RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

Issue 88

January 2024

HELLO

Welcome to Issue 88, January 2024, of the RCPsych Old Age Faculty Newsletter

Editorial Team

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Cover

Knitting is an accessible hobby across the lifespan, and continuing to knit into later life is associated with numerous benefits according to the, yes, knitting literature. Bailey and Sims (2014) suggest that continued knitting can be a predictor of preserved spatial ability, whilst Col et al. (2022) conclude that a 7-week knitting intervention can reduce stress and increase life satisfaction in later life. Léonard et al. (2021) have proposed knitting as a pain management strategy in the context of hand osteoarthritis.

This newsletter's cover depicts rhythmic knitting needles working as deftly as they had always done, despite the frailty otherwise suggested.

References available on request.

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UPDATE FROM THE EDITORIAL TEAM

Happy New Year from the Editorial Team. Hope you are all keeping safe and well and enjoyed a lovely Christmas.
We are sad to say that as an Editorial Team, this will be our last update.

We took over in September 2015 and with the help of some excellent trainee editors have thoroughly enjoyed reading, editing and producing the Faculty newsletter for the last 8 years. Its time now for new blood and hence we welcome Dr Shaheen Shora who will be leading on the Newsletter with our two fantastic Trainee Editors Jennie and Curtis from the May 2024 edition. We wish them all the best for the future.

It has been a great journey of learning, friendship and reflection for us and we hope the new team are able to enjoy editing this newsletter as much as we did.

This edition has all the usual updates from the Chair and Dr Amanda Thompsell, the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement.

This edition also has articles from international colleagues on how services work in countries India and Morocco- both these articles make interesting reads. Please also have a look at the advert for the Essay competition.

Our two new trainee Editors Dr Parker and Dr Osborne have joined us from September 2023 and as always been fantastic in developing the newsletter including the Trainee corner and the research update.

We wish you all good luck for the future and do please continue to submit articles as before. The next newsletter is May 2024 and the last date for submission is 30th March 2024.

Please submit articles or queries to Kitti.Kottasz@rcpsych.ac.uk.

Sharmi, Helen and Anitha

Dr Sharmi Bhattacharyya
Lead Editor

VIEW FROM THE CHAIR

Dr M S Krishnan (Krish)
Chair of the Faculty of Old Age Psychiatry

@deliriumkrish

Dear colleague

Hope you all had a restful time during festive period. Can I take this opportunity to wish you all a very happy New Year 2024.

Since I wrote in the newsletter last time, we have had some more developments in new treatments for Alzheimer's disease. We ran a series of webinars to go through the current evidence and how we can raise awareness, knowledge on this topic. The recorded sessions can be accessed here:
Are we ready to deliver disease modifying treatments? Royal College of Psychiatrists (rcpsych.ac.uk) - Available here

Our new treatment group from the faculty exec led by Bob Barber submitted a paper the IAGP which has been published in December - *http://dx.doi.org/10.1002/gps.6030*

I was interviewed by BBC morning live to talk about challenges for older adults with mental health problems to access talking therapies and other supports in the community I used the opportunity to raise awareness on depression in older adults and also quoted our CMOs annual report on health in ageing society.
I signposted the new resources that were developed by NHS England (Thanks to Amanda Thompsell and her team for commissioning this work). There is an eLearning module as well as YouTube videos and Spotify podcast for public.
Videos:
https://www.youtube.com/@MakeADifference-23
Podcasts:
https://open.spotify.com/show/3QcIUhUN3FpJ3bmJNNFoQs

I would like to congratulate our trainee reps Becky and Lizzie who organised an excellent trainee conference.

I am delighted to share the news that the college will be running an international Diploma in Older Adults' mental health and Dementia. Drs Kallur Suresh and Alex Bailey are the course leads. Watch the space.

I want to give special tribute to our Editorial Team who will be stepping down after 8 years of excellent work in producing excellent resources for our faculty members. Thank you, Sharmi, Anitha and Helen. Special thanks to Sharmi for leading the work and look forward to working with her as the Welsh chair. I welcome our New Editor Dr Shaheen Shora who will be supported by our trainee editors and faculty exec members.

Talking about change you may have seen the announcement of nominations for the faculty elections. The closing date is 26 January 2024. We have a dynamic executive team and look forward to your nominations to join the exec or take up one of the officer positions including the chair and vice chair.

By the time the next edition comes we would have the election results. I want the thank all our exec members and officers for supporting me in my role as chair and special thanks to our faculty manager Kitti.

We will be running another faculty strategy day in 2024 and look at our priorities. We also will have our next faculty annual conference on April 11 and 12 2024 in our college – This will be a Hybrid conference for delegates to attend F2F or online. Look forward to seeing you at the college.

I once again wish you all a very happy and prosperous New Year. Look forward to meeting in person or online at the faculty conference. Considering the work pressure, we are all under please be kind to yourself.

With warm wishes
Krish
Chair of the Faculty of Old Age Psychiatry
@deliriumkrish

THE TIMES THEY ARE A-CHANGING

Professor Alistair Burns - alistair.burns@manchester.ac.uk
Dr Amanda Thompsell - amanda.thompsell@nhs.net

Other than death and taxes, the only certainty in life is that things will change. Certainly we are seeing change in the team at NHSE, with major changes coming in the leadership team there. Most immediately we must wave goodbye to Professor Alistair Burns, who now has retired from his role as National Clinical Director for Dementia and Older People's Mental Health. I want to thank Alistair for the tremendous work he did and his inspiring leadership. He will be sorely missed.

As I write this I am currently waiting to learn who will be taking on Alistair's role and I look forward to supporting them, albeit probably for a short time only as my own contract with NHSE is due to end in March 2024 and currently I am not sure if this role will continue.
In the absence of a National Clinical Director I will try to cover all the latest news in dementia as well as my own area, older people's mental health (OPMH).

And what news there is. Never mind the shenanigans in the political world, the most important news this autumn has been Professor Chris Whitty's annual report which came out in November and which this year has focussed on Healthy Ageing and therefore places the searchlight on issues relating to both dementia and OPMH.

Follow this link for a PDF version of full report.
Professor Whitty recommends actions to improve quality of life for older adults.

The report states that "providing services and environments suitable for older adults in these areas (referring to rural and coastal areas) is an absolute priority if we wish to maximise the period all older citizens have in independence."

The report provides numerous useful graphs about our ageing population and the extent of comorbidities as one ages. There is a particular focus on promoting and improving health in later life by for example addressing risk factors for dementia and falls. It speaks out against the unfairness that research commonly excludes older people or those with common comorbidities and it recommends research into multimorbidity, frailty and mental health.

The most eye-catching recommendation for me was Recommendation 10 page 8 where it said that a "Renewed focus on mental health improvement interventions and services for older adults is key to improving overall quality of life in people's later years" .

To do this it recommends systematically collecting and sharing data on the health and care needs of older adults, including by ethnicity, sex and other protected characteristics.

This is a really useful document for dementia services and OPMH services. It is something you can use in your discussions with your local ICBs and service commissioners.

I will start now by briefly covering Dementia .
What's new in dementia?

I wrote last time about the imminent publication by the DoH of its Major Conditions Strategy.Whilst the strategy itself is still awaited, we now have a paper advocating the case for change and setting out a strategic framework. The DoH published this paper in August 2023- Major conditions strategy: case for change and our strategic framework - **GOV.UK (www.gov.uk).**

Major recommendations include :

- ·rebalancing the health and care system, over time, towards a personalised approach to prevention through the management of risk factors
- ·embedding early diagnosis and treatment delivery in the community
- ·managing multiple conditions effectively - including embedding generalist and specialist skills within teams, organisations and individual clinicians
- ·seeking much closer alignment and integration between physical and mental health services
- shaping services and support around the lives of people, giving them greater choice and control where they need and want it and real clarity about their choices and next steps in their care

The report includes a focus on dementia, summarising the actions that are being taken to improve dementia diagnosis and treatment. With winter coming and the inevitable focus on the need for timely discharges from acute hospitals it enhances the likelihood that more attention will be focused on dementia.

Moving on on to what the NHSE dementia team have been doing

After consultation with stakeholders, NHSE's Dementia Team hosted executive leaders from other parts of NHSE to encourage and consider the implementation of a strategic system-wide approach to supporting people with dementia and their carers. The aim of this process is to develop a strategic action plan and then review it at the next roundtable meetings in 6 months. This is work in progress but has helped highlight the need for a whole-system approach to meeting the needs of people with dementia.

Latest reports and seminars
Practitioners, particularly those responsible for dementia services, may find the following reports and webinars useful.

The National Audit for Dementia (focused on Acute Hospital care) was published in the summer and highlights issues around engaging with carers, knowing enough about the person with dementia and staff training Layout 1 (rcpsych.ac.uk)

The All Party Parliamentary Group on Dementia has published a report entitled **"Raising the Barriers: An Action Plan to Tackle Regional Variation in Dementia Diagnosis in England" Raising the Barriers" (alzheimers.org.uk).** After an extensive survey the group has identified various barriers to early dementia diagnosis and has suggested actions that include:

- requiring each Integrated care system to develop a comprehensive dementia strategy to enable and support the implementation of the Group's recommendations, driven by an overarching target set by the Government to return and go beyond the national 66.7% dementia diagnosis rate.

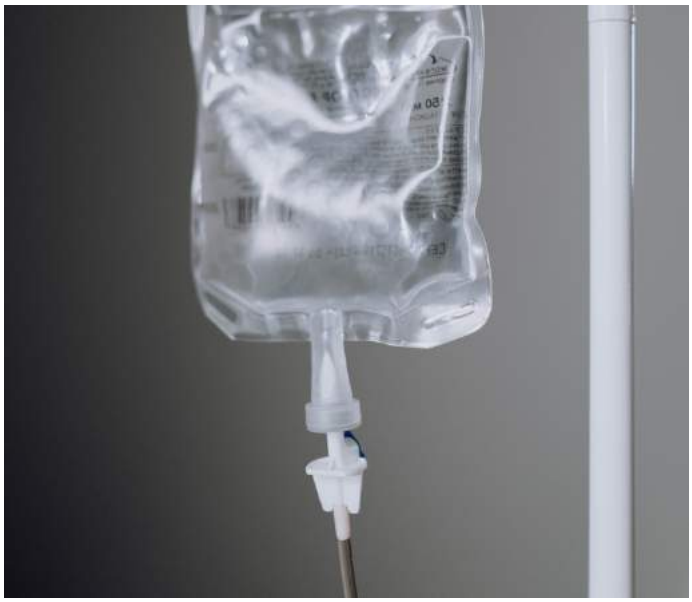
- requiring all dementia diagnoses to include an accurate subtype (thus requiring an end to regional inequity of access to advanced diagnostics

- NHS England must continue to review and develop its methods for calculating dementia prevalence and dementia diagnosis rates and develop more sophisticated calculations of dementia diagnosis rates.

- A national Dementia Observatory should be created to collate and publish existing data collected across system levels

NHS Right care is due to publish "The right care scenario for dementia" is in a final draft form whilst publication is agreed (**Dementia Scenario**). This is an updated version based on two case studies. In one case the person with dementia and their carer gets the care and support that meets their needs. In the other scenario this does not happen. The negative impact on quality of life and services of the second scenario are starkly highlighted as is a financial impact assessment comparing the optimal and suboptimal pathways .

There was a GIRFT webinar on 15th November 2023 which discussed how healthcare services can address the increasing need for dementia services. **This is available here.**



Finally, disease modifying treatments (DMTs) continue to be an area of focus for NHSE and there is a dynamic team working within NHSE to ensure the NHS is ready for these treatments. We can expect new care pathways involving new needs in relation to workforce and availability of investigation. This is likely to have a substantial impact on our wider dementia services. This interest in DMTs provides another opportunity to discuss with your ICB the needs of people with dementia and their carers.

Older Adult's Mental Health

Finally the penny seems to have dropped. Quite apart from the CMO Report mentioned above, I am now finding that I am in meetings and seeing slides presented by others that highlight the fact that our population is ageing and the need for services to reflect this.

This has been the backdrop to several new resources launched since the last newsletter. These include

- the Enhanced care in care homes framework has been published **here**. Whilst it might feel that it has been a long time coming I think this framework will be helpful in any service discussions you may have around supporting care homes The framework includes the contractual expectations and also provides practical guidance and actions for care home staff, managers, community services providers, commissioners, and PCNs to go further in enhancing the care for those in care homes. It clearly outlines what MDT support to care homes should look like and specifically mentions the importance of mental health.
- a resource for care homes on suicide **Promoting Emotional Health and Wellbeing and Preventing Suicide: A resource for Care Home Settings (yhphnetwork.co.uk);**
- the Medicines and Falls guidance document published by the RCPsych, available **here.** The guidance includes considerations for falls assessments and tests, medication reviews, falls risk increasing drugs FRIDs, medicines and fractures, treatment of osteoporosis and orthostatic hypotension.
- An e-learning package on depression in older adults which has been developed for staff and carers in any setting including care homes ,social care and the voluntary and charitable sectors as well as the NHS . This is available at this link **(Latest reports and seminars).** It is in the form of short podcast/animated videos /and case studies game to help support engagement with the training.
- The National Collaborating Centre for Mental Health (NCCMH) has developed and finally published an implementation guide for routine Patient Reported Outcome Measures (PROMs) in community mental health services for adults, including older adults, with severe mental illness. This is available at Patient Reported Outcome Measures (PROMs) for People with Severe Mental Illness in Community Mental Health Settings. Implementation guidance (rcpsych.ac.uk) .

I have been actively engaging with the National Autism team at NHSE and the plan is to have a national webinar on autism in older adults in February 2024 so please do look out for this

The Equality Agenda

A more general policy that every clinician needs to be aware of is NHS England's first ever anti-racism framework launched in November 2023.

The Patient and Carer Race Equality Framework (PCREF), (available **here**) which applies to all NHS mental health trusts and mental health service providers. This mandatory framework is to support trusts and providers on their journeys in becoming actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. Adherence to the PCREF will also become part of Care Quality Commission (CQC) inspections.

The PCREF aims to support improvement in three main areas (described as domains):

- Leadership and governance: trusts' boards will need to lead on establishing and monitoring concrete plans of action to reduce health inequalities
- Data: new data set on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets.
- Feedback mechanisms: visible and effective ways for patients and carers to feedback will be established, as well as clear processes to act and report on that feedback

Conclusion

The increased realisation that our population is ageing provides opportunities to come up with solutions that can benefit the older people we care for and dementia is steadily moving up the agenda in national planning.

The work at the centre however will come to nothing without local leadership and innovation both of which are in abundance in Faculty members.

As always, I would be happy to hear your views and thoughts on national developments so please do not hesitate to contact me.

Amanda Thompsell
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The Old Age Psychiatrist Annual Essay Competition 2024

The title for this year's competition is:
'Who needs an old age psychiatrist?'

The concept of 'old age' is undergoing a profound transformation; nearly 20% of the UK's population is now aged 65 or above and this diverse group defies stereotypes. We invite you to ponder where old age psychiatry fits in an evolving landscape, perhaps considering ideas such as longevity, vitality and frailty. Is age a disease state? Can we stop the relentless march of time?

Entries should be no more than 1000 words long. We welcome all forms of creative writing including essays, poetry, comic strips and short stories.
We invite submissions from everyone interested in Old Age Psychiatry, including consultants, SAS doctors, trainees and medical students.
There is a first place prize of £100, and £50 for the runner-up. Winners will also have their essays published in the May 2024 edition of the Newsletter and will receive a day's free registration at the RCPsych Old Age Faculty Conference in April 2024.

Please submit your entries marked as 'OAP Essay Competition' to Kitti.Kottasz@rcpsych.ac.uk by no later than 5pm on **Friday 1st February 2024.** Remember to include your name, job role and preferred email address.

REVIEWING CARDIO-PULMONARY RESUSCITATION STATUS FOR OLDER ADULT INPATIENTS WITH DEMENTIA

Dr Lydia Parker, Foundation Year 2 Doctor, and **Dr Tharun Zacharia,** Consultant Psychiatrist
Bethlem Royal Hospital, South London and Maudsley NHS Foundation Trust

Introduction

Proactive advance care planning is widely recognised as an important part of holistic care for patients with life-limiting conditions such as dementia. Moreover, transitions between different settings of care have been identified as appropriate timepoints to prompt engagement in advance care planning discussions [1].

We have undertaken a quality improvement project addressing an aspect of advance care planning, specifically reviewing cardio-pulmonary resuscitation (CPR) status, for newly admitted inpatients in our 18-bed dementia-specialist Older Adult psychiatric ward. Our primary aim was to increase the proportion of inpatients for whom CPR status was formally reviewed during their admission to >75%.

Methods

We made several interventions, the first of which was to design and implement a new standardised protocol for the routine review of CPR status for all newly admitted inpatients. We added this protocol to our pre-existing medical admission checklist, as well as updating our ward round template and discharge summary template to include prompts for checking whether CPR status had been reviewed. We also incorporated the new protocol into our ward induction booklet for new junior doctors, as well as delivering a formal 30-minute training session for the multi-disciplinary ward staff team on decision making and practical implications relating to CPR status.

We audited the proportion of inpatients for whom CPR status had been formally reviewed at set timepoints before and after the above interventions were implemented.

Results

Prior to these interventions, our baseline audit in January 2023 showed that 5 out of the total 17 inpatients (29%) at that time had had their CPR status reviewed so far during their admission.

We implemented the interventions described above in early March 2023.
Following this, our subsequent re-audit at the end of March 2023 showed that 13 out of the 15 current inpatients (87%) had had formal reviews of their CPR status (see Figure 1).

Discussion

The primary aim of this project was met, given that the proportion of inpatients for whom CPR status had been reviewed increased to >75% following the project interventions. In addition, feedback from the staff training session suggested that the ward multi-disciplinary team felt more knowledgeable and confident in contributing to reviews of CPR status where appropriate following the session.

The project had several limitations, one of which was its relatively short timeframe. Ideally, going forwards, we would like to continue to re-audit at several later timepoints and adapt the project interventions as needed to ensure that the improvement we have seen in routinely implementing reviews of CPR status for newly admitted patients is sustained over time.

The staff training session was well-received, although many participants felt that a longer session would have been helpful to allow further time for discussion and questions given the complexity of the topic. In light of this feedback, we hope to run further training sessions on this topic with more time allocated and also to incorporate these sessions as part of induction training for new staff.

It is well recognised that patients and carers as well as healthcare professionals can sometimes find conversations relating to CPR status challenging [2]. Going forwards, we also hope to gather feedback from our patients and carers regarding their experiences of having these conversations, in order to continue to work on ensuring that we communicate with sensitivity and clarity on this topic.

Furthermore, reviewing CPR status is of course only one aspect of wider advance care planning for patients with dementia. In the future, we would like to build on this project to routinely incorporate further discussions regarding broader priorities and wishes for future care with inpatients and their carers where appropriate, including for example utilising ReSPECT forms [3].

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IDENTIFYING DEMENTIA USING MEDICAL DATA LINKAGE IN A LONGITUDINAL COHORT STUDY: A HIGHER TRAINEE PERSPECTIVE OF INVOLVEMENT IN RESEARCH

Elizabeth Robertson(1,3), **Donncha Mullin** (1-3), **Tom Russ** (1-4)
1.Alzheimer Scotland Dementia Research Centre, University of Edinburgh, United Kingdom; 2. Division of Psychiatry, Centre for Clinical Brain Sciences, University of Edinburgh, United Kingdom; 3. NHS Lothian, Royal Edinburgh Hospital, Edinburgh, United Kingdom; 4. Lothian Birth Cohorts, University of Edinburgh, United Kingdom.

As a higher specialty trainee in Old Age Psychiatry we are privileged to be allocated a session a week to pursue research activities. This experience can be varied depending on the interests of the trainee and what opportunities are available locally. In Scotland we have added an annual research focused day to our national training schedule and just held the second of these in late June. It has become clear to us that developing a network between the trainees to share experience and opportunities is going to be a valuable addition to our training. We explored our research involvement so far and ascertained a number of trainees are involved in clinical trials and before this, completing a Good Clinical Practice course is an essential and useful experience. Other options include pursuing a systematic review which can include linking in with researchers in local academic institutions. In Edinburgh I was lucky to have the opportunity to become involved with the Lothian Birth Cohort 1936 (LBC1936).

LBC 1936 is a longitudinal cohort study that has followed a group of people born in 1936. This group all did an intelligence test aged 11 years old and have been followed up every 3 years or so since they were 70 years old. They are now roughly 86 years old. Working with this group I am mindful of their commitment over a long period of time to research, attending detailed assessments for over 16 years.

As well as the commitment of the participants there is the significant groundwork put in by researchers and coordinators who have obtained consent and ethical approval for the access to the participants' medical records, which has allowed us to undertake the dementia ascertainment work, the part of the study I have been directly involved with. The data collected over the LBC 1936 study provides a key tool for researchers to examine the ageing process and figure out why some people get illnesses like dementia and others do not. The work that I conducted along with fellow trainees used our medical expertise to examine the participants' notes and add dementia diagnosis information into that data. More on the process of this work below.

The process of dementia ascertainment started, before my involvement, with some of my fellow higher trainees devising a protocol to standardise our search of the electronic health records. During our allocated research time we were then able to independently search through the electronic health records for evidence of cognitive impairment and prepare case vignettes for each participant to inform discussion at the diagnostic team meeting. As Old Age Psychiatry Higher Trainees, we formed a core part of this consensus diagnostic team, alongside senior clinical colleagues from neurology and geriatrics.

A diagnosis of probable, possible or no dementia was confirmed, at these consensus meetings and a subtype identified where possible. In addition to this, some home visits were undertaken where concerns had been flagged by researchers. This gave variety to the work and presented a challenge as we were in a different role in the clinical encounter than usual – being research doctors rather than NHS clinicians, for a change.

It was helpful to work with other trainees as we could be available to answer each others' queries about the process. It has also been beneficial to work with the non-medical LBC1936 researchers to gain their experience and perspective.

It is exciting to look forward and think about what this new dementia measure, added to the LBC 1936 data, will allow future research to identify. For example investigating whether there were any clues or signals captured within this data which can differentiate participants living with or without dementia now. I would certainly recommend to higher trainees seeking out interesting research opportunities locally. This involvement also offers the possibility of publication in a peer reviewed journal, as this work has been by Mullin et al. (2023).

References:

Mullin et al. (2023). Identifying dementia using medical data linkage in a longitudinal cohort study: Lothian Birth Cohort 1936. BMC Psychiatry. 23. 10.1186/s12888-023-04797-7.

IMPLEMENTING GENETIC TESTING IN MEMORY SERVICES ACROSS NORTH LONDON

Dr Alex Ostenburg, ST4 in Old Age and General Adult Psychiatry at East London NHS Foundation Trust

The changing shape of genetics in medicine...

Twenty years ago in 2003 the Human Genome Project was completed. The project sequenced a single human genome and mapped all the genes therein. This took over 10 years to achieve at a cost of around $3 billion.Now, we can sequence an entire human genome, (that's 3 billion base pairs) in less than a day at a cost of under $1000. Thus it has now become possible for us to bring genetics into our daily practice and fulfil part of our role as doctors in bringing the scientific advancements of a population to the individual.

The Genomic Medicine Service (GMS)(1) was launched in 2018 with the intention of doing exactly that. The plan is to incorporate genetic testing into NHS services and to become the first healthcare system in the world to use a standardised system of testing to improve outcomes for its patients.

With the GMS, came the National Genomic Test Directory(2). This comprehensively itemises the possible diagnoses that qualify for genetic testing, as well as detailing which clinicians can make these requests. The test directory applies to specialities across medicine, from cardiology to psychiatry and provides a list of possible diagnostic uses. Furthermore all the tests on the directory are centrally funded meaning the lengthy and sometimes obstructive step of obtaining local funding has been removed.

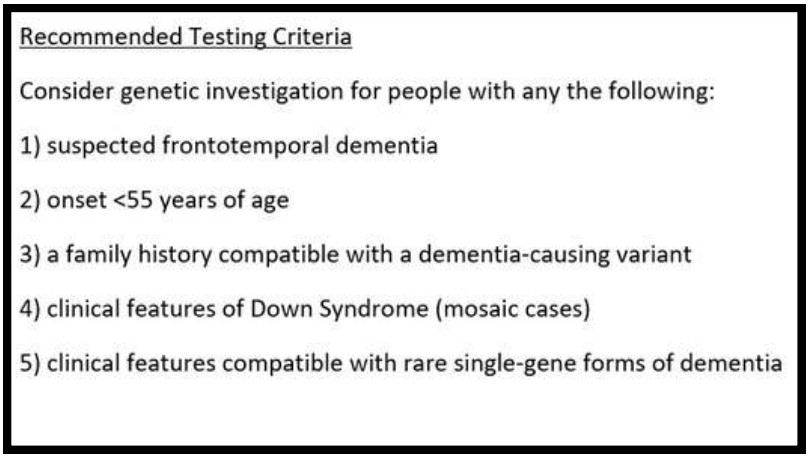
Enter the Psychiatrists...

'Adult onset neurodegenerative disorders' is listed in the directory as a set of conditions where offering genetic testing may be appropriate. Initially only neurologists (and clinical geneticists) were able to request these tests. However, psychiatry was added to the list of requesting specialties last year, in recognition of the fact that a large proportion of dementing illness in the UK is actually diagnosed in psychiatry led memory clinics.

While only a very small proportion of people presenting with dementia will have an identifiable genetic cause for their dementia, for the families that are affected, that genetic diagnosis can be profoundly important. Furthermore it has become clear that genetics are particularly relevant to Fronto-Temporal Dementia (FTD), which can account for 7% of our under 65 caseload. An autosomal pattern of inheritance can be observed in over a quarter of people presenting with FTD and comprehensive WGS based testing can identify the underlying genetic cause in a large proportion.

While the tests has been available to psychiatrists for about 18 months, data from the NT Genomic Laboratory Hub indicates that up-take has been very low so far. In fact, of the 660 tests ordered, it appeared that none were made by a psychiatrist. A survey of clinicians and feedback from presentations on genomic medicine suggest that there is a lack of awareness about the availability of testing and lack of clarity about the process.

Last month, the Royal College of Psychiatrists issued a report that offers guidelines(3) on the use of genetic testing in mental health services. It talks about how we should be engaging patients in discussions about testing and how it should be applied (or not) across different mental health services. [BN-DCTI] This includes how and when it should be offered in CAMHS and LD services and details its use (or not) in the conditions, schizophrenia, autism, ADHD and dementia. The message here for the older adult psychiatrist is, yes, genetic testing should be discussed for a small selected proportion of people being assessed within our memory services. The guidelines also emphasised the need for establishing clinical pathways in liaison with local genomic medicine services.


Recommended Testing Criteria

Consider genetic investigation for people with any the following:

1) suspected frontotemporal dementia

2) onset <55 years of age

3) a family history compatible with a dementia-causing variant

4) clinical features of Down Syndrome (mosaic cases)

5) clinical features compatible with rare single-gene forms of dementia

Why testing is important to our patients...

The purpose of all this is to provide better care; and better care, like genetic testing, means different things to different people.

We know that genetic testing can improve detection rates of rare and disabling disease. It can provide a faster and more accurate diagnosis which then grants people more time to make choices about their future care. In a proportion of cases, we may no longer have to wait for the slow emergence of symptoms to determine outcomes and prognosis.

Diagnostic testing in people with symptoms also allows for predictive testing for their family members.

Currently, asymptomatic individuals who are 'at risk' can be referred for potential predictive testing via their GP as long as there is a positive test in a family member. We can therefore play an important role in facilitating that choice for families affected by an inherited disease. It should be acknowledged however, that predictive testing comes with its own pitfalls and requires expert pre-test counselling within the genomic medicine service.

One patient explained to us in a recent clinic that if he had a positive genetic test, he could make decisions about planning his retirement, retiring early and refocussing his priorities on family. In a recent webinar about genetic testing, hosted by The Young Dementia Association, a young lady spoke about her experiences of testing and about the considerations she had for family planning and IVF.

Sometimes the benefits of genetic testing are less concrete, but nonetheless present. Patients may speak of a greater understanding of their illness, of peace of mind for their children and of taking away the fear from something previously unknown.

Ultimately, what we could be providing through our memory services, is greater choice to a small group within our population. Genetic testing can give those patients and their family's choices in planning for a future living with a disease that has inherently taken choices away.

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THE IMPLICATIONS OF SENSORY IMPAIRMENTS ON MENTAL HEALTH IN THE OLDER PERSON

Dr Deepash Hosadurg, and **Dr Vandana Menon.** Brookfield's Hospital

Sensory impairments include loss of sight, hearing, smell, touch, taste or spatial awareness. These impairment become more common in older age; it is estimated hearing loss is present in approximately one third of people aged 65-74 and half of those aged 75 and older. In high income countries around 10% of people over the age of 65 have a visual impairment, while in low income countries the prevalence can be much higher (World Health Organisation, 2023). Sensory impairments can often have widespread mental health implications in the elderly such as affecting conditions such as psychosis, depression and cognition.

Sensory impairments can be closely linked to depression in many ways. Firstly it can lead to decreased social interaction due to difficulties in participating in social activities and reduced ability to fully engage with and enjoy various activities and experiences (Petrovsky & Cacchione, 2020). In addition to this, sensory impairments can impact self-perception and self-esteem which may result in the individual developing negative beliefs about themselves such as being a burden to others or limitations due to their impairments. Furthermore, sensory impairments can affect an individual's ability to carry out daily activities independently. This loss of independence and increased reliance on others for assistance can lead to feelings of frustration, decreased self-worth, and a sense of being a burden, all of which can contribute to depression (Zhang & Zhou, 2022).

Hearing and visual impairments have been associated with psychosis however, the reasons for this are poorly understood. There are several possible hypotheses to explain this association such as sensory impairments could be a biomarker of psychotic illness. Additionally, physiological factors such as oxidative stress, NMDA receptor damage and deafferentation could underlie both sensory impairments and psychotic conditions such as schizophrenia. (Geiser, 2017) On the other hand, sensory impairments could be thought to cause psychosis in the same way that sensory deprivation in a normal individual can induce psychotic symptoms (Mason & Brady, 2009). Similarly, as with depression, sensory impairments can make it more difficult to be socially active which can lead to isolation, loneliness and chronic stress which can increase the risk of psychosis (Shoham, et al., 2020).

Sensory impairments can also affect cognition in many ways. As mentioned earlier, it can restrict meaningful social interaction, which is known to be crucial for cognitive simulation and maintaining cognitive function (Curhan, Willett, & Curhan, 2020). Sensory impairments also mean that there is reduced amount of sensory information reaching the brain.

This reduced simulation affects cognitive function, leading to difficulties in processing information, maintaining attention, and engaging in complex cognitive tasks (Rong, Lai, & Jing, 2020).

In the same light, having these untreated sensory impairments can lead to increased cognitive fatigue because the brain has to work harder to compensate for the lost sensory input. For example, individuals with vision loss may rely more heavily on their remaining senses, such as touch and hearing, to gather information about their environment. These compensatory efforts can place an additional cognitive load on the individual, as they need to allocate more cognitive resources to process sensory information and integrate it into their overall understanding of the world. This leads to quicker mental exhaustion, reduced attention span, and difficulties in sustaining cognitive effort over time. (Pichora-Fuller & Reed, 2015)

In view of the wide range of mental health implications that are associated with sensory impairments in the elderly it is imperative that these are identified early and managed appropriately. Given that the treatments of some of these sensory impairments are fairly straightforward, correction via glasses or hearing aids to manage vision and hearing impairments respectively, it is a cost-effective way to reduce the associated mental health complications outlined above. In a clinical setting this would involve identifying these impairments in the initial assessment and then signposting the patients to the appropriate services to receive the treatment. This can then be followed up on in the next consultation and if necessary, additional support can be provided to patients who are more vulnerable.

In conclusion, sensory impairments can be associated with significant mental health implications in terms of increased risk of depression, psychosis and cognitive impairment. As such, it is valuable to identify these impairments early on and manage it appropriately.

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EXPLORING THE LINK BETWEEN VISUOSPATIAL SCORES AND DRIVING WITH DEMENTIA: AN AUDIT STUDY

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Introduction

Safe driving incorporates certain cognitive skills such as memory, attention, visual processing, etc. These skills can be impaired with cognitive decline and patients with a dementia diagnosis are at risk of losing their driving license. Losing the driving license often adds on to the anxieties of patients with dementia diagnosis as it can limit independence and can add to social isolation. On the other hand, the potential risks associated with driving in patients with a dementia diagnosis cannot be ignored. Following the dementia diagnosis, DVLA is informed who then make further enquiries by writing to the patient and to the psychiatrist. There has not been a profound amount of evidence to ascertain driving capability about the Visuospatial Scores (VS Score) on the Addenbrooke's Cognitive Examination III (ACE III). An audit of VS scores and driving status was conducted to identify any potential patterns and trends which can help clinicians in their holistic assessment of patients' driving ability.

Method

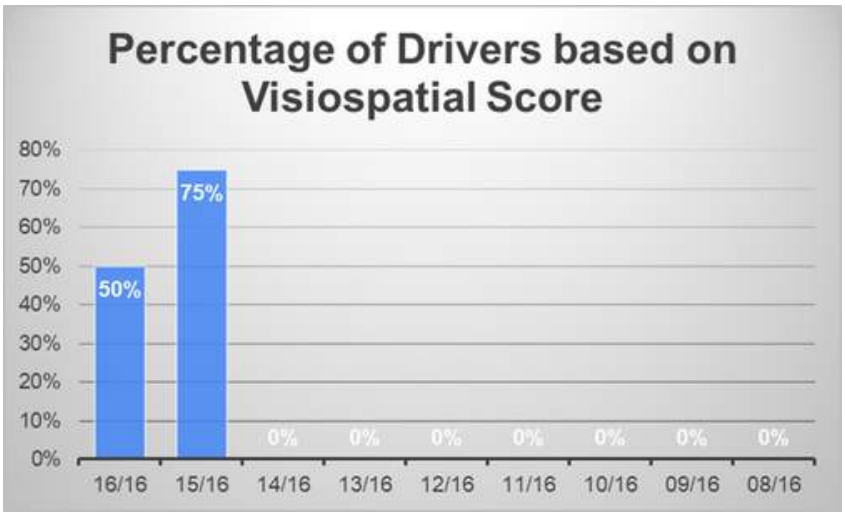
A retrospective study of 27 patients assessed in a memory clinic who were diagnosed with dementia was conducted. An attempt was made to find the relationship between low scores on visuospatial aspect of Addenbrookes Cognitive examination (ACE III) and driving ability. Additional variables pertaining to visuospatial decline and driving behaviours were examined to identify trends.
These included physical, sensory and mental health comorbidities. The standards used were from "Driving with Dementia or Mild Cognitive Impairment (consensus guidelines for Clinicians)" and "Assessing Fitness to Drive: a guide for medical professionals by DVLA."

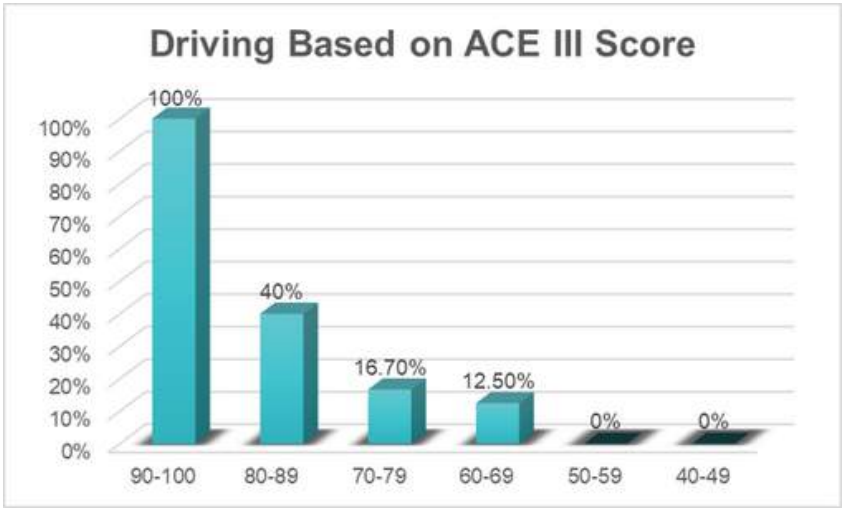
Characteristics of the Audit

Gender	Male Female	12 15
Age	Range Mean	73 – 91 years 79 years
Type of Dementia	Alzheimer's Disease with Late onset Alzheimer's Disease, atypical or mixed type Parkinson's	15 9 1
Driving Status	Yes No	5 22

Results

As the ACE III score decreased, generally, there were a higher proportion of people who did not drive. Those scoring lower on visuo-spatial part of ACE III had an overall low score on ACE III. The audit revealed that only participants with a VS score of 15 or above out of 16 were still driving. The criteria for visual deficits were inclusive of any condition that affects the eye apart from visual impairment from natural ageing. In those who were driving there was a 16.7% decrease in chance of having a visual deficit. There were no significant findings as to whether driving ability was affected due to a hearing deficit. The audit findings also showed that 11.1% more people were driving when no significant mental comorbidity were present. 96% of participants had physical comorbidities and 22.7% of those not driving listed frailty as one of the reasons for not driving. The majority of 54.5% recognised that their decline in cognitive function limited their ability to drive..





Discussion

The analysis of visuospatial scores and their relationship to overall ACE III scores indicated that as the visuospatial component score decreased, generally there was a corresponding decrease in the other domains of ACE III. The results indicate the importance of visuospatial functioning as every single person in the audit who had scored 14/16 or less in the ACE III for this component did not have the ability to drive. The results of the study revealed that driving status was influenced by numerous factors, including mental, physical, and sensory comorbidities. It was observed that participants with higher ACE III scores had a higher driving status percentage compared to those with lower scores. This finding suggests that driving abilities encompass more than just a good visuospatial score. Other cognitive components and overall cognitive function, play a significant role in determining driving capability.

In clinical practice a comprehensive evaluation made by a healthcare professional plays a crucial role in assessing the driving capabilities of individuals with dementia. Visuospatial skills which include tasks such as distance perception, object recognition and judging relative positions are essential for safe driving (Alberti et al., 2017).

Therefore, evaluating an individual's visual spatial abilities is crucial in determining an individual's driving potential and identify deficits that could compromise driving safety. Driving requires many parts of the brain to be working optimally, and so even though a visuospatial score may be high, it cannot alone determine driving capability. The overall cognitive picture of the patient plays a significant role in determining and individual's fitness to drive.

Conclusion and Recommendations

In conclusion, this audit helped to highlight the complex relationship between visuospatial abilities and driving status. The findings displayed that the ACE visuospatial aspect was a valuable metric when assessing the driving capabilities of an individual with dementia. However, the results also showed the presence of a variety of conditions which influenced driving capability. This makes it especially important to have a comprehensive evaluation of cognitive function, physical and mental comorbidities, to obtain a holistic understanding of an individual's driving potential. A limitation of this audit primarily focused on assessing whether a patient with dementia drives or not rather than determining their driving skill.

It would be beneficial to re-audit with a larger sample size that may find patterns between different types of dementia which can help provide objective values for assessments that may dictate safe driving. Further research is required to further understand the impact of VS scores on driving and would require a comprehensive driving ability test.

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IMPROVING THE ASSESSMENT AND MANAGEMENT OF ACUTE ALCOHOL WITHDRAWAL RISK ON PSYCHIATRIC WARDS

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Introduction

Individuals with significant psychiatric conditions have an increased risk of co-morbid harmful alcohol use or alcohol dependency compared to the general public[1]. This fact becomes important in the context of psychiatric hospital admission because it means that many of our patients are at risk of alcohol withdrawal syndrome (AWS). If this is inadequately treated it causes unnecessary suffering or can even be life-threatening.

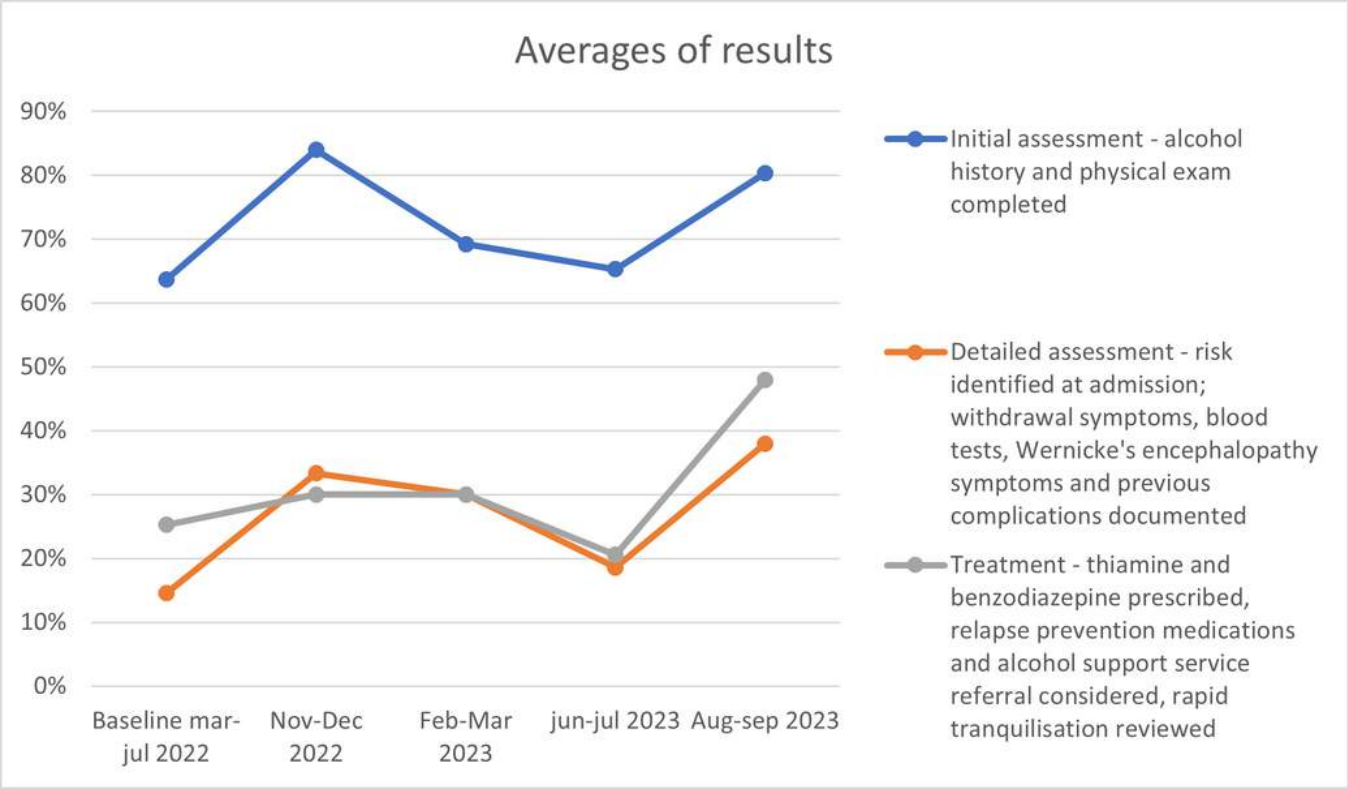
The management of co-morbid harmful alcohol use in psychiatric patients has been highlighted nationally as an area requiring improvement. In the past year, the RCPsych have run a Dean's grand round[2] on the topic, and have updated the core trainee curriculum to place greater emphasis on the need to develop these skills. In addition, a recent POMH audit[3] looked nationally to quantify how well these patients are managed. This highlighted areas where improvement is needed both in the initial assessment and management.

In this context, locally we ran a project to improve assessment and management of AWS, including developing a policy instead of relying upon one from the local physical health trust. Here we offer some reflections on this process in the hope this will aid other teams in their quality improvement efforts. In particular, we have separated out the consequences for older adults, a group where this is becoming an ever-increasing issue[4].

QI project local findings

The project used standard quality improvement techniques of plan-do-study-act cycle with each cycle using 2-4 months of admission data. This data was audited using the standards set out in the national POMH-UK audit and the summary run chart below produced. All patients admitted during the time periods were audited for the initial basic assessment but only those who were at risk of AWS (11%) were audited for a more detailed assessment and management.

In brief, we found that the trust was initially on a par with national data: documentation of alcohol use was inconsistent (63% documented in initial audit) and once identified as needing active management, assessment of high-risk features was poor (presence or absence of features of Wernicke's encephalopathy documented in 9%, previous withdrawal complications in 0% and blood tests for alcohol-related health problems in 0%). Only a third of patients at risk of AWS were prescribed a benzodiazepine and a third were prescribed thiamine with most given oral rather than the recommended parenteral doses. None were prescribed medications that aren't included in national guidance. Prescription of relapse prevention medication was poor (0%) with referral to specialist alcohol services on discharge also inconsistent (44%).
The audit was then repeated over the next 18 months as new cohorts of junior doctors joined, with some exposed to teaching at induction, later in their placement or not at all.



This run chart shows that although there was improvement in each of the three areas assessed, this varied through the year. The main intervention, teaching to doctors, was provided in November 2022 and August 2023. It was either not included in other induction dates (December 2022 and April 2023) or only delivered to a small handful of trainees (February 2023).

This run chart shows that although there was improvement in each of the three areas assessed, this varied through the year. The main intervention, teaching to doctors, was provided in November 2022 and August 2023. It was either not included in other induction dates (December 2022 and April 2023) or only delivered to a small handful of trainees (February 2023).

Looking at the subset of data for older adult patients, similar results were seen. 56 patients over 65 years old were admitted across the sample periods and of these only three (5%) were assessed as at risk of AWS.

The initial assessment results were on average better than for younger adults with 84% having their alcohol history recorded versus 69% for general adult patients.

This may simply reflect natural variation in a small data set or could suggest that the admitting doctor felt more able to ask about alcohol when talking to an older patient.

In the teaching sessions, some reflected that it can be easier asking some patients than others and that older adults can sometimes be less intimidating when discussing alcohol. Reviewing the detailed assessment and management data is not meaningful due to the very small number of patients at risk of AWS but they were broadly in line with the wider data set.

Patient involvement

Focus groups were held with community patients and this information was then fed into the project. These individuals provided insight into what was helpful or otherwise when their alcohol history was addressed and this then fed into the teaching. This included advice on how to communicate and most importantly to not be afraid to ask. Most people reported that they expected to be asked about their alcohol use and being asked in the right way made them feel listened to and cared for rather than judged.

Discussions and conclusion

There were limitations with this data, primarily that the datasets were small and staff changes may have led to inter-rater reliability issues. This second issue was minimised by providing explanatory notes with the data collection form and talking through potentially subjective issues as a group ahead of each audit cycle.

All patients admitted during the time periods were audited so the data is a true reflection of what happened across the patient group. However, as only 11% of patients admitted were judged to be at risk of AWS, the full audit was only completed on a total of 43 patients across all time points.

The data suggests that training improved performance, but the impact was temporary. In addition, new influxes of doctors who did not receive training led to worsening performance. This may also have been complicated by the fact that many of the trainees hadn't worked in psychiatry before and so at induction were assimilating a huge array of information, with alcohol assessment a small piece of the admission assessment.

Another point to note is that across the whole data set, 11% of patients admitted were at risk of AWS versus 5% of older adults. This appears to reflect data in the community suggesting that alcohol prevalence has historically reduced with age[1] and could suggest that this a less important issue in the care of older adults. However, given that older adults are more likely to have multiple co-morbidities, those who go through AWS are more likely to have other factors complicating their care and therefore have an increased risk of harm. It therefore remains important to assess patients of all ages for their alcohol risk.

As a result of feedback from staff, the trust has published a policy in this area and training for nursing staff will be provided to further improve patient safety. Of note, this policy is significantly different to those encountered in general health hospitals as it uses a fixed-dose regime rather than a symptom-based one.

This is because of the overlap in symptoms of AWS and various psychiatric presentations meaning that a symptom-triggered regime would be unreliable. This would increase the risk of over-treating leading to sedation that in older adults could then lead to falls and respiratory depression. This is especially the case in a setting with predominantly mental health nurses who have little experience of AWS. This difference in policy means that even doctors with prior experience will be using protocols unfamiliar to them. All of this complicates the process of improving treatment in this area, but highlights just how important attempts to do so are.

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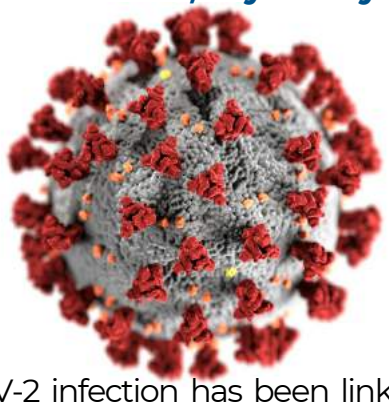
RESEARCH UPDATE

Dr Jennifer Parker, ST5 in Old Age and General Adult Psychiatry, Avon & Wiltshire Mental Health Partnership NHS Trust; **Dr Curtis Osborne**, ST4 in Old Age Psychiatry

Original Research: 'Development of criteria for cognitive dysfunction in post-COVID syndrome: the IC-CoDi-COVID approach' Matias-Guiu JA et al, Psychiatry Research



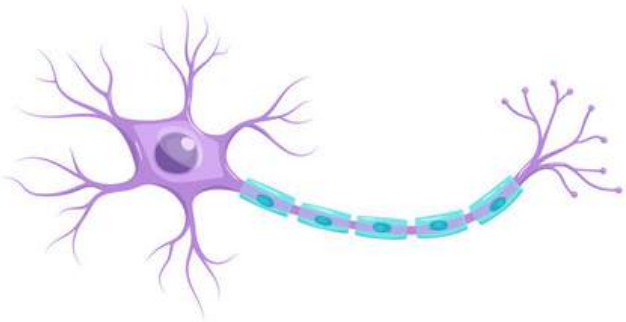
SARS-CoV-2 infection has been linked to brain damage and cognitive symptoms, with patients reporting issues even months after COVID-19 onset. Cognitive symptoms are common in post-COVID syndrome and have led to increased referrals to neurology and psychiatry clinics. However, diagnosing cognitive deficits accurately remains challenging due to varying assessment methods and cutoff criteria.

To address this, this study adapted a classification for cognitive disorders (IC-CoDE) from epilepsy and applied it to post-COVID syndrome. The study included 404 patients who met WHO criteria for post-COVID condition and experienced new cognitive complaints. The classification categorised patients as cognitively intact or impaired and identified specific cognitive profiles. The prevalence of cognitive deficits was consistent across two cohorts, mainly involving attention, executive function, and memory. Unsupervised clustering analysis supported the classification's reliability and consistency.

Younger age and lower education were associated with cognitive impairment, suggesting a potential vulnerability in younger populations. The study proposed specific cutoff criteria to define cognitive impairment in post-COVID syndrome.

Overall, this approach provides a standardized method for diagnosing cognitive impairment in post-COVID syndrome, enabling collaboration and research in this area.

Full article available: https://www.sciencedirect.com/science/article/abs/pii/S0165178122005972?via%3Dihub



Clinical Review: 'Management of psychiatric and cognitive complications in Parkinson's disease' Weintraub D et al, British Medical Journal

This study reviewed the current treatment options for neuropsychiatric symptoms (NPS) in Parkinson's disease (PD). NPS in PD are increasingly acknowledged as common and impactful, affecting long-term outcomes and caregiver burden. These symptoms encompass depression, anxiety, psychosis, impulse control disorders (ICDs), apathy, and cognitive impairment.

Management strategies involve psychopharmacology, psychotherapy, and non-pharmacological interventions, which they outlined as follows:

1. **Depression:** Antidepressants such as SSRIs and SNRIs are effective. Whilst cognitive behavioral therapy (CBT) is a recommended psychotherapeutic approach.
2. **Anxiety:** Limited data support buspirone and CBT for managing anxiety.
3. **Psychosis:** Can be addressed through PD medication adjustments and the use of medications like pimavanserin or clozapine.

ICDs and dopamine dysregulation syndrome can be managed by reducing dopaminergic medications. CBT has shown efficacy in treating ICDs alone. Non-pharmacological interventions include non-invasive neuromodulation (such as transcranial magnetic stimulation) and deep brain stimulation.

They concluded, however, that a comprehensive assessment and tailored treatment are essential for effectively managing NPS in PD. The prevalence of non-motor symptoms in PD is higher than previously estimated, and research is ongoing to develop more effective treatments and interventions to improve the lives of patients.

Full article available:
https://www.bmj.com/content/379/bmj-2021-068718.long

Practice Pointer:
'How to support the sexual wellbeing of older patients'
Hinchcliff S et al, British Medical Journal

This article supports clinicians to manage older adults' sexual wellbeing - highlighting that this is a quality of life issue. It speaks to the conflict between an increasing burden of sexual problems as one ages alongside increased barriers to seeking support, and highlights that this topic is increasingly relevant given that older adults are more likely to expect their doctor to

support their sexual wellbeing than previous generations.

In terms of the causes of sexual problems, it highlight physical factors, such as menopause and pain; mental health factors, such as depression and anxiety; medication side effects, including antidepressants, and social factors such as the loss of a partner.

Regarding barriers, it describes personal difficulties like taboo and stigma, and depicts a 'dance of shame' which can arise in the consultation room, when both patient and doctor want to raise the subject of sex but fear causing embarrassment to the other.

Finally, it offers pointers on supporting sexual wellbeing, including using the 'Three Ps': Privacy, Permission (allowing the patient to speak about sex) and Practice (using open and inclusive language). It offers the approach of topic card and waiting-room checklists as other potential avenues to opening up the conversation.

Full article available:
https://www.bmj.com/content/380/bmj-2022-072388

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AN INNOVATIVE GERIATRIC PSYCHIATRY SERVICE DEVELOPMENT IN INDIA

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INTRODUCTION

India is the country with the largest population in the world. The population above 65 has tripled in India over the past 50 years. Many live longer but carry a risk of living with multiple disabilities, including mental illness and dementia. This may place an additional burden on the services. The services should evolve using innovative, interdisciplinary, evidence-based strategies

OVERVIEW OF THE CURRENT SERVICE DELIVERY MODELS IN INDIA

- **Public services**

The state-run psychiatric facilities cater to many persons with mental illness in India.

- **The District Mental Health Programmes (DMHP)**

make the services accessible to those in semi-urban and rural regions. However, the main drawbacks of public psychiatric services even though they make services accessible, are the inadequate infrastructure, limited human resources, restricted availability of special interventions for the elderly people, and a lack of specialist elderly mental health services.

- **Private service**

While private healthcare providers play a significant role in providing services in India, not many cover comprehensive elderly mental health. They are available in urban centers and are expensive. Many private mental health services are delivered by single medical practitioners without the support of a trained multi-disciplinary team

- **Non-Governmental Organizations (NGOs)**

NGOs aid in healthcare service delivery in India. Again, there are not many that focus on elderly mental health. In addition, they are dependent on donors and inconsistent funding for their work. Nonetheless, working closely with the various stakeholders, they test models, make recommendations for policymakers, and provide services at a low cost, though to a limited extent.

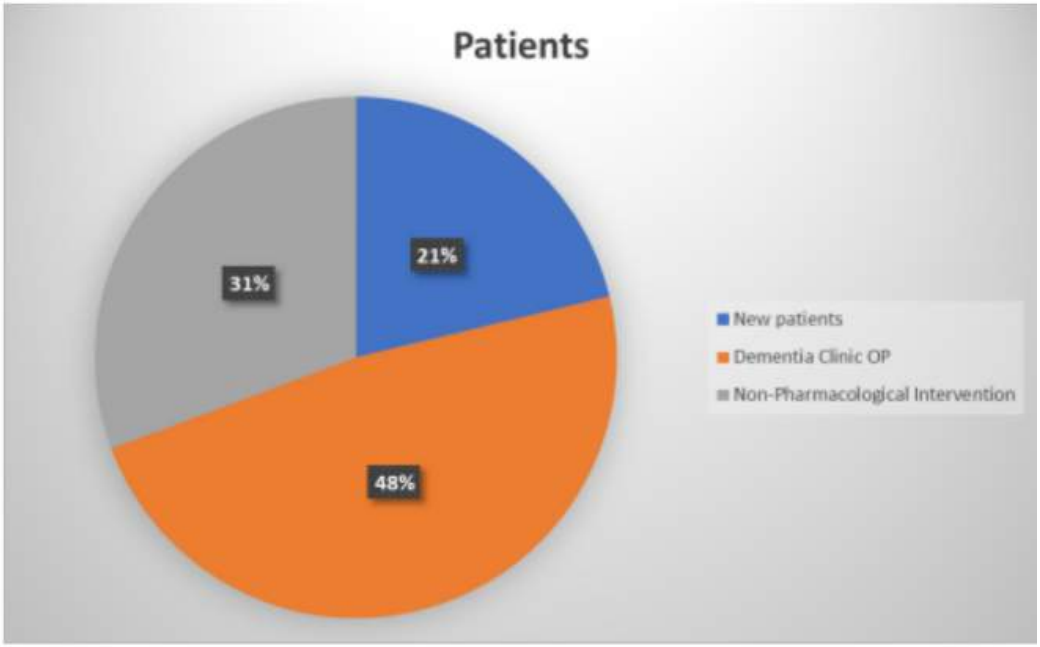
BRIDGING THE GAPS - "THE DEMCARES MODEL"

The Urban Model

SCARF -Schizophrenia Research Foundation (Chennai) is an NGO established in the year 1984, collaborating with the World Health Organisation since 1996, offers multidisciplinary and comprehensive psychiatric care. Dementia Care in SCARF (DEMCARES), a specialist elderly mental health service with multi-disciplinary staff was started in 2014. The services provided by DEMCARES for the urban population include the following.

Outpatient Clinic

The clinic offers an initial assessment, diagnosis, developing a person-centered care plan, reviews and teleconsultations. There is access to a dementia-friendly inpatient facility with 20 beds.



(Fig.1.1 shows the graphical representation of patients in the past 10 months on the basis of services provided by DEMCARES)

Center for Active Aging

It is primarily designed to provide non-pharmacological interventions to delay cognitive impairment and to improve the quality of life. Interventions include CST (cognitive stimulation therapy) management of behavioral and psychological symptoms in dementia (BPSD), and cognitive behavioral therapy for depression are delivered by trained professionals.

Caregiver support

The sessions are designed to improve the caregiver's understanding of illness and to make informed decisions. START (Strategies for relatives) is an intervention that is predominantly used for helping caregivers manage distress and improve their quality of life.

Dementia Friends

The main aim of this program is to build a friendly community for the people with dementia, a volunteer is assigned to the family who has a person affected with dementia, and the volunteer makes weekly visits to have a friendly interaction and build structured activities for clients with dementia.

THE RURAL MODEL: "ADDRESSING THE TRIPLE JEOPARDY HYPOTHESES"

It is very evident from the literature that the majority of the services are limited to urban areas. In order to address the gap DEMCARES recently launched a rural community mental health program funded by the Azim Premji Foundation. The main focus of the program is to make mental health services accessible to the elderly population with an interdisciplinary team.

Training the community workers and volunteers

Community workers and volunteers are recruited from the same rural community as the older adults. They help the participants overcome a feeling of alienation and promote better rapport building.

In the first phase of the project, the community mental health workers are trained by the psychiatrists and clinical psychologists on various mental health disorders and their screening process. Training modules are provided to them and they are trained to use basic screening tools.

(Fig. 1.2 shows the training program conducted for rural community mental health workers for the community service project)

Culturally relevant awareness campaigns and screening

In India, it is frequently observed that the mental health camps are stigmatized, hence encounter opposition and minimal participation. The staff will present awareness campaigns in the form of street plays and theaters as it will reach a much wider audience than conventional campaigns. The participants who are screened positive in any of the screening tools will then receive an in-depth clinical and cognitive assessment. Based on the diagnosis they will be referred to the local services for further intervention. The programme aims to network with all the relevant stakeholders, including local service providers, to build their capacity to manage common mental illnesses in the elderly people. When a client is diagnosed with a mental health disorder they will be given a disability score or percentage, and those who have 40% or more impairment are considered to have a severe disability. They can obtain a disability card through the IGNDPS (Indira Gandhi National Disability Pension Scheme), The clients are qualified for a monthly disability benefit. They can utilize the card to get physical assistive devices too.

Evidence based culturally adapted non-pharmacological interventions.

The Non-pharmacological interventions are implemented through trained psychologists and the community workers. Indian adaptations of interventions such as CST (Cognitive stimulation training), START (Strategies for relatives), PDIL (Prevention of depression in later life) will be used.

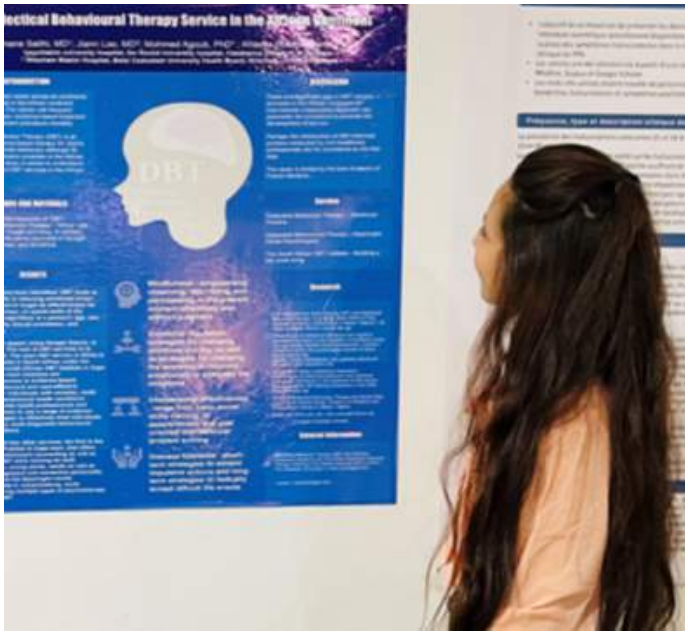
Conclusive remarks

Older persons with mental illness in India, as in many other regions of the developing world, are often neglected and do not receive specialist services they need. We have incorporated innovative means by task-shifting, capacity building, networking, and using culture-sensitive means to deliver evidence-based interventions using multi-disciplinary teams to implement a elderly psychiatry programme in India. We hope this model could be sustained locally, and used in other regions of the world.

References available upon request

PSYCHIATRY TRAINING PROGRAM IN MOROCCO

Salihi Imane - Drsalihi.imane@gmail.com.



MEETING THE INCREASING DEMAND

With heightened awareness and reduced stigma surrounding mental health, more individuals are seeking help and support. However, the shortage of well-trained therapists poses a significant obstacle. Psychotherapy training plays a pivotal role in bridging this gap, ensuring that there are enough qualified professionals to cater to the growing demand for mental health services.

ADDRESSING THE MENTAL HEALTH CRISIS

The mental health landscape in Morocco is undergoing significant changes, with a growing recognition of the importance of addressing mental health challenges. As the demand for mental health services increases, it becomes crucial to emphasize the significance of psychotherapy training in meeting these challenges effectively. Morocco, like many countries, faces a pressing mental health crisis. The prevalence of mental health disorders, such as anxiety, depression, and post-traumatic stress disorder (PTSD), is rising. By offering comprehensive psychiatry training, we can equip professionals with the necessary skills to address these challenges head-on.

CULTURAL SENSITIVITY AND CONTEXTUAL UNDERSTANDING

Morocco's rich cultural diversity and unique societal context necessitate therapists who are culturally sensitive and knowledgeable about local customs and beliefs. Psychiatry training programs can incorporate cultural competence components, helping therapists understand and respect the cultural nuances and values of the Moroccan population.

PSYCHIATRY TRAINING PROGRAMS IN MOROCCO

Moroccan Postgraduate Psychiatry Residency Program: Concours de Résidanat en Psychiatrie au Maroc

- Duration: Four years
- Entry Requirements: Completion of one year of foundation training and passing the entrance examination consisting of psychiatric semiology and pharmacology.
- Training Centers: The postgraduate psychiatry residency program is offered in collaboration with local universities and the Ministry of Health in Morocco.
- Accreditation: The program is accredited by the Moroccan government, ensuring that it meets the established standards for psychiatric residency training.
- Training Posts: Upon acceptance into the program, residents are assigned voluntary or contractual positions with the government or University Hospitals. These training posts provide hands-on clinical experience under the supervision of experienced psychiatrists. Residents have the opportunity to work in diverse clinical settings, including psychiatric hospitals, outpatient clinics, and community mental health centres.
- Curriculum Overview: The postgraduate psychiatry residency program in Morocco is designed to provide a comprehensive and in-depth education in psychiatry. The curriculum covers various areas, including psychiatric assessment, diagnosis, treatment planning, and therapeutic interventions. It emphasizes the integration of biological, psychological, and social aspects of mental health. During the four-year program, residents rotate through different subspecialties within psychiatry, such as child and adolescent psychiatry, adult psychiatry, geriatric psychiatry, addiction psychiatry, and forensic psychiatry. These rotations allow residents to gain expertise in specialized areas and develop a well-rounded understanding of the field.
- Research: Residents also receive training in research methodology, ethics, and evidence-based practice to foster critical thinking and scholarly activities. They have the opportunity to engage in research projects, case presentations, and academic discussions.
- Evaluation and Certification: Residents undergo regular assessments throughout the program to monitor their progress and competency development. These assessments may include written exams, oral presentations, clinical evaluations, and research evaluations. Successful completion of the four-year program leads to certification as a psychiatrist in Morocco.

CHALLENGES AND OPPORTUNITIES IN PSYCHIATRY TRAINING PROGRAMME

Psychiatry training encounters various challenges, including combating stigma and misconceptions surrounding mental health, limited resources in low-income regions, diverse patient needs, the need to stay updated with evolving research and treatments, and maintaining work-life balance and self-care. However, amidst these challenges lie opportunities for growth.

Duration	12 months	12 months	10 months	2 months	12 months
Postings		General Adult (inpatient and outpatient)		Old age and Neuropsychiatry	Any elective in areas relevant to psychiatry (local or abroad)
	-		Liaison psychiatry		
Methodology			Lectures, Seminars, ward rounds, case conferences, journal clubs, Skills training workshops.		
Other mandatory competencies (to be learned throughout the posting	Electroconvulsive therapy Psychotherapy (Interpersonal therapy, behvioural therapy...) Research. *Addiction psychiatry/ sexology/ psychoanalytic therapy are optional (university diploma). **There is no child and adolescent psychiatry posting availability yet.				
Formative Assessment			Case-based discussions, Mini-CEX.		
End of Year Summative Assessment	Modified essay question, clinical short case and long case.	Modified essay question, clinical short case and long case.	Modified essay question, clinical short case and long case.		Modified essay question, clinical short case and long case. Viva voce for research

These opportunities include fostering awareness and understanding to overcome stigma, advocating for increased resources and support, preparing psychiatrists to work with diverse populations, embracing advancements in research and treatment, and promoting a healthy work-life balance to prevent burnout and ensure sustainable careers in psychiatry.

Government support provides a chance for increased backing and investment in psychiatry training programs, as the Moroccan government recognizes the importance of mental health services. Collaborations between the government and educational institutions can expand resources and enhance the quality of training.

The integration of community-based care offers opportunities to emphasize early intervention and prevention through the development of mental health services in local communities. Psychiatry training programs can equip trainees with the necessary skills to work effectively in community settings and foster collaboration with primary care providers. Multidisciplinary collaboration, involving professionals from various healthcare fields such as psychology, social work, and nursing, can enhance the efficacy of psychiatric care. Psychiatry training programs can actively promote interprofessional education and create an environment that fosters collaboration across disciplines. The diverse cultural landscape of Morocco presents an opportunity for psychiatry training programs to prioritize cultural competence. By addressing cultural beliefs, practices, and values, these programs can equip psychiatrists to deliver care that is sensitive to diverse cultural backgrounds.

Leveraging telepsychiatry and technology can significantly improve access to mental health services, particularly in remote areas. Incorporating training on virtual care and digital tools prepares psychiatrists to adapt to the evolving landscape of healthcare practices. By capitalizing on these opportunities, psychiatry training in Morocco can advance, with increased support, community-based care, multidisciplinary collaboration, cultural competence, and the integration of technology to enhance accessibility and quality of mental health services.

OLD AGE PSYCHIATRY TRAINING

In Morocco, there is an increasing focus on education and training in the field of old age psychiatry. Efforts are being made to enhance the knowledge and skills of mental health professionals who work with older adults, as well as to raise awareness among the general public about mental health issues in the elderly population. This emphasis on education and training is crucial for several reasons, as Old age psychiatry requires specialized knowledge and expertise to address the unique mental health challenges faced by older adults. Through education and training, mental health professionals gain an understanding of common disorders like depression, anxiety, dementia, and latelife psychosis, as well as
age-related cognitive changes and effective interventions. Emphasizing person centered care, professionals consider individual needs, preferences, and circumstances, respecting autonomy and dignity. Interdisciplinary collaboration promotes a holistic approach, recognizing the impact of physical health, social factors, and the environment on well-being. Research and evidence-based practices are integrated into clinical care, ensuring up-to-date and effective treatments. Education initiatives also target public awareness, reducing stigma, and improving acceptance and access to mental health services for older adults. In addition to the aforementioned points, it is worth noting that there are further developments in old age psychiatry in Morocco.

Currently, a dedicated department specifically focused on old age psychiatry is under construction. This dedicated department will provide specialized care and services tailored to the mental health needs of elderly individuals.
While awaiting the completion of the dedicated department, consultations for older patients are conducted within the existing general psychiatry department. Mental health professionals in this department are trained to address the specific concerns and challenges faced by older adults, including those related to cognitive decline, neurodegenerative disorders, and late-life psychiatric conditions.
Education and training in old age psychiatry in Morocco involve various avenues. Mental health professionals acquire skills and knowledge through university diploma programs that specifically focus on geriatric psychiatry.

These programs provide theoretical foundations and practical training related to the assessment, diagnosis, and treatment of mental health disorders in older adults. Furthermore, internships and training opportunities are available for mental health professionals in France and other European countries. These internships provide valuable hands-on experience in specialized settings dedicated to old age psychiatry. By learning from experienced professionals and exposure to different approaches and practices, mental health professionals in Morocco can expand their expertise and apply it in their local context.
Studies conducted within the department of old age psychiatry contribute to the growing body of research in this field. These studies aim to improve understanding of mental health issues in the elderly population, evaluate the effectiveness of interventions and treatments, and address specific challenges faced by older adults in Morocco.

The findings from these studies can inform evidence-based practices and contribute to the development of better care strategies for elderly individuals with mental health concerns. By establishing a dedicated department, providing consultations within the existing psychiatry department, and offering educational opportunities, Morocco is taking significant steps to strengthen its old age psychiatry services and ensure that mental health professionals are equipped with the necessary skills and knowledge to address the unique needs of older adults. These efforts contribute to the overall improvement of mental healthcare for the elderly population in Morocco.

SUCCESS STORIES

The success stories of residents who have benefited from psychiatry training programs in Morocco are testament to the transformative impact of accessible and high-quality mental health care. These stories showcase the profound changes experienced by individuals who have received support from well-trained psychiatrists. By highlighting these success stories, we can shed light on the positive outcomes that can be achieved through psychiatry training programs.

Residents who have received proper training and guidance are equipped with the skills and knowledge to provide comprehensive mental health care to those in need. As a result, patients have experienced significant improvements in their mental well-being, leading to enhanced quality of life and overall personal growth. These success stories also underscore the importance of accessible mental health care services. Through psychiatry training programs, professionals are being trained and placed in various regions, including underserved areas and rural communities.

This ensures that individuals who previously had limited access to mental health care now have the opportunity to receive the support they require.
The impact of this accessibility cannot be understated, as it breaks down barriers and promotes inclusivity in the delivery of mental health services. Moreover, these success stories highlight the significance of high-quality mental health care. Residents who have undergone comprehensive training are wellprepared to provide evidence-based and culturally sensitive care. Their expertise and competence enable them to address the diverse needs of their patients, taking into account cultural,social, and individual factors.

The impact of receiving high-quality care extends beyond symptom management, positively influencing the overall well-being and functioning of individuals. In conclusion, the success stories of residents who have benefited from psychiatry training programs in Morocco demonstrate the transformative impact of accessible and high-quality mental healthcare. These stories serve as a powerful reminder of the positive changes that can occur when individuals have access to well-trained psychiatrists and comprehensive treatment. It reinforces the importance of continuing to invest in psychiatry training programs and striving for accessible mental health care for all individuals in Morocco.

Acknowledgements
The professors who have guided my academic journey possess remarkable expertise and qualifications in their respective fields. Their academic achievements, research publications, and specialized areas of expertise exemplify their credibility and ensure the provision of valuable insights and guidance. Their exceptional teaching skills effectively convey complex concepts through engaging methods such as interactive lectures, case studies, and practical demonstrations.
Their commitment extends beyond the classroom as they embrace the role of mentors, offering unwavering support and guidance for my personal and professional development. Their availability and willingness to assist outside of regular class hours create an environment conducive to dialogue and critical thinking. Their contributions to research, publications, and active participation in conferences demonstrate a commitment to advancing knowledge in their fields, affording me the privilege of learning from experts at the forefront of their disciplines. Their approachability and openness foster a supportive learning environment, encouraging meaningful discussions and enhancing the educational experience. The profound impact of these professors on my academic journey is evident in the shaping of my knowledge, skills, and career aspirations. Through their teachings and mentorship, I have experienced personal and intellectual growth, with specific examples and anecdotes attesting to their influential role in my educational path.

TRAINEE FOCUS: INTRODUCING 'CPD CORNER'

Lizzie Robertson and **Rebecca Fitton,** Higher Trainee Representatives of the RCPsych Old Age Faculty

One of the frequent dilemmas as a higher trainee is how best to use your study leave. Now that we are out of core training and membership exams are done, we have more freedom and flexibility to use our study budget to shape our training in a particular way. However it can be difficult to know what opportunities are out there and whether they are worth the money.

To help inspire you, we are introducing "CPD corner" to the trainee section of the newsletter. Each edition we will invite short reviews of any courses or conferences you have attended. We will also have a round up of any upcoming courses or conferences that might be useful.

Old Age Faculty Trainees' Conference on 6th November 2023

To kick this off, we are reporting on the recent old age faculty trainees' conference on 6th November. Admittedly we are not the most unbiased reviewers as we organised it! However, as it was the first time we ran this event face to face it is worth reflecting on how it went. We had been determined from the outset that it would be in person rather than online to allow trainees to network and share training experiences from around the country. We felt that you have all had enough of full days sat in front of Microsoft teams! However, we all know that travelling long distances is a hassle and eats further into your study budget, so we weren't sure how many people would feel it was worth the extra effort.

We were grateful from support from the NIHR who subsidised the registration fee and were relieved that in the end nearly 120 delegates registered from across the country.

The programme reflected the diversity of our specialty, including sessions on Neuroimaging updates, Alcohol use disorders and Prevention of dementia as well as topics less familiar to old age psychiatrists such as Autism in older people, personality disorders and forensic services for older people.

A particular highlight was the panel debate around the use of disease modifying drugs in dementia. This featured Dr Bob Barber painting an optimistic picture of potential transformation in our services and Dr Robert Howard's more cautious approach given the limited clinically meaningful difference in primary outcomes, advising us to focus our efforts on better delivering established treatments and support.

Dr James Hotham gave his reflections as a trainee on the need for old age psychiatrists to be leading the discussion and future decisions on treatment, as well as how training may need to adapt if these drugs are approved. We also had rapid fire presentations from trainees as well as a poster display. It was great to see trainees talking to each other and sharing experiences in the breaks as well as chatting to the speakers, which for some people led to opportunities to arrange special interest or research opportunities.

If you attended the conference please let us know your feedback, in particular we are interested on your views about in-person events. Your feedback will help us plan next year's conference!

Upcoming Conferences/ Events

1. Masterclass: Parkinson's Disease: The Spectrum of Physical and Psychiatric Health Issues, 8th February.

This one day course aims to cover the identification and differential diagnoses of Parkinsonian syndrome, the motor, non-motor and psychiatric aspects of Parkinson's and the risks and benefits of Parkinson's medications.

Run by the Andrew Sims centre in Leeds (in person)

Cost: £150

Mental Health & Learning Disability Training: The Andrew Sims Centre

2. RCPsych Disease Modifying- Treatments Webinars

If you missed the "Getting ready for disease modifying treatments" webinar series in November, they are available for free on the RCpsych website (Linked here)

https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/are-we-ready-report

Covering everything you need to know regarding the potential anti-amyloid drugs for Alzheimer's disease including imaging, biomarkers and administering monoclonal antibody therapies

3. RCPsych Faculty of Old Age Psychiatry Annual Conference - 11-12th April 2024

A chance to get together with old age psychiatrists from throughout the country to share learning and practice. We're planning to have some trainee focused sessions so get in touch if there's any topic, clinical or not, you'd like to see on the programme.
Hybrid in person in London or online

Cost: £265
https://www.rcpsych.ac.uk/events/conferences/detail/2024/04/11/default-calendar/faculty-of-old-age-psychiatry-annual-conference-2024

Tip: It is always worth submitting abstracts for a poster, even for small projects, as there is always wider learning that can be gained and it often attracts funding for conference registration or travel.

4. The British Geriatrics Society Frailty E-Learning

The British Geriatrics Society have developed a Frailty eLearning course which is free to access until June 2024.
Access it **here**.

Please send us any reviews of courses or conferences that we can feature in the next edition!
Email Rebecca.fitton1@nhs.net or E.Robertson@nhs.scot

A FEW OF MY FAVOURITE REVIEWS

Anitha Howard, Consultant Psychiatrist, Benham Hospital , Gateshead

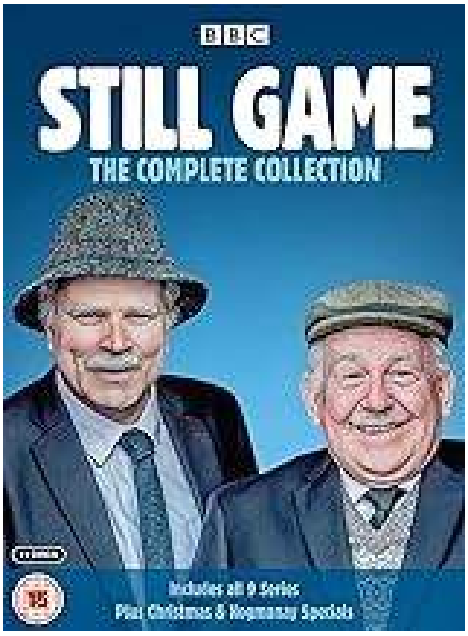
I can't believe it has been eight years since I joined the newsletter's editorial team and what a journey it has been. I've enjoyed enjoying reviewing books, film and tv as an old age psychiatrist as well as finding new books and films through the reviews submitted to the newsletter.

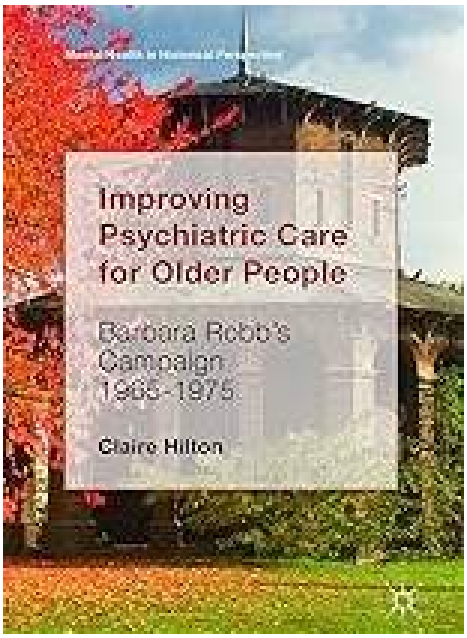
I just want to thank everyone who submitted a review and here is my review of all the books, films, and TV shows from the last eight years.

The Best TV positive portrayal of getting older: Still Game

This TV show featuring a group of older adults living their lives shows older people living and thriving instead of just surviving. This show is hilarious with some of the funniest scenes I have ever watched.

Scenes such as the Craglaing gang staging a night raid in a respite faculty, the local older hardman beating off a potential mugger with his artificial leg to the residents forming a football team training very slowly to the Rocky soundtrack.



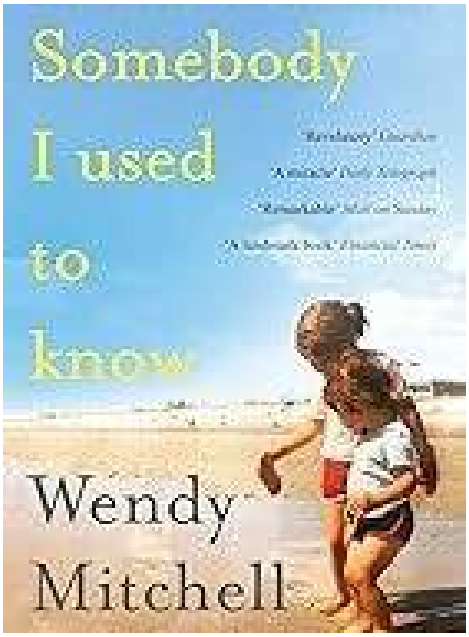


The Best Book showing us why older people need specialist service: 'Improving Psychiatric Care for Older People' by Claire Hilton

Claire Hilton's book remains the best book for anyone else who wants to learn how older people's mental health services started. I had no idea who Barbara Robb was before I read this book and her contribution to reforming how mental health services were delivered.

The Best Book written by a person with dementia: 'Someone I used to know' by Wendy Mitchell

I heard Wendy Mitchell speak at one of the faculty conferences and was moved by her experiences of being diagnosed with early onset dementia. Her book, reviewed for the newsletter by Dr Fiona McDowell, is a descriptive, reflection by an amazing writer living with the illness.

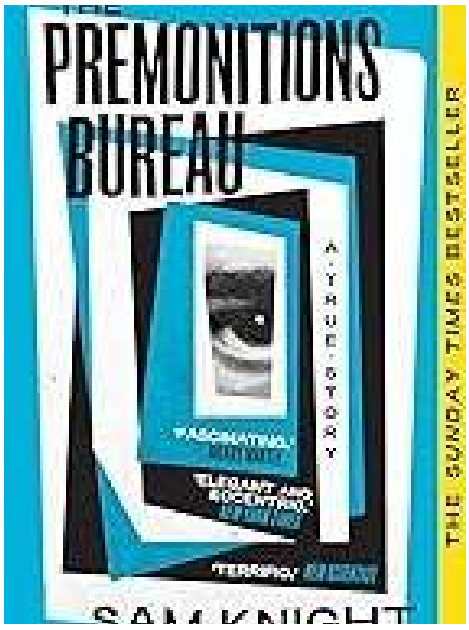


Best book about dementia for 10- to 14-year-olds: 'Hour of the Bees' by Lindsay Edgar

This book reviewed by Rebecca Davy would be perfect for any young person who recently has had a loved one diagnosed with dementia.

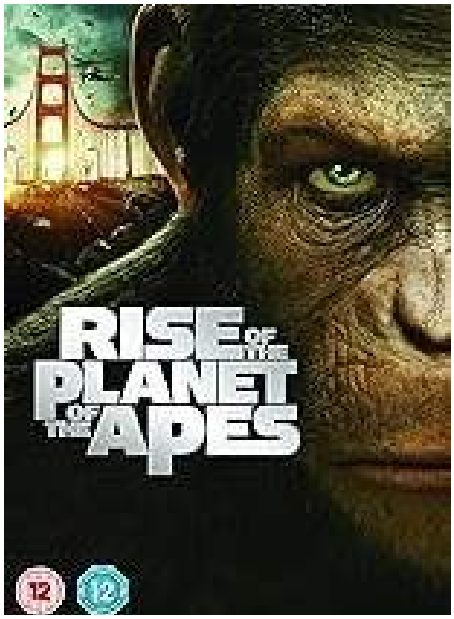
Best Book to remind you why fire safety training is important: 'The Premonitions Bureau' by Sam Knight

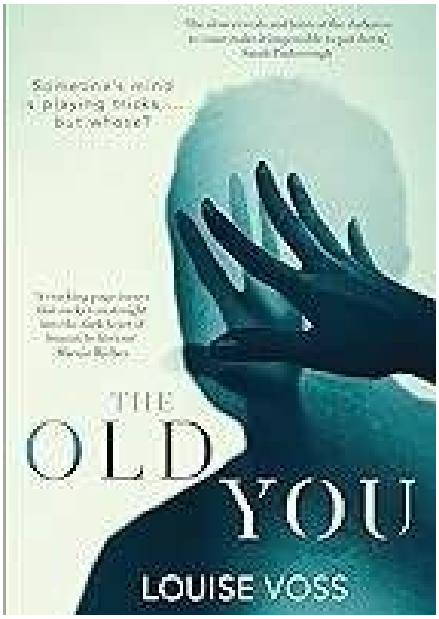
This book about an NHS Psychiatrist who set up a research project about whether premonitions could help prevent disasters was fascinating. But it was the description of a horrific fire in the hospital, Dr Barker worked in that left an impact on me. The lack of fire safety awareness in staff and patients led to so many deaths and why fire safety is such an important part of our working environment.



Best film highlighting why ethical approval for research is important:
Rise of the planet of the apes

So, this one is a little tongue-in-cheek, but the film does show the pitfalls of unregulated and unmonitored research and experimentation on family members. The film also has one of the most realistic and sensitive portrayals of dementia I have seen so far.





Best book showing how not to give a diagnosis of dementia:
'The Old You' by Louise Voss

I wasn't very impressed, when in this book, a person is given a diagnosis of young onset of dementia with no scans or memory tests and no empathy.

Best film highlighting the importance of older people being able to challenge medico-legal decisions:
I care a lot (2020)

This black comedy is chilling in its portrayal of how older people in the US can lose the rights to all aspects of their life from where they live to how much pain medication, they receive to how many times they can see their oved ones. This happens easily, by people who wish to make money off them through the system of guardianship with no apparent way being challenged. Watching this film made me feel glad to work in a system where any patient or person can challenge a legal decision affecting them.

Please continue to submit your reviews of films,TV, books ,theatre and podcasts featuring older adults or psychiatry.