms can certainly be made of his work, of note his neglect of old age. Paradoxically it is in later life, particularly in cases of dementia where the alliance between neurology and psychology, brain and mind - joined by a psychodynamic bridge is now being described. Psychoanalysis is a disciplined way of thinking about a problem which focuses on the internal world of the individual, in the context of both early and later psychosocial experiences. Psychodynamic work makes a number of assumptions: symptoms and personality difficulties have meaning, which is hidden or unconscious; a person has a complex inner world of which they may be unaware but which interacts powerfully with their conscious life. It also assumes a developmental process which can be in or out of step with a person's stage of life or particular needs as life's vicissitudes demands. The relationship with the therapist (the transference relationship) is considered as an example of how the person experiences the world and others and is both a diagnostic and therapeutic tool.

It is a privilege as a clinician to be allowed to witness and capture some of the patient's inner life and experience. We know the importance of the relational aspect of our work. Ultimately the aim of all interventions is to decrease emotional isolation. There is ample evidence of the efficacy of psychodynamic psychotherapy. The concepts, capacities and techniques used in psychotherapy can be transferred to enable further understanding in psychiatry. The RCPsych. has now put an increased emphasis on neuroscience with the award of a

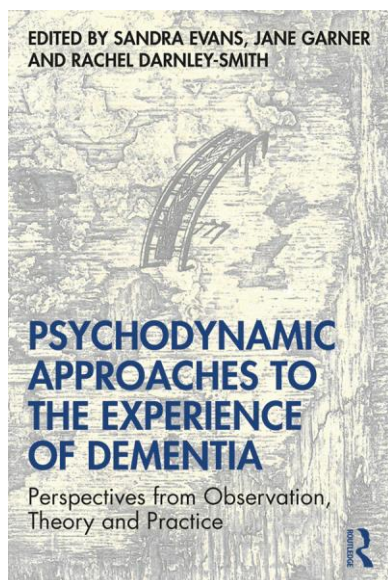
Wellcome and Gatsby Foundation grant. Neuroscience and psychoanalysis may be describing the same thing but with different language, different epistemology, both imperfect, both important for the psychiatrist. There are those, who while coming round to the idea that an emotional life does not end at 65 but continues until death, nevertheless divide people into those considered to have organically determined disease and those with psychogenic conditions and reserve therapeutic zeal for the latter. There is not a linear relationship between brain pathology (e.g. on scans) and levels of ability. We are all a mixture of biology and psychology, psychogenic factors undermining or enhancing our potential and ability. Using a bio-psycho-socio-cultural model is more inclusive in understanding problems as a combination of factors. There is welcome neurobiological and pharmacological research into dementia but the person in front of us with neuropathic changes is just that, a person; a person whose organic presentation is influenced by previous and current life experience, a history of social and intimate relationships and an unconscious.

Any member of staff or therapist in contact with the person with dementia may need to act as their auxiliary memory, repeating things and using the words they have previously heard from the patient, as the cognitive memory deteriorates. However, affective memory (a subcortical function) is retained for much longer. The more important task still is of empathic listening and returning an understanding to the patient. A psychodynamic perspective, involving the value of containment, is well suited to this patient group. With its emphasis on understanding verbal and also non-verbal communication, it is a theory and therapy which sees the individual as unique. Older people with dementia are so often stereotyped and as people with learning difficulties, are often put together into a grouping which inevitably loses out when resources are scarce or expediency deemed necessary.

We have seen examples of this most starkly since the Covid pandemic. Older people with dementia in hospitals and care homes, simply not considered, not held in mind by pandemic strategists and epidemiology modellers. The one size fits all scramble to "keep old people safe" also caused huge misery and irreversible deterioration for many. The howls of anguish from family members at the resulting painful separations and the responses from the media and care home staff was however a sign that the world has already moved on. *People*

recognise that the person with dementia has feelings and reactions to changes in their lives. The distress among care home staff was in direct response to their understanding of the pain being experienced by their frail charges. Caring for people with a dementing illness is not usually seen as skilled work, staff may attract the stigma directed to the patients. To do it well requires professional and personal skills, patience, imagination, understanding and ongoing support. Care staff collectively demonstrated their skill and experience in this instance.

A psychodynamic framework also has the capacity to deal with containing staff feelings and fears of working with this patient group. In normal times this would have been enough. In a global pandemic, the institutional response became pragmatic at best; reactionary at worst.



The authors of this piece, with professionals from different disciplines, recently contributed to and edited a book (immediately pre-pandemic) published by Routledge, 2020, with a foreword by Nori Graham - Psychodynamic Approaches to the Experience of Dementia: Eds. Sandra Evans, Jane Garner and Rachel Darnley-Smith. ISBN PB:978-0-415-78665-2

The book covers theory with stories and case vignettes of work with the individual, with couples, groups, the family, informal and professional carers and staff, touching also on the role of politicians. Encompassing a variety of settings, it describes work in NHS facilities including liaison in the general hospital, residential care, the patients own home, art and music therapy. Clinically it spans mild cognitive impairment, early dementia, planning for the future, to end of life care and experience. It wonders whether any reparative work may be done in a relationship where one has a dementing illness.

We hope you may recognise something of yourselves, your work and your patients on the pages.

A personal perspective

by

Dr Don Williams

Formerly Consultant in Old Age Psychiatry in Swansea

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Last year, 2020, the Covid-19 tsunami swamped everything. The whole world was turned upside-down. The media and the medical journals were so preoccupied with every aspect of the SARS-Cov-2 virus that other developments may have been ignored or overlooked. In Old Age Psychiatry two significant events occurred. In January a new book was launched: *Psychodynamic Approaches to the Experience of Dementia*. In May Professor Tom Arie died. Tom was an inspirational colleague who led the development of a new discipline, Old Age Psychiatry, although he preferred the term Psychogeriatrics.

For me both events are significant. Two years after qualifying I decided to train as a surgeon but failed at the first hurdle. After doing six months of casualty I was unable to find a post as an anatomy demonstrator. As a stop gap I worked in a traditional psychiatric hospital in Northampton. Soon, I enjoyed the work and its fringe benefits; a nine to five routine and superb married accommodation. I embraced the new discipline and after a year started formal training in Oxford with Dr Felix Letemendia, an erudite, cultured Basque who had abandoned Franco's Spain to train in psychiatry at the Maudsley Hospital in London. Unlike most of his British colleagues he was interested in psychotherapy and psychoanalysis, reflecting a European culture that was engaged with psycho-dynamic concepts. I found his approach fascinating and rewarding. Later as a senior registrar in general psychiatry I attended the Tavistock Clinic for psychotherapy training.

In 1974 I was appointed a consultant in general psychiatry, one of five at Cefn Coed Hospital, Swansea. Soon, we knew that our biggest challenge was to provide a better service for patients with dementia. By this time I had attended

the Maudsley Bequest lectures at the Royal Society of Medicine where Tom Arie had convinced me that working with the elderly, in a new way, could be rewarding. The hospital already had a psychogeriatric assessment unit, a day hospital and several long-stay wards. In 1976 I volunteered to start a dementia service which evolved into a comprehensive department of old age psychiatry. This was a decision I never regretted as it gave me a rewarding and fulfilling professional career in Swansea.

In the early years the divide between general psychiatry and old age psychiatry was fluid. Patient placement usually reflecting which service could best meet the needs of the individual. In this culture I was able to continue to treat and support a small number of younger patients. I was interested in conjoint therapy. Sometimes patients preferred to see a Welsh speaking psychiatrist and I was keen to respond positively to such requests. Over the years I tried to keep up with developments in general psychiatry but was disappointed that biological psychiatry remained firmly anchored to the medical model. I had hoped that acquiring basic psychotherapeutic skills would become part of every psychiatrist's training but I did not see this evolving.

The news about the new book, *Psychodynamic Approaches to the Experience of Dementia*, gave me great pleasure. The Freud museum in Hampstead was the ideal location for its launch on 24th January 2020. The book is edited by Sandra Evans, Jane Garner and Rachel Darnley Smith published by Routledge 2019 and available directly from the publisher www.routledge.com in paperback or e-book £21.59

The evening was a combination of a scholarly event and a party, polished presentations by the three joint editors and a celebration of a remarkable achievement. Tom Arie was not present but he would have applauded what was happening; a landmark for Old Age Psychiatry, the specialty he had pioneered, showing its maturity and growing sophistication. This augurs well for its future.

Cochrane Corner

by

Jenny McCleery

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I expect there will be many articles in this newsletter touching on the effects of the pandemic on services, so this month I offer our most pertinent review in this context. Life has been hard for many in the past year, but people caring at home for a family member with dementia must be among those who have had it toughest. Yet even in 'normal' times, carers of people with dementia can be isolated and can find it hard to access support services for all sorts of reasons, including geography and lack of suitable transport or substitute care. There is therefore quite a substantial literature on carer support services which are delivered remotely using written materials, telephones, computers and mobile technology. The efficacy of these interventions was assessed in our review on ***Remotely delivered information, training and support for informal caregivers of people with dementia***

(<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006440.pub3/full>) by Gonzalez-Fraile and colleagues, published in January 2021.

Most interventions for informal caregivers are complex, consisting of several different components. In this review, the components were categorised as information, training or support. Information interventions were defined by two key elements: (i) they provided standardised information, and (ii) the caregiver played a passive role. Support interventions promoted interaction with other people (professionals or peers). Training interventions trained caregivers in practical skills to manage care. Interventions that were primarily individual psychotherapy were not included.

The review included 26 studies with 2367 participants. Twelve studies (944 participants) compared interventions involving support or training or both (almost all also with an information component) to usual care, waiting list or an attention control. Fourteen studies (1423 participants) compared similar

experimental interventions with a control condition consisting of provision of information only. About half of the studies used the telephone and half the internet to deliver the interventions. Three studies were done in China and the other 23 in Europe or North America. The authors used a structured template to extract, collate and report information about the interventions. Most of the studies were well-conducted although randomisation methods were not always well-reported and there were obvious risks of bias related to self-rating of subjective outcomes when blinding was not possible. For some results, the authors also downgraded the certainty of the evidence due to inconsistency between studies.

The review found that, when compared with usual care or attention control, the experimental interventions probably have little or no effect on caregiver burden, depressive symptoms or health-related quality of life, or on the likelihood of caregivers dropping out of the studies. In the comparison with a control condition of information alone, the experimental interventions may result in a slight reduction in caregiver burden (nine studies, 650 participants; SMD -0.24, 95% CI -0.51 to 0.04, low certainty evidence) and probably also a slight improvement in depressive symptoms (11 studies, 1100 participants; SMD -0.25, 95% CI -0.43 to -0.06, moderate certainty evidence). They may result in little or no difference in caregiver health-related quality of life (two studies, 257 participants; SMD -0.03, 95% CI -0.28 to 0.21, low certainty evidence). They probably result in an increase in dropouts for any reason (12 studies, 1266 participants; RR 1.51, 95% CI 1.04 to 2.20, moderate certainty evidence).

The authors found no evidence of important differences in effect estimates between intervention types (e.g. predominantly training or predominantly support) although data for these or other subgroup analyses were limited.

Overall, then, mixed results for remotely-delivered interventions for caregivers, but some positive signals of efficacy. It is not immediately clear why results should differ between the two comparisons, although it is perhaps not surprising that the efficacy of this kind of intervention will vary depending on what information and services are available to and accessed by the control group. There was often little information in the papers about the nature of usual care in

the study contexts and it is possible that participation in a study may have affected the behaviour of control group participants.

It was not possible to determine why there was a higher rate of dropout from training and support interventions than from information-only interventions, but there is always a risk that complex interventions for caregivers may themselves be perceived as an added burden. Very few studies even considered harms as an outcome. Qualitative research on participant experience of these or similar interventions would clearly be useful but was not sought for this review.

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Research update

by

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Benzodiazepines and antidepressants: Effects on cognitive and functional decline in Alzheimer's and Lewy body dementia¹

This study aimed to look at the effects of prescribing benzodiazepines (BZD) and antidepressants (ADep) on cognitive and functional decline in adults with mild dementia. It used data from a pre-existing Norwegian cohort study of patients with mild dementia (determined by a MMSE of 20 or more or a Clinical Dementia Rating global score of 1). Within this sample were subgroups of Alzheimer's disease (AD) and Lewy body dementia (LBD).

Three groups of prescribing patterns were included; those prescribed BZD, those prescribed ADep, and those prescribed both, and comparing to those prescribed neither. Cognitive decline was measured using the MMSE and functional decline with the Rapid Disability Rating Scale.

The results showed that 45.4% of the overall sample of 196 participants were prescribed either a BZD, ADep or a combination of the two. The study claims to show that a combination BZD and ADep in individuals with AD and LBD is associated with a faster functional decline, and that this was a small but statistically significant difference. Looking at the group with Alzheimer's alone, there was an observed impact of BZDs (without ADep) on functional decline compared to the LBD group, suggesting perhaps a greater susceptibility to BZD in those with AD; however it is noted that the LBD group was smaller than the AD group (85 compared to 111).

Unfortunately, the study cannot conclude that the direction of potential causality is not in the opposite direction, and that individuals with faster functional decline are then prescribed BZDs and ADep. Importantly, the prescription of other drugs in combination with the BZDs and ADep was not included as a co-variable, and

depending on what might have been included in these drugs, it is potentially a significant limitation.

Recurrent delirium over 12 months predicts dementia: results of the Delirium and Cognitive Impact in Dementia (DECIDE) study²

The DECIDE study aimed to further investigate the association between recurrent delirium and the subsequent development of dementia. This population based cohort study of incident dementia was designed in order to ensure prior cognition was accurately assessed, and that the episodes of delirium are reliably measured; a combination which they argued has been lacking in most previous studies.

The sample of participants in the DECIDE study was taken from the larger Cognitive Function and Ageing Study II (CFAS-II), and surviving participants in the Newcastle-Upon-Tyne group were contacted regarding DECIDE. Agreeable individuals admitted to either the Royal Victoria Infirmary of the Freeman Hospital between January 2016 and January 2017 were included (provided they had capacity to consent at the time, or had a suitable consultee to consent on their behalf).

The study aimed to assess participants each day during admission in regards to whether or not they met DSM-V criteria for delirium using various scales or tests relating to the criteria. On some occasions daily reviews were not possible, so retrospective reviews of the medical notes were used to determine the presence of delirium (something they acknowledge as a potential limitation). They were then followed up at each subsequent hospital admission within the study period. At 12 months, the participants were reviewed at home where they completed a MMSE and the CFAS-II interview for dementia ascertainment.

The main conclusion that the study discusses is that it shows that delirium is associated with a new diagnosis of dementia and cognitive decline, independent of baseline cognition and illness severity (which, as mentioned before, has reportedly not been done). Unsurprisingly, the data also showed that repeated episodes of delirium, greater duration of delirium and greater severity of delirium were all associated with worse cognitive outcomes. It is highlighted that

there were varying periods of time between baseline and follow up assessments, wherein cognition could have declined further. I would also suggest that a larger sample size (perhaps with DECIDE being replicated throughout each of the three geographical areas used for CFAS-II) would have provided even greater weight to the findings.

Towards safer risperidone prescribing in Alzheimer's disease³

The authors of this study discuss the role of risperidone in the pharmacological treatment of psychotic symptoms in Alzheimer's disease, and the need for more personalised prescribing approaches to reduce the risk of EPS and other adverse effects.

The study used data from the pre-existing Clinical Antipsychotic Trials of Intervention Effectiveness in Alzheimer's Disease (CATIE-AD) study. Specifically, the data on plasma levels of risperidone and 9-OH-risperidone to determine an estimate of risperidone clearance in certain subpopulations, estimates of various different pharmacokinetics for risperidone and 9-OH-risperidone, and to investigate the relationship of these with Extra Pyramidal Side-Effects (EPS).

The CATIE-AD study was a double-blind randomised parallel group trial with three phases. The first phase compared risperidone, olanzapine, quetiapine and placebo, and there were further phases where an alternative antipsychotic could be used, or citalopram. The study involved measuring plasma drug concentrations at 2, 4 and 12 weeks. The study authors devised a statistical model to analyse this data.

The study included data from 108 of the 110 patients who had received risperidone in the CATIE-AD study. The patients were determined to be either functionally normal or functionally poor metabolisers. They found that independent of the metabolic function, where biomarkers that could predict the development of EPS, and lower MMSE scores could also predict this. Age was also independently associated with risperidone clearance. The study makes suggestions of dose reductions to 0.5mg (from the suggested 1mg/day to balance efficacy and side effects as per meta-analysis data) for individuals with a MMSE of 5 or less, those aged 85 and over, and alternate day dosing in those

considered functionally poor metabolisers. The determination of whether or not someone is a functionally poor metaboliser can be made by measuring the trough concentration-to-dose ratio

The limitations of the study include the small sample size, use of concomitant medications, and the use of data from a trial which was not originally designed with this study's aims in mind.

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Film Review

Rise of the Planet of the apes, 2011

by

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Director: Rupert Wyatt

Image from https://www.amazon.com/s?k=rise+of+planet+of+the+apes&ref=nb_sb_noss_1

This film was described as the prequel to the classic film Planet of the apes and seeks to explain how the apes came to be more intelligent than humans. The film Rise of the Planet of the Apes may be your standard blockbuster but in the midst of the all the action and drama is a compelling depiction of a person with dementia.

Will Rodman, a scientist, works for a drug company and is in the middle of a successful trial on a pregnant ape for new drug designed to help the brain repair itself and improve cognition. Will has a compelling personal reason for the drug to succeed- his father, Charles, has dementia. Unfortunately, the trial is stopped when the ape turns violent trying to protect her newborn, Caesar. Will takes Caesar home for a few days while a sanctuary can be found for Caesar but he soon realises the ape has inherited improved cognition from his mother and keeps him. He studies Caesar's rapidly progressing cognition as Charles's cognition continues to decline and after one difficult episode with his father decides to give him the experimental drug.



John Lithgow as Charles delivers a realistic performance as a person with dementia from the subtle changes in his appearance to his frustration in not being able to drive, but also his empathy when he comforts Caesar despite his

own confusion. The film portrays the slow, creeping grief of the family as they watch Charles lose his skills bit by bit. The slow, decline from forgetting notes while playing the piano to holding his fork the wrong way. The film also captures the ongoing battle when a person with dementia retains their desire to drive; the film dramatically changes direction when there are consequences to Charles attempting to drive his neighbour's car.

When his girlfriend challenges Will about his experiments with his father, his reply " My father was gone, the drug brought him back. You had no idea how bad it was" will no doubt resonate with family living through dementia.

The film also made me wonder about consent and capacity in dementia. Did Charles have capacity to give informed consent for an experimental drug? He is able to decline a further injection and soon dies from the illness. After his death, Will's girlfriend tries to comfort him with the words " Some things can't be changed, we have to accept that" but Will like all scientists won't accept that and will continue to try change things for the better.

While Rise of the Planet of the apes is pure science fiction and sets the origin for the eventual ape takeover seen in Planet of this Ape, the film has one of the most accurate and sensitive descriptions of dementia that I have seen.