RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

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May 2024

HELLO

Welcome to Issue 89, May 2024, of the RCPsych Old Age Faculty Newsletter

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RC PSYCH
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Cover Information

'The Garden of Life', by Dr Brian Wang, CT1 Psychiatrist, Wessex Deanery

'In the garden of our minds, where seasons intertwine, Old age psychiatrists, like gardeners, align. Tending to the blooms of memories and thought, They nurture the wisdom that the years have brought.

As vines of time grow thick, weaving tales untold, Psychiatrists gently prune, memories unfold. With watering care, they sustain the roots, Ensuring resilience against life's bitter pursuits.'

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UPDATE FROM THE EDITORIAL TEAM

Hello from me to all our faculties members, trainers, and trainees in Old Age Psychiatry & all subspecialties to this edition of the Old Age Faculty newsletter. This is my first one as the editor after taking over from Dr Sharmi Bhattacharyya, Lead Editor for the newsletter for 8 years. Sharmi and her colleagues Helen and Anitha did a wonderful job and thank you to them & the trainee editors for their dedication and unwavering support to the faculty all these years. This edition is a mixture of few fond goodbyes and few warm welcomes!

We have a final piece from our Faculty Chair Dr Krish who along with Dr Josie Jenkinson worked tirelessly for 4 years, some part of their tenure during the Covid-19 pandemic and have ensured the faculty grew from strength to strength under their leadership. A warm welcome to our New Chair Dr Mohan Bhat and new Vice Chair Ben Underwood.

Another final piece from Dr Amanda Thompsell, National Specialist Advisor (NSA) for Older Peoples Mental Health (OPMH) at NHS England. I heard Amanda at our recent Old Age faculty conference in April '24 and I would like to share her important message 'We need a voice in every (decision/policy making) room!'

There are many changes happening in Older Peoples Mental health including Dr Jeremy Isaacs being appointed as the New National Director for Dementia and Older Adults' Mental health succeeding the most wonderful, highly respected, and much loved, larger than life Prof Alistair Burns CBE who took the role in 2010. Alistair will be very much missed by us all & our hearts are filled with gratitude for all times to come for everything he did for Older Peoples mental health services!
I want to take this opportunity to thank Jennie and Curtis, our 2 amazing trainee editors who put in a tremendous effort & their valuable time to get this edition of the newsletter ready. I also want to thank all of those who contributed by sending us useful articles, interesting case studies & made this edition exciting which I hope you all will enjoy reading.

A final thanks you to our faculty manager, Kitti Kottasz for her unwavering support. Do consider sharing your interesting pieces of work and articles for the newsletter by emailing oldage@rcpsych.ac.uk For the September edition, deadline for submission is 31st July 2024. Kitti will be happy to answer any queries.

With best wishes

Dr Shaheen Shora
Lead Editor

VIEW FROM THE CHAIR

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

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Dear colleague

It was wonderful to see many colleagues at the college on 11,12 April at our faculty annual conference. It is nice to getting back to face-to-face events where we are able network.
We had over 510 delegates attending the conference 200 face to face and 300+ online.
We had an excellent like of speakers and experts on both days, and it was a fulfilling couple of days. We also polled the audience on our faculty name. Majority would prefer the name to be Psychiatry of Older Adults. We are hoping to send the polls to all members soon.

The future of Psychiatry of Older Adults is bright even though we are going through challenging time we have the opportunity to demonstrate our expertise in improving mental health of older Adults.

As I come to the end of my 4-year tenure as faculty chair, I am delighted to be handing over the leadership to Dr Mohan Bhatt who was elected as the chair and welcome Ben Underwood Vice Chair and Dr Bob Barber Finance officer. They take up their role from 18 June. I wish them well.

I want to thank and acknowledge our outgoing Vice-Chair Josie Jenkinson; she has been a rock solid support to me throughout the past 4 years. I could not have done my job without the support of Josie, Chineze and Mohan.

My profound gratitude to Kitti Kottasz our faculty manager who has tirelessly worked with me and all the exec members. I also welcome our newly elected faculty exec member and thank our exec member who have been instrumental in developing our faculty strategy.

Looking back and reflecting on the past 4 years when I was elected at the start of the pandemic, we have come far as faculty. We had to adapt and move all our events online and still successfully conducted our annual conference and winter conference with over 800 people attending, making it one of the most successful faculty events.

We have been working closely with the chairs of our devolved nations, external partners, and other agencies. You would have received an update email on DMT from me we will continue keep you updates as we get new information form regulators.

We have delivered modules to Trainees in Ghana and done a contributed to the Dean's grand rounds. We are also the first faculty to be developing an international diploma in Old Age Psychiatry.

I am confident that the future is bright for Psychiatry of Older Adults.

As I take leave from my role, I wish you all well in your clinical leadership career and life.

Considering the work pressure, we are all under please be kind to yourself.

With warm wishes and Goodbye. (Sharing some lovely memories below)

Krish
Chair of the Faculty of Old Age Psychiatry
@deliriumkrish

THE END OF AN ERA?

Dr Amanda Thompsell - amanda.thompsell@nhs.net

It is all change at NHSE, where sweeping alterations are being made to the management structure, particularly as regards clinical governance. First, we have a new National Clinical Director for Dementia and Older Adults' Mental Health. I congratulate Dr Jeremy Isaacs on his appointment, and I wish him well in this role. He has big shoes to fill and I want to acknowledge the amazing contribution that Alistair made whilst he was National Clinical Director. He made sure that those people with dementia and their carers were at the centre of all he did. He was a powerful advocate for older people and his charm and wit ensured he was respected and well-liked by all. These attributes helped him to form alliances to ensure dementia was considered across the whole pathway. His legendary ability to devise mnemonics to get his message across will be greatly missed. I personally feel extremely fortunate to have had the privileged to have had him as a mentor and colleague.

My own role as National Clinical Adviser on Older People's Mental Health was originally due to end on 31 March but there has been a temporary reprieve to the end of June.

This then may be my last Newsletter (apologies for those of you who are getting a sense of deja vu). As ever I will cover the latest developments and draw your attention to resources that may help those providing care for older people with the mental health issues and or dementia.

What's new in Dementia?

The interest in dementia modifying treatments (DMTs) is increasing at pace and it is very helpful to Jeremy in place to articulate the clinical view as this is one of his interests. The pros and cons of DMTs and the difficulties of rolling them out were well covered in the recent excellent Faculty conference. If you weren't there and are interested in what was said I would highlight the recent email sent to Faculty members by Krish with the local resources and position of the Faculty. Perhaps the biggest thing to be aware of is that the local pathway for DMTs is going to be set a local level. Old age specialists need therefore to make sure they are at the table when decisions are being made about DMTs as the resource implications are substantial.

Regular readers of this newsletter will know that I recommend anyone concerned about patient care to join **FutureNHS** by going to the Future NHS Collaboration Platform website [https://future.nhs.uk/] to access the resources and webinars that are on the site.

I urge you to keep an eye out on that platform for the launch of the refreshed Right Care scenarios for dementia. These scenarios involve Tom, a man with dementia, and Barbara, his wife and carer – surely this was scripted by an aficionado of *The Good Life*. The scenarios are informative, thought-provoking, and moving. They also provide a useful framework for discussions with and among commissioners. They demonstrate what a good care pathway and what a sub-optimal pathway could look like for somebody with dementia and that person's carer.

These scenarios are aimed at helping local health systems think strategically about designing care pathways that are optimal for both people with dementia and their carers. These scenarios link to the Dementia Wellbeing Pathway and the Model Health System (see below). I apologise that I cannot give you an exact date of release as it keeps changing.

An important resource when considering service development is the Model Health System which now has been expanded to include data on the pathway relating to dementia. The Model Health System is a data-driven improvement tool that enables NHS health commissioners and providers to benchmark quality and productivity. You can use the Model Health System to dive deeper into your data and compare yourself with other Integrated Care Boards (ICBs) and identify unwarranted variation. The indicators available cover each stage of the dementia wellbeing pathway from diagnosis though inpatient admissions to discharge as well as statistics for community services. The tool includes data on dementia risk factors, such as prevalence of coronary heart disease; prescribing of anti-dementia drugs; A&E attendances; inpatient admissions; care plan reviews; care home capacity and place of death to name but a few. The aim of this system is to bring together existing and new dementia measures in one place.

To register for an account visit https://model.nhs.uk/ Register | NHS England applications (model.nhs.uk).The implementation team helpfully provide regular webinars to explain how to get the most from the system

Finally, if you have not seen the various interactive dementia surveillance factsheets on the home page on the Fingertips platform (available at Dementia Surveillance Factsheet) I would urge you to look at them. They allow you to see how your ICB compares to others in relation to various parameters, such as giving up for a people a formal diagnosis of dementia or how long or how many referrals you're getting from primary care.

As there remains a stated ambition to achieve dementia diagnosis rate of 66.7 % by March 2025 going forward there will be increased scrutiny on these figures.

What's new in older adults' mental health?

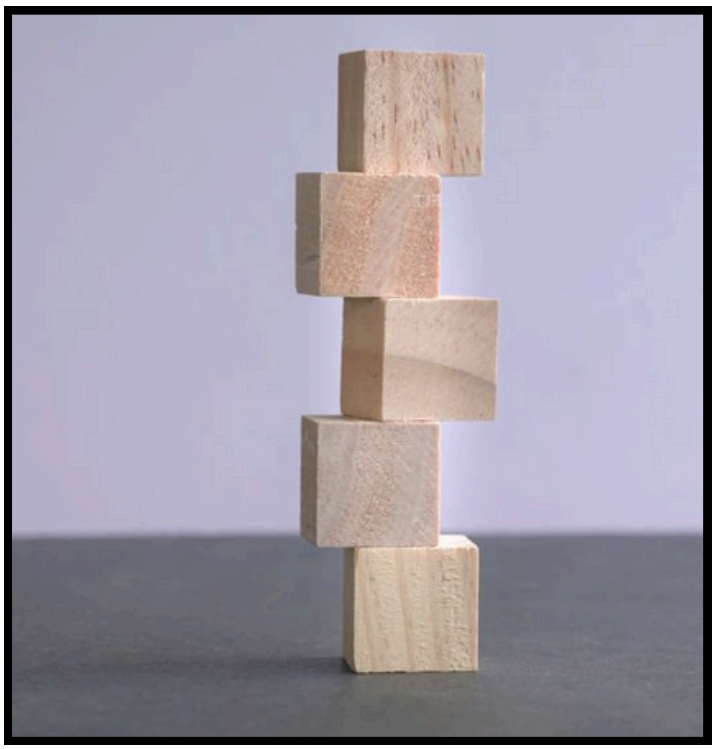
As I reflect on the last few months, I sense that – finally – we are seeing increased acknowledgement that the population in the UK is ageing and that the implications of this are profound. The recent report by the Centre for Mental Health CentreforMH_MentalHealthInLaterLife-1.pdf (centreformentalhealth.org.uk) reinforces the importance of addressing ageist assumptions and tackling isolation. The Age UK report in March "I just feel that no one cares' also highlighted the significant number of older adults who feel anxious and less motivated to do the things they previously enjoyed. Finally another report again from Age UK offline-and-overlooked-report.pdf (ageuk.org.uk) has highlighted the issues some older people can have accessing services which use web-based forms. Whilst these reports largely tell us what we already know, it may be helpful for you to ensure that service commissioners to be aware of them.

The NHSE published its priorities and operational planning guidance for in 2024/25 in April - PRN00715-2024-to-2025-priorities-and-operational-planning-guidance-27.03.2024.pdf (england.nhs.uk).

Whilst this covers the whole of the NHS, as regards mental health needs, there is a specific focus on improving access to care for those with mental health needs; therapeutic care in mental health inpatient settings; and reducing inequalities. These areas of focus also apply to older people. There is similarly a wish to expand NHS talking therapies, it being acknowledged that older adults are not accessing these services as much as they should be. The access agenda is a key issue, and it is important that we ensure that locally older people are able to access the developing services such as the rehabilitation mental health inpatient services (see NHS England » Commissioner guidance for adult mental health rehabilitation inpatient services) autism services and the upcoming gambling services.

The focus on therapeutic inpatient care and equalities presents us with an opportunity to ensure that services can meet the needs of their local population so that "all means all". We can help achieve this by ensuring we ensure that the voice of the older adult experts by experience and that older adult clinicians are heard in the room where decisions are made. It will nonetheless be essential when in these meetings that we know what supporting data and evidence there is. I am fully aware that in older people's mental health there still is not always good data – and indeed there are also many pathways that older adults use within the whole system where important data is not even being collected. I believe this is an important issue to highlight locally to help address any inequalities.

Finally what I believe may come to be seen as one of the most important developments in the last few months has been a commitment by government via NHSE to develop parity of esteem between physical and mental health (see the letter to the Public Health Committee on behalf of DHSC and NHSE). Parity of esteem means that mental health is valued equal to physical health.



Five building blocks have been identified to achieve parity:

- Parity of timely access
- Care being offered in a similarly patient-centric, therapeutic and evidence-based manner
- Every part of the NHS recognises the importance of parity and gives equal priority so that at all levels patients can access care without fear of stigma or of obtaining worse treatment
- Data is collected in the mental health sector . equivalent transparency and urgency as other sectors, and
- Funding decisions close the gap between mental and physical health.

This is a radical manifesto and we should celebrate the fact at long last this important ambition has been articulated and supported in principle at the highest level. Although there will remain much to do to make this happen on the ground.

CHALLENGING DEMENTIA AS AN INEVITABLE PART OF AGEING

Rebecca Kingston, CT1, Avon & Wiltshire Mental Health Partnership NHS Trust

Introduction

My first rotation as a core trainee was with the wonderful Dementia Wellbeing Service in Bristol. The service is made up of a team of passionate members of staff, who positively and creatively support those living with dementia. It can be a very emotive disease and sadly lots of stigma around it still exists.

Whilst there is amazing work being done to ensure people living with dementia achieve a quality of life that is important to them, I must admit that seeing the more challenging impacts of the disease caused me to think not only about patients' health but also my parents' and my future health too.

Thankfully, a growing body of research suggests that dementia may be substantially preventable through lifestyle modifications.

The Scale of the Challenge - Global and Growing

In the UK alone, there are currently around 944,000 people living with dementia, a number projected to reach 1 million by 2030 (1). Globally, over 55 million people are affected, with dementia costing the world an estimated $1.3 trillion in 2019 (2). These figures underscore the urgent need to address this public health crisis.

The Lancet Commission on Dementia's Findings - Potential Prevention of over 40% of Cases

In 2017, the Lancet Commission on Dementia convened to review the evidence and produce recommendations for managing dementia (3). Their groundbreaking report, updated in 2020, identified several modifiable risk factors that could potentially prevent or delay a significant proportion of dementia cases (4).

According to the Commission, at least 40% of dementia cases worldwide could be prevented or delayed by addressing modifiable risk factors (3, 4). This estimate may be considered conservative, with not all the risks being fully integrated due to a lack of high quality evidence. A more recent study using UK Biobank data suggests 47% to 72.6% of cases could be preventable (5).

The 12 modifiable risk factors for dementia highlighted by the Lancet Commission are: Smoking, obesity, less education, hearing loss, hypertension, depression, social isolation, physical inactivity, diabetes, excessive alcohol consumption, air pollution, and traumatic brain injury (3, 4).

Interventions that target these risk factors, such as minimising diabetes, treating hypertension, stopping smoking and maintaining frequent social contact, can enhance and maintain cognitive reserve as well as reduce neuropathological damage, leading to a reduced risk of developing dementia (3, 4).

It's important to recognise that many of these risk factors also impact other preventable diseases, such as cardiovascular disease, and therefore modifying them will have further health benefits.

The Holistic Approach: Interventions that Increase Cognitive Demand

At the British Society of Lifestyle Medicine conference in September 2023, one of the talks given by Dr Tommy Wood discussed the topic of dementia prevention. Wood, a medical doctor and neuroscientist, has an interest in brain health across the lifespan. He shared findings from a paper he co-wrote with his colleague Dr Josh Turknett (6).

The premise of the paper is that higher cognitive demands upregulate cellular repair and improve function, while lower cognitive demands downregulate these restorative processes leading to decreased function. Comparing this concept to skeletal muscle, much like muscle hypertrophy is a result of stimulus to that muscle tissue, increasing cognitive stimulus is associated with improvements in cognitive function (6).

Interventions that reduce the risk of age-related dementia, where benefit is likely through cognitive demand, include education, exercise, learning a language, learning and playing a musical instrument, social connection and maintaining sensory inputs such as hearing. Conversely, factors that reduce cognitive demand and therefore increase the risk of cognitive decline include retirement, social isolation, sensory loss and sedentary behaviour (6).

For these demands to be impactful, the authors highlight the importance of sleep and recovery for growth and repair (6). Sleep disturbances and sleep deprivation have also been associated with a higher risk of dementia and cognitive decline (7, 8). In a society that has deprioritised sleep and where sleep can almost be considered a commodity, a focus on sleep opportunity and sleep hygiene is becoming ever more essential.

A Note About Nutrition - Nutrient Deficiencies and Ultra-processed Foods

Nutrition and dietary advice is often hotly debated and controversies persist. It is not referred to as a modifiable risk factor in the Lancet Commission due to a lack of strong evidence.

However, some nutrient deficiencies have been linked to cognitive decline, such as vitamin D, B vitamins in relation to high homocysteine levels and anaemia (9, 10, 11).

In addition, ultra-processed foods, which are garnering much media attention, have been linked to a variety of diseases including an increased risk of dementia and cognitive decline (12, 13).

ome of these health conditions are in themselves a risk factor for dementia, such as type 2 diabetes, obesity, hypertension and depression (14).
A significant challenge is that ultra-processed foods are part of our culture, cheap, readily available and difficult to avoid, dominating media, advertising, high streets and supermarkets.
I talked about ultra-processed foods during a presentation I gave to colleagues recently. It stimulated a good discussion, particularly around the benefits of supporting patients to understand how to eat more healthily and the challenges of driving changes in behaviours to help them.

In Summary - Prioritise Physical, Cognitive and Social Activity to Reduce Dementia Risk

While the research on dementia prevention is still evolving, the evidence is clear: adopting a lifestyle that prioritises physical, cognitive, and social activity, promotes vascular health, and supports restorative sleep can significantly reduce the risk of developing dementia.

It's never too late to start making positive changes. Simple steps like incorporating regular exercise, consuming a minimally processed and nutrient-dense diet, nurturing social connections, getting adequate sleep, and reducing exposure to toxins can all contribute to a healthier brain and a reduced risk of cognitive decline.

As healthcare professionals, we should support patients with the practical lifestyle interventions that can make a meaningful difference. By empowering individuals with this knowledge, we can challenge the notion of dementia as an inevitable part of ageing and work towards a future where cognitive health is prioritised and preserved.

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COGNITIVE ASSESSMENT AND ACTIVITIES OF DAILY LIVING: THE POWER OF TECHNOLOGY

Dr Curtis Osborne, ST4 Old Age Psychiatry

Introduction

The term dementia encompasses a range of neurodegenerative neuropsychiatric conditions, with the most common being Alzheimer's dementia, dementia with Lewy bodies, vascular dementia, and frontotemporal dementia. Dementia has been described by the world health organization (WHO) as a global priority, there are currently over 850,000 individuals in the UK living with dementia, incurring an economic cost of approximately £23 billion per year (1). Therefore, there is a great need to use technology to provide cost-effective diagnostic and post-diagnostic support to those living with dementia. Individuals living with dementia may experience both cognitive and functional impairment these include deficits in executive function in addition to language and physical activities such as dressing and personal hygiene. Digital technologies offer a diverse range of tools and applications to aid in the assessment of cognition and functional ability

. These include tools such as digital cognitive assessments and the use of wearable devices. This short report will explore how digital technologies can be utilized to assess cognition and activities of daily living in people with dementia.

Enter the Psychiatrists...

Technology in the Assessment of Cognition
Digital cognitive assessments

At the core of dementia diagnoses is the clinical assessment, which includes a review of the individual's psychological and mental well-being, as well as objective cognitive assessment tools. The most commonly used tools are the Mini-Mental State Examination (MMSE), the Montreal Cognitive Assessment (MoCA), and the Addenbrooke's Cognitive Examination (ACE-III/R). These tests consist of a selection of questions and tasks that objectively measure memory, attention, language, and other cognitive functions. These tests are delivered in person by a clinician to ensure the integrity of the answers and to provide any further explanations the test-taker may require.

Figure 1: Item selection in the VR Vstore which can be used to assess associate learning and pattern recognition (Porffy et al., 2022).

This can be time-consuming for both the patient and the clinician; thus, more modern technology-based methods of cognitive assessment have been developed. These modern methods include semiautomated test batteries, such as the Cambridge Automated Neuropsychological Test Battery (CANTAB) and the COGNIGRAMTM system, both of which have received approval European and US Food and Drug Administration (FDA) approval for use in detecting clinically-relevant memory impairment in older adults and can be administered via portable touchscreen devices.

The CANTAB can be used to assess multiple features including an individual's functional impairment and mood. In a study by Staffaroni et al., (2020) the CANTAB-PAL, an 8-minute stand-alone task, was found to demonstrate a sensitivity of 83% and specificity of 82% to the detection of mild cognitive impairment (MCI) (2). Whilst the COGNIGRAMTM has been found to have a sensitivity of 73% and specify of 93% in the detection of prodromal Alzheimer's dementia (3). In addition to these, other digital techniques for the diagnosis of cognitive impairment include smartphone and virtual reality-based assessments such as the VStore which has been found to have a sensitivity of 87% and specificity of 91.7% in the detection of age related decline (4). The benefits of digital cognitive assessments include automated scoring which can remove some of the subjectivity, which can arise with in-person testing, reduced cost and administration time as well as the ability to deliver these assessments using online methods to increase access of specialist neuropsychological services to more rural and remote communities.

Wearable devices

Wearable devices have the ability to passively collect health-related data which can be used as indirect markers of cognitive function. The presence of accelerometers, gyroscopes, and other sensors within these devices presents a cost-effective way to measure disease burden and monitor progression of dementia.

The advantage of wearable devices is that they can continuously monitor physiological parameters over extended periods within the home.

Physiological parameters that have been found to be significant in the assessment of cognition include sleep quality and circadian rhythm, gait and motion tracking. A Hooghiemstra et al., (2015) study using actigraphy found that individuals with dementia demonstrated greater circadian rhythm disturbance, a longer sleep onset latency and lay in bed longer than healthy controls (5). Further to this a metanalysis by Cote et al., (2021) found that gait speed and daily activity were significantly reduced in those with dementia compared to controls.

This is significant as with lower gait speed found to correlate with increased fall risk in older adults and reduced physical activity has been found to associated with both development of dementia and is marker of disease progression (6). Thus the use of wearable devices can play a key role in remote monitoring of individuals living with dementia. Some obstacles to the use of wearable devices in older persons were identified by Paolillo et al., (2002) which reported that adherence to wearing the device in addition to charging and synchronising the data on the device with the computer were significant issues, particularly in those with cognitive impairment (7). Thus a support structure that encourages engagement and interaction with device is accordance with the users preference is required in order to obtain optimal benefit from the use if the devices.

Figure 2: VR checkout as part of the VStore Pay which can be used to engage working memory, executive functions, and required processing speed (Porffy et al., 2022).

Figure 3. The range of wearable Light-and-Motion Dataloggers available for Sleep/Wake activity research (Danilenko et al., 2022

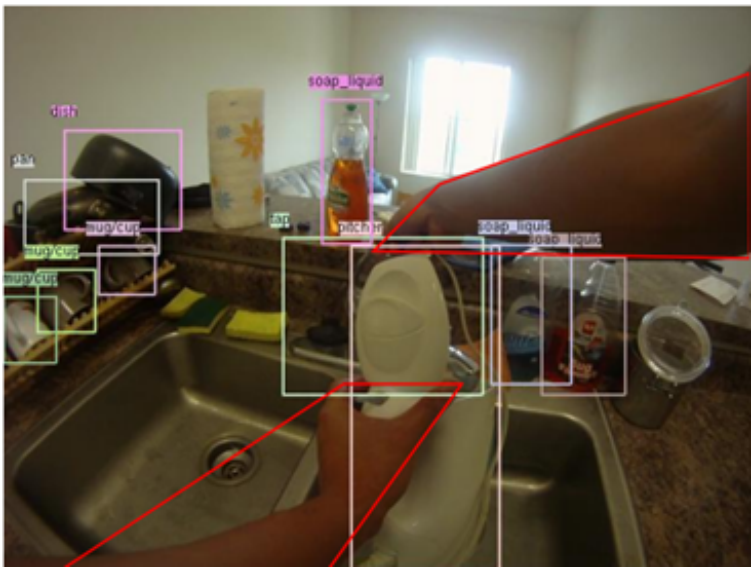
Neuroimaging

Neuroimaging is also a useful tool in the assessment of cognition, several studies have found correlations between neuroimaging modalities and the level of cognition. This includes a study by Jack et al., (1999) who followed 80 patients over 32.6 months with serial MRI brain scans and found that size of the hippocampus was able to predict the level of cognitive decline from MCI to Alzheimer's dementia (8). Further to this, specific changes on PET scans and EEG have been found to be able to differentiate MCI from Alzheimer's dementia with the changes correlation to cognitive assessment scores.

Figure 4: A washing up scene captured by the camera to for use in ADL assessment (Pirsiavash and Ramanan, 2012)

Technology in the Assessment Activities of Daily Living (ADL's)

As discussed above wearable devices have been found to be effective in the monitoring of an individual's activity levels, furthermore several studies have looked specifically at how technology can be used to assess an individual's ADL's. These include a recent systematic review by Camp et al., (2020) in which they used the Barthel ADL index and, Lawton and Brody iADL scales to identify 14 distinct activities, which could be measured via the use of room and wearable sensors, 5 which including dressing, bed usage and mobility could be measured directly whilst the remaining nine were measured indirectly using the sensor data (9). This is extremely useful as this technology is readily avaible and the longitudinal data gained from it can be uploaded on to a cloud server for security and used to remotely assess an individual's function in addition to their care needs. Another study which used technology to assess an individual's ADL's was conducted by Pirsiavash and Ramanan (2012) who used a novel algorithm and a first person camera with computer vision to capture 18 ADL activities in 20 individuals. The algorithm was able to use the recording from the camera to determine the activity being undertaken with a greater degree of accuracy than wearable ADL recognition technology (10). Thus it has the potential to allow for a more accurate approach to the automated assessment an individual's functional ability.



Conclusion

This report provides just a few examples of the digital technologies that hold promise for the assessment of cognition and activities of daily living. They have the potential to provide for more effective diagnosis, management, and interventions, to improve the quality of individuals living with dementia.

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WORKING WITH THE PSYCHIATRY OF DYING IN THE OLDER ADULT

Dr Jonathan Olds, SAS Psychiatrist in Later Life Liaison Psychiatry, Bristol Royal Infirmary

The past six year s of working as a SAS doctor in older adult psychiatry have provided a unique perspective on my own life, values and fantasies. One might suggest that anyone working with older adults will be afforded such a perspective, but I believe the intimate nature of psychiatry with the interest in both conscious thought as well as unconscious motivation and phantasy has allowed me to begin to come-to-terms with the ageing and inevitable deterioration of not only my own parents, but perhaps that of my loved-ones and myself.

As older adult psychiatrists, we must align ourselves both the patient's mind which may be prone to error, misinterpretation and with perhaps a psychotic focus on themes of intrusion, being taken-over and death; but we also must align ourselves with those that provide care for the person, whose focus may be polarly opposite – on safety, empowerment and on sustaining life. To hold both in mind calls for a degree of psychic flexibility and will often lead to a degree of introspection with regard to our own thoughts and feelings regarding the process of ageing and dying.

I'm currently reading the letters that were sent between Sigmund Freud and Carl Jung in the early 1900s1 and have been reminded of the powerful forces involved in the oedipal complex between father and son.

The mutual unconscious understanding of the child's anihilation of the parent suggests to me that the older adult is perhaps wary of the destructive forces at play as they become frailer – "my children want me in a home, out of the way" or "my children are only interested in my money" – themes that can be often seen as the basis of psychotic delusions within the older adult that are manifested as themes of poverty, passivity and nilhism and in the extreme are manifested as cotard delusions. Again, to truly align oneself with the patient as well as those that provide care (i.e the children of the patient) requires a degree of psychic flexibility – holding the notion of recovery in-mind at all times whilst avoiding the temptation to "drag the patient kicking and screaming into external reality" to align themselves with the child.

Of course, for the carer, death may be the ultimate enemy, but for the patient, we often observe and feel in the countertransference an acceptance of the inevitability of death and a desire to die on one's own terms and to perhaps embrace death.

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IDIOPATHIC NORMAL PRESSURE HYDROCEPHALUS AND THE ROLE OF THE OLD AGE PSYCHIATRIST

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What is idiopathic normal pressure hydrocephalus?

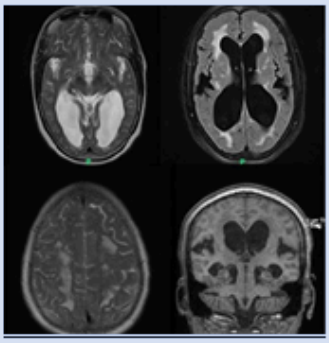
Idiopathic normal pressure hydrocephalus (INPH) is a progressive, potentially treatable condition causing dementia. INPH is characterised by gait disturbance, cognitive impairment, and urinary incontinence, with a build-up of cerebrospinal fluid (CSF) in the brain ('hydrocephalus'). In INPH, there is no clear preceding trigger. People with INPH usually present with gait or balance problems, while a minority (11%) may present with memory impairment as a first symptom2. Imaging findings such as ventriculomegaly, disproportionate enlargement of the subarachnoid space hydrocephalus (DESH), and an acute callosal angle are characteristic of INPH3.

Investigations for possible INPH include gait speed measurement before and after lumbar puncture to remove CSF, known as a 'tap test'. If this is negative and INPH is still suspected, then a 48-hour lumbar drain test may be carried out to assess whether gait speed is improved with CSF removal3. This latter investigation is as an inpatient. Treatment for INPH is usually through surgical placement of a tube into the brain to divert CSF to the abdominal cavity, known as a 'ventriculoperitoneal shunt' (henceforth referred to as 'shunt').

Case descriptions[1]

Vignette 1

76-year-old woman referred to local memory clinic with a 2-year history of progressive episodic memory impairment and reduced appetite. Gradually less independent and needing formal support.



MSE: Polite, well dressed. Her personality is relatively preserved. Some paranoia. Limited insight. Her cognition is far more affected than her mobility.

Cognitive assessment: MoCa is 5/30
Registration 3/7, recall 0/7, recognition 1/5
Fluency: phonemic 7/min
Semantic: 2/min
She cannot name the current PM. Can remember Margaret Thatcher.
Names 7/12 pictures. She super-ordinates e.g. "camel" to "animal".
Cannot read fragmented letters.
Normal eye movements. Moderate limb-kinetic dyspraxia. .

Gait is slightly wide-based but stride-length and take off are normal.
She can independently get up and out of a chair. Gait speed is fairly fast (10mWT 12 s). She has mild postural instability and fails a retropulsion pull-test.

Lumbar puncture with large volume tap-test does not improve gait and CSF analysis confirms low abeta 42:40 ratio (<0.065) as clinically suspected.

Diagnosis: Alzheimer's disease.

Why is this condition important?

INPH is thought to be under-treated in the UK. Studies suggest up to 55,000 UK older people may be living with INPH4, but only about 2,000 shunts were inserted for INPH between 2004 and 20135. Under-treatment of INPH has significant impact on patients, carers, and health and social services. In untreated people with probable INPH, the risk of dementia or death is three to four times higher than the general population6. This risk is halved among those who are shunted7, so prompt identification and assessment of people with possible INPH is key.

What is the role of old age psychiatrists?

Old age psychiatrists are likely to see possible cases of INPH clinically. 98% of INPH occurs in people aged 60 years or older and about half of people with INPH score within the dementia range on cognitive testing4, so many people may be referred to memory clinics. Falls, slow gait, urinary incontinence, and memory problems are common and non-specific symptoms in older adults. INPH may be difficult to distinguish from and often coexists with other conditions that old age psychiatrists manage, such as Alzheimer's disease8.
With routine brain imaging becoming more widespread in memory clinics9, imaging features of INPH may be identified more frequently. However, a substantial proportion of older adults that do not have INPH have non-specific imaging findings. For example, Jaraj et al found that 20.7% of people aged 70 and over in the general population have ventriculomegaly10. Appropriate interview to determine whether the clinical syndrome of INPH is present in these cases is essential. In addition, assessment and treatment of INPH is invasive, so careful consideration must be given to the person's individual circumstances and likelihood of successful treatment before onwards referral. Old age psychiatrists therefore play a key role in the initial assessment of possible INPH.

When treatment is either not advised or not successful, old age psychiatrists will also have a role in ongoing support and management of the dementia caused by this condition.

What are the next steps to improving care for INPH?

Specialist multidisciplinary assessment is needed to identify differential and co-existing diagnoses, risk factors, and carry out detailed radiological review before deciding who may benefit from invasive investigations for INPH. The number of specialist services assessing suspected INPH in England is not known but is thought to be few, with few established pathways for access to these. Improving clinical pathways for INPH should increase detection of likely cases of INPH and avoid inappropriate referrals of people with, for example, imaging changes in the absence of the clinical syndrome of INPH. For example, one outcome might be a multidisciplinary team of psychiatrists, neurologists, and radiologists delivering a person-centred assessment regarding potentially invasive investigations (eg. lumbar puncture) before considering referral to neurosurgery.

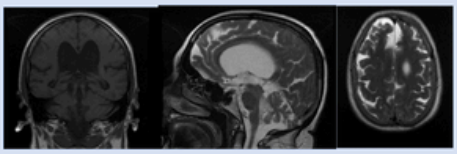
INPH rarely presents with isolated cognitive impairment. As described in case vignette 1, if a patient presents with a primary cognitive problem without gait impairment and there is communicating hydrocephalus on the scan, the likely cause is neurodegenerative. Given these diagnostic challenges, collaborative working is key. One example of such working is the Imperial College Healthcare NHS Trust Dementia Multi-Disciplinary Team, which has a monthly meeting with neurology and regional old-age psychiatry consultants.

A Special Interest Group (SIG) at the Association of British Neurologists (ABN), set up and led by Dr Chris Carswell, seeks to bring together interested clinicians to develop pathways of care and research into INPH, and engagement from Old Age Psychiatry is needed. Current plans include setting up a national INPH registry. Please consider contacting Dr Carswell (c.carswell@imperial.ac.uk) for further information if you are interested in joining the SIG.

***Case descriptions*[1]**

Vignette 2

60-year-old lady presents in 2014 with gradual unsteadiness, falls and intermittent vertigo. Past medical history of biopolar disorder on anti-psychotics since the age of 15 years. She takes Lithium and Quetiapine. She also has problems with urinary incontinence and has had multiple pelvic floor operations.



Lost to follow-up. Re-presents in 2018 as her walking is dramatically worse, she has a tremor and is forgetful.

On examination: MOCA is 22/30. Cognitive processing speed is very slow. Clinically she has postural tremor and postural instability, no overt supranuclear palsy. Gait is wide, short-stepped and slow, and she turns with many steps.

CSF tap test shows an opening pressure of 15cm of water. Timed 10m WT reduces from 1 minute 42 seconds to only 38 seconds. VP shunt inserted in September 2019 and dramatically improves further. Independent with a stick 4 years later.

Diagnosis: Idiopathic normal pressure hydrocephalus

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DILEMMA OF PANCYTOPENIA BY METHOTREXATE AND RISPERIDONE

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Abstract/Summary

Methotrexate is known to cause pancytopenia which could have fatal outcome. However, antipsychotic induced haematological side effects especially with risperidone are uncommon. The interaction between methotrexate and risperidone is especially little known. Risperidone is licensed for behavioural and psychological disorders in dementia. Elderly are more susceptible to side effects. This case report is about how risperidone might be playing a secondary role on a patient with methotrexate induced pancytopenia.

A 92 year old female developed pancytopenia while receiving treatment for infection of likely urinary origin. Following ba rief period of non-compliance to medication due to poor physical health, she was re-commenced on methotrexate 15mg weekly for rheumatoid arthritis in the hospital. Due to presentation of psychosis and challenging behaviour associated due to delirium, she was started on risperidone. In the due course, she developed pancytopenia which did not improve despite stopping methotrexate. Risperidone was the only new medication apart from an antibiotic since hospital admission. After stopping risperidone, there was marked improvement in cell count especially platelet within 24 hours (increased from 109 to 189) and white cell count returned to normal level after 10 days (Figure 1& 2).

Introduction/ Background

Pancytopenia is a deficiency of all three types of the blood (red blood cell, white blood cells and platelets). Haemoglobin count is less 120 g/l ; the leucocytes count is less then 4.0 X 10*9/l and the platelets count is less than 150 X 10*9/l. It a life-threatening haematological condition which could be caused by various factors such as bone marrow failure disorders, idiosyncratic (drug induced, pregnancy associated), viral illness (HIV, hepatitis), autoimmune disorder, nutritional deficiencies, malignancy(15).

In the world of psychiatry, we are well versed with agranulocytosis due to use of clozapine hence have strict monitoring guidelines. However, an event of pancytopenia or thrombocytopenia is little known especially with antipsychotic like risperidone.

Atypical antipsychotic are the drug of choice due to their safer side effect profile compared with first generation antipsychotic. In elderly, risperidone is the drug of choice due to being licensed for the use of behavioural and psychological disorders in dementia.

Methotrexate is a disease-modifying anti-rheumatic drug (DMARD) commonly used in Rheumatoid arthritis. It causes range of side-effects involving multi organs – diarrhoea, stomatitis, liver cirrhosis, skin reactions (16).

Case description

A 92 year old female was admitted to medical ward with presenting complaints of poor oral intake, increased confusion and poor adherence to medication. She had been referred to memory service hence awaiting appointment with no previous contact with mental health services. She had a medical history of Seropositive rheumatoid arthritis, Hypertension, Hypothyroidism, Primary generalised osteoarthritis and Fibromyalgia. Her regular medication consisted of amlodipine 5 mg once a day, candesartan 16 mg once a day, methotrexate 15mg weekly , alendronate weekly and calcium supplement.

On 3rd day of admission, her lab results showed rise in inflammatory markers with CRP 112. However, WCC and platelet counts were within normal limit.

A diagnosis of hyperactive delirium was made while physical health investigations were undergoing and was commenced on oral clarithromycin which was switched to intravenous due to poor oral compliance.

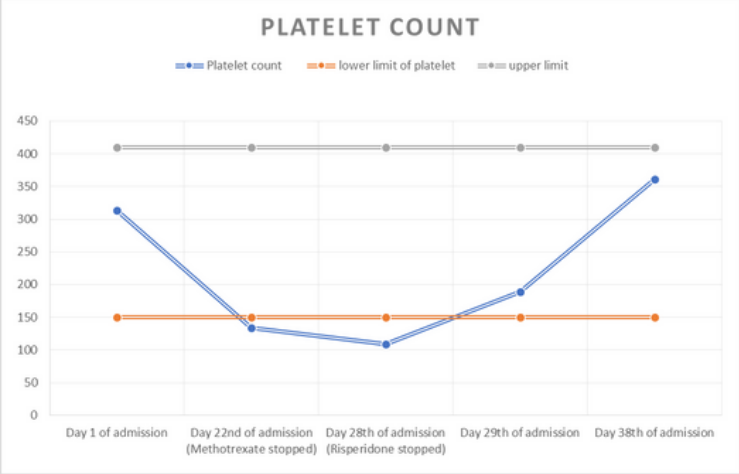

FIGURE 1 PLATELET COUNT , UNITS OF 10*9/L

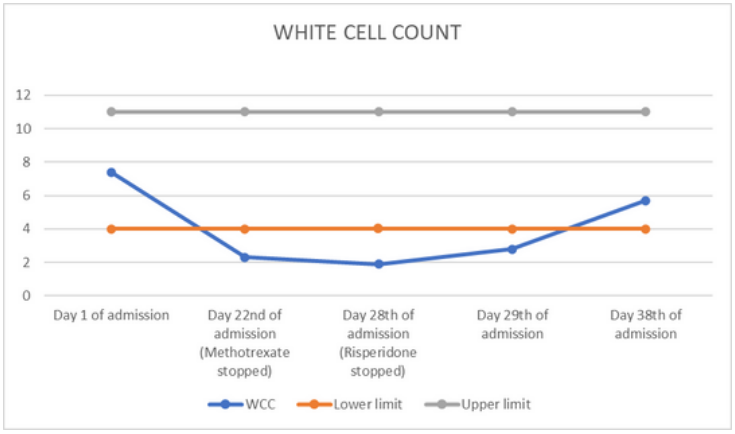

FIGURE 2 WHITE CELL COUNT, UNIT 10*9/L

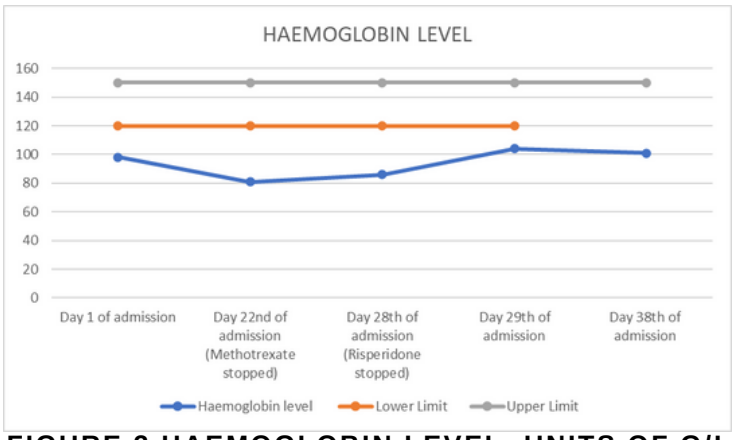

FIGURE 3 HAEMOGLOBIN LEVEL, UNITS OF G/L

A diagnosis of hyperactive delirium was made while physical health investigations were undergoing and was commenced on oral clarithromycin which was switched to intravenous due to poor oral compliance.

She presented with persecutory belief against family and staff, believing that someone is trying to harm her and had been displaying disrupting behaviour in the ward. Due to this, medical team started on risperidone 250 mcg oral once a day on 5th day of admission which was increased to 500 mcg once a day two days later due to increased behavioural disturbances – agitation, verbal aggression, poor sleep and persecutory beliefs. On 14th day of admission, risperidone was further increased to 250mcg in the morning and 500mcg in the night.

Methotrexate 15mg weekly was commenced on 9th day of admission and had 2 doses only. On 21st day of admission, the patient had a defecation syncope episode with haemoglobin level of 68 X 10*9/L and had one unit of blood transfusion. CT head was done which showed global symmetrical moderate to severe involutional change with no acute changes. The medical team count identify a source of haemorrhage.

On 22nd day of admission, the blood result showed pancytopenia following which rheumatology was consulted and methotrexate was stopped. Despite this, there was no improvement and following consultation with haematology and liaison psychiatry, risperidone was stopped and olanzapine 2.5mg once a day was started on 28th day of admission.

There was drastic improvement in platelet count within 24 hours after stopping risperidone which shows the causal relationship between thrombocytopenia and risperidone. WCC improved after 23 days of last dose of methotrexate.

Outcome and Follow-up

After stopping both methotrexate and risperidone, the patient's blood counts and physical health continued to improve. With olanzapine, there was also improvement in her psychotic symptoms. She had become more mobile and going to toilet with help from staff. The medical team continued to monitor blood count on weekly basis. However, she continued to display disorientation to time, place and person which highlighted possible underlying cognitive impairment. The social services were involved for a care home placement as a discharge destination.

Discussion

1.Pancytopenia

Pancytopenia is a haematological condition where there is reduction of red blood cell, white blood cell and platelets. There are several causes of pancytopenia including autoimmune condition, medication, infection, malignancy. The mechanism of pancytopenia is divided among three forms : 1. Haemopoiesis where there is reduced production of blood cells, 2. The stem cells are replaced by malignant cells and 3. Increased destruction outside bone marrow.

2.Methotrexate – how it cause pancytopenia – mechanism

Methotrexate prevents the production of purine and pyrimidine precursors for DNA and RNA respectively. At high doses, it is known to halt the proliferation of cells by arresting RNA and DNA production (3). There are case reports which has identified poor renal function – reduced eGFR as a contributing factor to developing methotrexate toxicity (1,6) as it is excreted renally. Especially in elderly, the combination of poor renal function, polypharmacy , low albumin level could lead to bone marrow suppression causing reduction of levels of all cells (2,6).

3.Methotrexate – how long does it take to recover when stopped

As a consequence of pancytopenia, there are reports of fatal outcomes (4,5). There are studies which shows that the average duration to recover from pancytopenia is four to six days which is dependant on co-morbidities and concurrent infection (7).

4. Haloperidol and Risperidone are the only licensed antipsychotic in UK for management of non-cognitive symptoms in dementia (13). Risperidone, atypical antipsychotic is much favoured compared to haloperidol, typical antipsychotic which has more extra-pyramidal side effects (14).

5.Risperidone – how it causes thrombocytopenia – mechanism : Pancytopenia is an uncommon side-effect with antipsychotics. In our case, it's interesting that after stopping risperidone, platelet count improved within 24 hours and white cell count improved within 10 days. It favours a causal relationship. Also, olanzapine did not cause any haematological side effect.

Antipsychotic can reduce the production of platelet during differentiation phase of cell cycle which has two stages : megakaryocyte maturation and development requiring thrombopoietin as a growth factor and second phase involves platelet generation. Reduced Platelet aggregation is also an observed haematological side effect leading to increased risk of haemorrhage (10). Thrombocytopenia is not a dose-related event (9). A review has suggested that drug-induced immune thrombocytopenia with at least three antibodies being of significance (11).

The timeline in which a patient can develop thrombocytopenia seems to vary , some has reported as early as within 2 weeks of treatment with risperidone (9) and some developing even after 6 months (12). There are several case reports of thrombocytopenia caused by risperidone which improved within a week after its discontinuation.

6.Risperidone – how long does it take to recover

There was rapid recovery of platelet count after stopping risperidone which favoured the causal relationship.

A case of 14 years old female was described who developed pancytopenia after 2 weeks of increment of dose of risperidone from 0.5mg daily to 0.75 daily and thus experienced repeated urinary tract infection, heavy vaginal bleeding. No signs of splenomegaly, hepatomegaly, or lymph node enlargement were observed. Bone morrow showed normal cellularity with granulocytic hyperplasia, suggesting a peripheral cause that was most likely a drug-induced effect. The blood level returned to normal after stopping risperidone for 2 weeks (17).

7.Agranulocytosis is well known with clozapine hence have strict blood monitoring guideline in UK. However, blood dyscraisis being an uncommon side effect, both typical and atypical antipsychotic yearly monitoring is recommended. There are reports of isolated cases of leucopenia with risperidone, aripiprazole and olanzapine. Genetic vulnerability has been flagged up as one of the reason for developing leucopenia with multiple antipsychotics (18).

In this case, the patient presented with low haemoglobin level of 98g/l which reduced further to 81g/l needing blood transfusion due to an episode of syncope on 22nd day of admission. Within 24 hours of stopping risperidone, haemoglobin increased from 86 g/l to 104 g/l and remained stable.

Learning Points/Take Home messages

Despite being uncommon, risperidone can cause blood dycriasis hence the importance of regular blood monitoring and physical health review.

2.Elderly patients are more prone to side effects due to multiple co-morbidities, polypharmacy, ageing, frailty, poor renal function.

3.There is a possibility of interaction between methotrexate and risperidone which would need more research.

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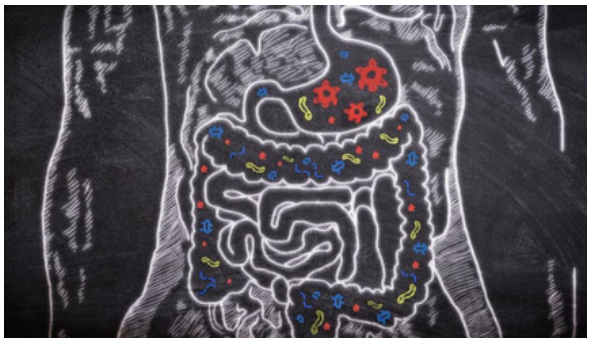
RESEARCH UPDATE

Dr Curtis Osborne, ST4 in Old Age Psychiatry

Original Research: Effect of gut microbiome modulation on muscle function and cognition: the PROMOTe randomised controlled trial

Ní Lochlainn M et al, Nat Commun 15



Introduction: The study suggests that gut microbiota may play a role in both muscle physiology and cognitive behaviour.

Method: Ní Lochlainn et al. (2024) undertook a placebo-controlled, double-blinded, randomized controlled trial involving 72 individuals aged 60 or older explores the effects of gut microbiota alterations on muscle physiology and cognitive behavior. Participants, were organized into 36 twin pairs, and received either a prebiotic supplement or a placebo for 12 weeks, along with resistance exercise and branched-chain amino acid (BCAA) supplementation. The trial, conducted remotely using video visits, online questionnaires, and cognitive testing, measured physical function and cognition outcomes.

Result: The prebiotic supplement induced changes in the gut microbiome, but it did not significantly affect the primary outcome of chair rise time. However, it did improve cognition compared to the placebo.

Conclusion: The study demonstrates the potential of inexpensive gut microbiome interventions to enhance cognition in aging populations. Additionally, the trial showcases the feasibility of remote delivery methods, which could address the under-representation of older adults in clinical research, especially amid challenges like the COVID-19 pandemic and mobility limitations.

Full article available: https://www.nature.com/articles/s41467-024-46116-y

Estimating demand for potential disease-modifying therapies for Alzheimer's disease in the UK

Laurell AAS et al. The British Journal of Psychiatry

Introduction: Phase three trials of monoclonal antibodies lecanemab and donanemab have shown significant clinical benefits in early Alzheimer's disease. These drugs, currently undergoing regulatory approval in the UK, raise concerns about healthcare system capabilities for administration and monitoring. This study aimed to estimate real-world demand for these antibodies in the UK.

Method: Laurell et al. (2024) analyzed patient records from two NHS trusts covering 2.2 million individuals in 2019.

Results: They found that approximately 906 people per year across these services would be eligible for treatment, which when extrapolated equated to around 30,200 nationally.

Conclusion: Delivery of monoclonal antibody treatments presents challenges in the need for increased access to investigation methods for dementia including neuroimaging, in addition to administration of these monoclonal antibodytherapies which are delivered intravenously. Understanding potential demand can help health services prepare for implementation.

Full article available:
https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/estimating-demand-for-potential-diseasemodifying-therapies-for-alzheimers-disease-in-the-uk/1C260715A34048C3F10EB49B3D42AD86

Practice Pointer:
New horizons in the diagnosis and management of Alzheimer's Disease in older adults

Dolphin H et al., Age Ageing

Introduction: Alzheimer's Disease (AD) is the leading cause of dementia, advances in biomarker technology can aid diagnosis and recognition of need for potential early intervention Recent studies suggest that precise clinical-biological AD diagnosis may reduce care costs and mortality.

CSF Markers: Obtained via diagnostic lumbar puncture (LP), can aid AD diagnosis, by showcasing depleted Aβ-42 and elevated p-tau levels. LP is invasive but generally well-tolerated. CSF analysis is particularly useful in predicting dementia conversion in older adults with mild cognitive impairment (MCI).

Neuroimaging Markers: Include MRI and FDG-PET, aid AD diagnosis by identifying hallmark findings such as medial temporal lobe atrophy and hypometabolism in specific brain regions.

Cognitive Markers: Accessible memory assessment services (MAS) which utilise a multidisciplinary approach.

Management: Primarily cholinesterase inhibitors and memantine. Cholinesterase inhibitors show modest cognitive improvements, whilst memantine offers moderate benefits, particularly when combined with cholinesterase inhibitors. Immunotherapies targeting amyloid plaques show promise in slowing AD progression but raise concerns about adverse effects like Amyloid-Related Imaging Abnormalities (ARIAs)

Conclusions: Enhanced diagnostic and treatment pathways, alongside multidisciplinary care, are essential for older adults with AD, ensuring improved quality of life while addressing potential challenges and costs.

Full article available:
https://academic.oup.com/ageing/article/53/2/afae005/7606142?login=false

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REVIEW SECTION: INTRODUCING YOUNG CHILDREN TO DEMENTIA

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

For this issue of The Old Age Psychiatrist, I have selected three favourite stories about dementia aimed at young children to review. There are myriad reasons why it's interesting to think about materials focusing on dementia for children. Firstly, our patients often have children in their lives who may benefit from narratives which reflect their experiences, and it can be empowering to guide them towards such stories. Relatedly, many of us know children who we would like to introduce to our professional sphere in an age appropriate way; several toddlers in my life have recently been gifted a copy of Lovely Old Lion. Finally, sometimes we wish to reflect on our professional roles through the medium of cultural output without wading through lengthy tomes and a short animated film proves just the trick – with or without a young child perched next to you.

Book: 'The Tide', by Clare Helen Walsh and Ashling Lindsay (2019)

This short book details a young girl's trip to the beach with her Grandfather, whose memory is failing on account of a suggested diagnosis of dementia. It is illustrated in a cheerful and playful style, with a warm colour palate which is thoroughly pleasing on the eye.

The Grandfather struggles with an array of seaside activities, becoming particularly muddled with setting out their picnic much to the initial chagrin of his granddaughter. The little girl's mother uses the simile of the tide to describe the Grandfather's failing memory, explaining that 'Grandpa's memories are like the tide', which means that 'Sometimes, they're near and full of life. Other times, they're distant and quiet'. The idea of fluctuation and relative inconsistency in dementia is an advanced concept which is touchingly translated for young children through this imagery. It allows the little girl, and perhaps the reader, to consider the scenario from the point of view of the grandfather, and to think about how unsettling it must be to be unable to remember how to go about everyday activities.

Cognitive concerns aside, a day on the beach presents an opportunity to enjoy splashing in the sea, to potter through rockpools and to share an ice-cream together.

This book's strengths lie in its optimistic message that people with dementia can live wholesome and meaningful lives, with the proviso that adaptations and understanding are essential to supporting this.

Movie:
Coco (2017) – A Disney Pixar film

This animated film is inspired by the Mexican holiday Day of the Dead, and follows a 12-year-old boy named Miguel on a journey through the Land of the Dead in pursuit of his late great-great grandfather in a bid to reverse a historical familial ban on music.

There are many wonderful moments in this film which will capture the attention and imagination of children and adults alike, not least the beautiful music, but perhaps most striking to an Old Age Psychiatrist is the prominent role of Mama Coco, Miguel's great-grandmother. Although never explicitly stated, it is clear that Mama Coco is demonstrating features of dementia: we watch as she fails to recognise her daughter ('Who Are You?') and as she misidentifies Miguel as her late father. Her memory is ever-failing, and her experience of the present is hazy and, at times, troubled.

Nevertheless, it is apparent that her long-term memory remains somewhat intact, and her memories of her early life remain available to her. n one particularly tender scene, she hears a song she used to sing with her father and it enlivens her – it is reminiscent of a video of a former Ballerina dancer, Marta Cinta González Saldaña, recreating moves from Swan Lake once the music played, despite her advanced dementia*.

IMAGE: DISNEY/ PIXAR

Mama Coco is markedly frail, which is made further apparent through her reliance on a wheelchair and regular familial support to fulfil basic tasks – which is provided gladly and with dignity. As the film progresses, she approaches the end of her life and dies. These are profound themes which you would not expect to encounter in a children's film, and yet they are handled with feather-lightness and warmth, as something of an aside. What is made profoundly clear in this film is the value of intergenerational relationships, the reservoir of knowledge available even in advanced dementia, and the importance of dignity in death.

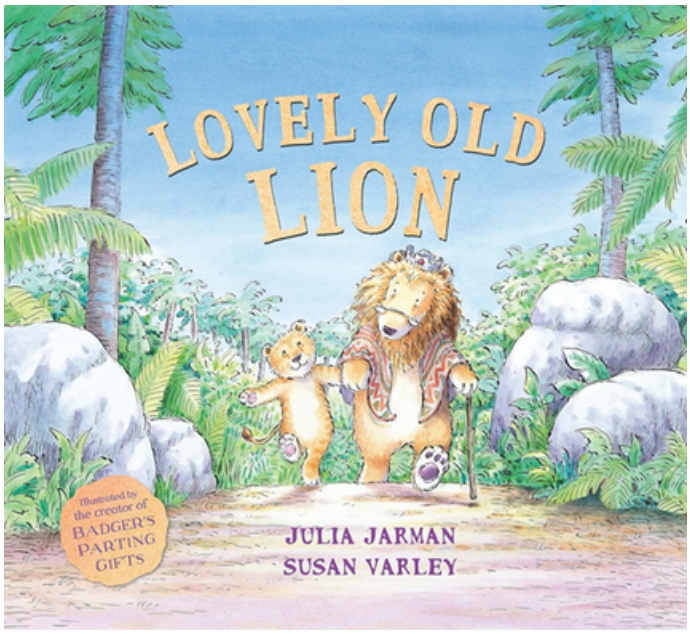
IMAGE: DISNEY/ PIXAR

Book:
'Lovely Old Lion' by Julia Jarman and Susan Varley (2016)

This beautiful picture-book tells the story of Lenny the lion and his grandfather, the King, who has dementia. We first meet the pair when Lenny is young, and are taken on a journey through the progression of the King's disease – with wavering memory, increasing physical impairment and ultimately death handled lightly and sensitively.

The story flashes forward to Lenny as an adult, now King himself, as he reminisces on the enduring rich memories he holds of his beloved grandfather.

This book handles the idea of legacy in dementia with spectacular ease and sensitivity; the Grandfather struggles to maintain his status as the head of the family, as King, but this does not prevent him from continuing to be an adored character with an ongoing contribution to his family and society, even after his death. His increasing impairments are problematic – but they are not a problem.



I found myself genuinely quite moved by this book, and my voice wavered as I read it. Perhaps this is because it so closely captures a prominent anxiety that comes up in dementia care– the stigma-laden idea of diminishing value- and turns it on its head. It speaks to an endurance of love and legacy which we so often see and hope for in our work, and more widely in our lives. This is my favourite of the three stories here, and I cannot recommend it more as an old age psychiatry themed gift for the preschool children in your life.

THE OLD AGE PSYCHIATRIST ANNUAL ESSAY COMPETITION 2024

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

Introduction

For the 2024 instalment of our newsletter's annual essay competition, we invited entrants to consider the question, 'Who needs an old age psychiatrist?'. We were looking for thoughtful and creative entries which considered ideas such as longevity, frailty and vitality – and we were delighted to receive a vast flurry of entries from across the career spectrum.

We were blown away by the overall quality of the work we received this year. It was a joy and privilege to read through the entries, and it clearly indicated to us the vast creative potential within the psychiatry community. It was no mean feat for our judging panel to narrow down the entries, and there was a cluster of entries which all deserved recognition; for this reason we awarded joint runners up, and also two highly commended entries.

We hope you will enjoy reading the winning entries below. Our winner, Dr Luke McGillycuddy, uses an assertive voice to compellingly argue the case for old age psychiatry, weaving together evidence and personal narrative.. Dr Rachael Elliot's skilful poem layers the tale of a patient with a failing memory with a reflection on previous interactions with old age psychiatry. Meanwhile, Dr Robert McClafferty, brings us the story of 'Margaret', with a compelling writing style, showcasing a remarkable penchant for storytelling. Our highly commended entries by Dr Maroulla Anderson and Dr Bharat Velani exhibit yet more imaginative prose, with a poem and a diary entry respectively to enjoy. A special mention goes to Dr Brian Wang. We loved his poem, 'The Garden of Life', which was accompanied by the original artwork which adorns the front cover of this issue.

Our Judges

We were incredibly lucky to have three thoughtful and accomplished judges who kindly gave their time and expertise to determine the overall winners. Thank you ever so much to Dr Lucy Pollock, Professor Gill Livingstone, Dr Mani Krishnan.

1. Dr Lucy Pollock trained in medicine at Cambridge and at Bart's Hospital, and worked as a junior doctor in East London before moving to Somerset, where since 2001 she has been a consultant specialising in the care of those who are frail and elderly. She is a writer, and her book, "The Book About Getting Older' was published in 2022 to widespread critical acclaim. Her forthcoming book 'The Golden Rule: Lessons in living from a doctor of ageing' is available for preorder now.

2. Professor Gill Livingston is a Professor in Psychiatry of older people within the Division of Psychiatry at University College London (UCL). She is also an honorary consultant psychiatrist at Camden & Islington NHS Foundation Trust. Her contribution to the field of dementia cannot be overstated with notable work including leading the Lancet Standing Commission on Dementia Prevention, Intervention and Care.

3. Dr Mani Krishnan is a Consultant in Old Age/Liaison Psychiatry at the Tees, Esk and Wear Valleys NHS Foundation Trust and outgoing Chair of the Royal College of Psychiatrists Faculty of Old Age Psychiatry.

WINNER: WHO NEEDS AN OLD AGE PSYCHIATRIST?

Dr Luke McGillicuddy
CT3 Psychiatrist, NHS Lothian

The 'aging population' represents a global demographic shift towards aging: the first of its kind in history,(1) with nearly 20% of the UK's population now aged 65 or over.(2) With an aging population, we'll need more psychiatrists specialising in older adults, right? Well, it's not that straightforward.

Greg Fell, director of public health for Sheffield, argues in his blog 'Ageing population lazy thinking for when you can't be bothered to understand the real issues',(3) that while population age is increasing, so are healthy life years, and the increasing demand on health services, of approximately 4% per year, far outstrips the morbidity levels which could be explained solely by an aging population. Further, while age itself is associated with increasing prevalence of multi-morbidity, dementia and delirium,(3, 4) the literature shows the strongest support for reverse U-shaped relationships between age and wellbeing, with decreased prevalence of mood, anxiety and substance use disorders in later life.(1)

'BY NAVIGATING THE COMPLEXITIES OF WHO ONE HAS BEEN, ONE CAN ACQUIRE THE VIRTUE OF WISDOM.'

Therefore, neither increasing population age, nor general increased disease prevalence in old age supports the necessity of a dedicated psychiatric subspeciality. So, who needs an old age psychiatrist?

Rather than age itself being the determining factor, old age creates unique challenges while also creating unique opportunities to reflect on life and allow development of abstract concepts such as wisdom.

A subspecialty with a nuanced understanding of these factors is required to ensure older adults are treated equitably and with dignity, in a manner which maximises continued development.

Erikson's theory of psychosocial development(5) advocates that as we age, we progress through changing life stages as a function of navigating biological and sociocultural forces. Different chapters of our lives are characterised by different questions of identity, love, role and purpose, as we seek to identify who we are and how to interact with the world.

In old age we face the existential question "is it okay to have been me"?(6) As people look back on their lives and accomplishments, and as family, career, social networks and physical function face great change, a reflective period may arise. Responses can emerge such as integrity – satisfaction in having led a meaningful life, or distress – about roles we have played or unfulfilled purpose. This is not merely a retrospective narrative however, as development continues. Skills gained from earlier in life are repurposed and integrated into new challenges as "the life cycle weaves back on itself".(5) By navigating the complexities of who one has been, one can acquire the virtue of wisdom.

In older adults facing illness, questions of identity and role take on a new importance, which has timely relevance as we consider the changing landscape of what it means to be old in our society, and what it is to face illness as we age.

A qualitative study by Perry et al.,(6) used Erikson's characterisation of wisdom to demonstrate that older adults with chronic health conditions can reassert autonomy by creative problem solving and are able to apply skills gained from early life experiences to problems arising in later life.

In older adults experiencing psychiatric illness, this concept is valuable in ensuring our patients are treated appropriately and with dignity. For example, in third wave cognitive-behavioural approaches, a fundamental premise of acceptance and commitment therapy(7) (ACT) is that by identifying our values, we can set goals which promote psychological flexibility, allowing us to determine our own course of action in line with our values. This results in reduced distress and ultimately, allows us to act in ways that enable us to bring vitality and meaning to our lives.

But what does this look like in practice? Last year my grandmother had a stroke and was subsequently diagnosed with vascular dementia. She had been a carer for much of her adult life, first for her mother, and latterly for her husband. She was selfless in these roles, as well as her support of friends, family and neighbours. In the aftermath of this stroke however, her speech, mobility and independence were impaired: the illness forced a change in role from carer, to cared for.
This abrupt role transition threatened to result in what in what Erikson might characterise as despair. How can one be at peace with a life well lived, when the opportunities and interactions which made that life meaningful have been torn away by illness?

Yet, with a compassionate and specialist neuro-rehabilitation team, my grandmother was able to focus on recovery. Framing her recovery in the anguage of ACT, she identified her values of independence and wanting to continue a life of helping others, so was able to focus on her goals of recovering enough ability in speech and mobility to allow her to perform these roles.

By cultivating the psychological flexibility to fully engage with recovery, she was eventually able to continue to act in a caring role, albeit a modified one. My grandmother drew on her past experiences to redevelop meaning and satisfaction in life, despite facing the challenges of old age and recovery from illness. Whether a developmental psychologist or not, one might describe this as wisdom.

'SO, WHO NEEDS AN OLD AGE PSYCHIATRIST? ANY OF US MIGHT'

Now, imagine if my grandmother, or someone very like her, faced this same scenario along with co-morbid depressive illness, psychosis or progressive cognitive decline. Imagine they were unable to resolve the conflict of who they have been with who they are becoming in the context of psychiatric illness. A clinician would be required with both a thorough understanding of the distinct conceptualisations of mental illness that occur in older adults,(8) as well as a nuanced grasp of the challenges, roles and opportunities faced in old age. Considering role transitions, and their impact on abstract concepts such as wisdom, is vital in supporting older adults navigating these complexities.

So, who needs an old age psychiatrist? Any of us might. And if I do, if I'm grappling with questions of wisdom and identity while facing psychiatric illness, I hope there's one available to treat me with the respect and care with which my grandmother was treated.

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RUNNER UP (1): WHO NEEDS AN OLD AGE PSYCHIATRIST?

Dr. Rachael Elliot, Foundation Year 1 Doctor, Doncaster and Bassetlaw NHS Trust

Summary narrative:

I was first exposed to the term "old-age psychiatry" when I was volunteering at a care home and a doctor came to see one of the residents. I knew the resident well. They were usually quite confused. I would often catch them trying to put socks in the dishwasher or pans in the washing machine. Some days, they struggled to remember who I was. Other days, I could be greeted by name and welcomed into their room. I felt confused by the fluctuation and was unsure what to expect when I arrived each day. I was just a teenager. I knew very little about dementia. When the doctor arrived, I remember the excitement of my supervisor. "These are the people that help with the minds of the old!" she explained to me. I remember thinking, "Well, they can't help! They can't make her remember all the things she has forgotten. And she's only 70!". I was lucky to grow up with grandparents that lived to 100. However, I was undeniably curious. After several questions, I was invited by the doctor to join a patient session about what was involved.

Ten years later, my exposure to old-age psychiatry both as a medical student and through personal connections has significantly deepened. A lot has changed in those ten years. I now recognize the various roles and responsibilities of old-age psychiatrists. I have seen people that I feel would benefit from input, but they are not aware that this type of doctor exists. As people live longer, the prevalence of diseases such as dementia increase. Widespread education about the role is needed as the demand for their expertise is more pressing than ever.

Embarking on a poetic voyage, I present a composition that I have written after reflecting on my personal experiences within old-age psychiatry and my journey of learning. I feel this poem reflects what it can be like to be a member of the public when you hear the word "Old-age psychiatrist" and demonstrates the importance of continuing to educate the public as well as ourselves.

'I FEEL THIS POEM REFLECTS WHAT IT CAN BE LIKE TO BE A MEMBER OF THE PUBLIC WHEN YOU HEAR THE WORD "OLD-AGE PSYCHIATRIST"'

"Who needs an old age psychiatrist?" by Dr Rachael Elliot

Who needs an old age psychiatrist?
What can an old age psychiatrist do for me?
The couple came to clinic,
Asking again, who are we here to see?

"I'm not that old", the wife exclaims!
"I've just turned sixty-five!
I've got so much more of life to live,
much more time to be alive.
I admit my memory can be poor,
But I'm old, and that is normal.
Sure, sometimes it makes me sad,
But I don't need anything formal.

I feel this won't be useful for me
And I feel a bit offended
That I need a doctor because I'm old,
And this has been recommended"

"I don't understand what's going on"
The husband sadly speaks,
"Sometimes it's like there's nothing wrong,
Other days are cold and bleak.

Some days she says she just feels down
The days she can't remember,
The date of children's birthdays
Or our Christmas last December.

I don't know how to help her,
I don't know the disease,
Today she became angry,
Because she couldn't find her keys.

We have been to many doctors,
We have done all of the tests
They suggested we come to clinic,
Where you can advise us the best"

I listen to their concerns,
A look of empathy on my face
It was not too long ago
When I thought too, that was the case.

I think back to the time, with
the frail lady in a care home,
The psychiatrist came to see her
Made her feel so less alone,

They helped her with the feelings
Of upset and distress
When she could not remember,
Weight lifted off her chest

She felt she had a purpose,
Combatted the loneliness
She developed some new hobbies,
And found a partner to impress

A sense of purpose she now had
Began to feel her best,
I was shocked to see the impact,
Unexpected, I confess

And understanding her decline,
I found it easier to cope
Knowing there was help for her,
And it filled me up with hope

I looked at the couple before me,
Knowing there was something we could do
To help them understand,
And begin to feel less blue

I knew that the psychiatrist,
Would be compassionate guide
To help navigate the storm,
Where difficult emotions did reside.

They discussed the many options,
Found something that was ideal,
And offered support for her husband
To help the partnership heal.

She was a particular patient,
That could be supported with medication,
She was enthusiastic to come back
For her re-evaluation.

On their exit room the room,
They both shook our hands
“I wish I knew you before” she said,
“You could have helped our Gran”

We cannot reverse the memory loss,
It will continue to decline,
The person we once knew,
May leave us far behind,
The memories we once had
Now a blur in their minds
What we all need to do
Is continue, to be kind.

We must continue to educate each other,
About what the psychiatrist can do
Let people know that help is near,
And their feelings are real and true.

There is no need to be alone
You don’t need to be left be,
What we all should be asking is:
“What can an old-age psychiatrist do for me?

RUNNER UP (2): WHO NEEDS AN OLD AGE PSYCHIATRIST?

Dr Robert Clafferty, Consultant Psychiatrist, NHS Lothian

I've learned the importance of a quick getaway. A seven point turn in a narrow street under the watchful eye of a patient and their relatives generates considerable stress.Today I am blessed with an easy space right outside the house. I take it as a small win.

My work life has been challenging of late: no applicants for the vacant consultant post (again), no sign of a locum on the horizon, no local admission beds available and a virtual admin mountain teetering in my digital in tray.

I re-read the referral letter: Margaret, 88, widow, retired teacher living alone, memory problems since the pandemic. Her GP suggests she is frail, feisty and fiercely independent. I wonder how best to engage her in assessment.

My evaluation begins outside her house. I suspect I share the kerbside observational skills of the rogues who recently convinced local elderly residents that they needed urgent roof repairs. Like them, I know the tell-tale signs of vulnerability: house facades which suggest maintenance schedules have fallen behind, handrails, ramps or key safes by the door and net curtains that have lost their glow.

There are two steps to the entrance – barriers to community integration. The door opens and I flash my identification badge. My name is in such small font I don't think anyone, certainly not my fellow presbyopics, could read it. Consultant Old Age Psychiatrist is partially hidden under the edge of the badge holder: sometimes it is no bad thing; I know the term frightens some people and irritates others.

"Hello, I'm the doctor here to meet your mother," I say before we begin an awkward "after you – no after you" progression down a narrow passageway towards the living room. A zimmer in the hallway is draped with coats; the rubber feet pristine.

Margaret sits regally on a winged mustard velour armchair. She is smartly dressed wearing a crew necked jumper and machine washable trousers – she could be a poster girl for M&S.She waves me towards an adjacent G-plan sofa.

She's the fourth patient called Margaret I've met so far this week and it's only Tuesday. I sit down but the seat sags such that my knees align with my shoulders. I shift the brown floral cushions attempting to gain professional poise. She's amused – I fancy she's enjoying my discomfort. She holds her right leg out straighter than her left.

'I SUSPECT I SHARE THE KERBSIDE OBSERVATIONAL SKILLS OF THE ROGUES WHO RECENTLY CONVINCED LOCAL ELDERLY RESIDENTS THAT THEY NEEDED URGENT ROOF REPAIRS. LIKE THEM, I KNOW THE TELL-TALE SIGNS OF VULNERABILITY'

"Your GP asked me to meet you."

"I've not seen him for years," she says, "you can never get an appointment."

"How are you?"

"I've been in pain since my operation... I don't feel steady on my feet... my ankles are puffy."

Then she tells me about her bowel habit. Her enthusiasm for the topic seems unbounded. Her daughter looks out the window through greyed net curtains to the uncut grass beyond.

After I have checked her pulse and she has, unbidden, twice rolled up her slacks to show me her knee operation scar I sensitively ask whether she has any concerns about her memory.

She fixes me with a look as unforgiving as the plastic splint on her oedematous right foot. I wish I could cross my legs.

"What a bloody cheek you've got!" she says with relish.

I see Margaret's daughter shifting uneasily. I too feel unsettled – I've only been allocated 45 minutes to complete the meeting. I surreptitiously glance at my watch and note with dismay that 30 minutes have passed already – I resolve to begin some direct, closed questions. I raise my gaze and find Margaret is glaring at me.

"The doctor I saw before wasn't any good," she declared, "he was always watching the clock or writing notes...he wasn't interested in me at all."

I let the pen in my hand slowly droop and I focus on my breath hoping to regain a feeling of calm centredness.

"Can I ask you some questions to test your memory?"

"There's nothing wrong with my memory!"

"Oh, you'll find it easy then...it will just take a couple of minutes... just a few standard questions I ask everyone."

"well, you'd be a real bore at a dinner party."

She knows her date of birth but is uncertain of her age or the date.

"You don't need to know these things when you retire," she says defiantly.

I think about my own impending retirement – I will leave by Christmas and there's no clear plan yet to cover the service.

Margaret is reciting the months of the year in reverse – when she reaches June she returns to July then looks a bit annoyed and declares my questions are silly. I think she might hit me with her Woman's Weekly when I ask if she can remember the name and address I had told her a few minutes earlier. I run through some depression and psychosis screening questions.I recognise the skilled teacher deflecting attention. She shoots me a withering look when I ask if she has been able to hear anything other people can't.

"He thinks I'm doolally!" she says turning to her daughter, circling her fingers beside her temple.

I carefully discuss dementia as her likely diagnosis. We talk of how she can use her strengths to be involved in planning her future. I suggest options for medication trials, links to community supports and methods to enhance her independence. She can live a fulfilling life despite dementia. I've been having discussions like this for decades: still, I don't feel I always get it right.

Margaret seems to brighten up considerably when I tell her the meeting is coming to an end and I am going to leave.

"Is there anything else you felt it was important for me to know?" I ask.

Margaret nods and shifts her weight in the chair. Her daughter and I lean forward expectantly.Margaret savours the moment as if holding the attention of a class waiting to be released after the bell has rung.

"I think I need a psychiatrist," she says, "do you know any good ones?"

HIGHLY COMMENDED (1): WHO NEEDS AN OLD AGE PSYCHIATRIST?

Dr Maroulla Anderson
CT3 Psychiatry trainee based within Greater Manchester Mental Health Foundation Trust

Let us look into the future, the year is 2059, I am now 70 years old, and I know we will always need old age psychiatrists and here's why:

Old age psychiatry is a continuing testament to medicine and psychiatry. Through the years, our understanding of pathology of disease and the pharmacology of treatments as well as the psychological aspects of treatments have grown and evolved with the times, and we are still at the forefront of research and development. This will continue especially as our population is growing larger, it is estimated there are 10,629,867 people aged 65 years or older within the UK. That is approximately 18.6% of the total population[1]. This includes over half a million (527,900) people who are at least 90 years of age.

How will this look around the world and not just the UK? In 2030, 1 in 6 people are aged 60 years or over. At this time the share of the population within this age bracket will increase from 1 billion as it was in 2020 to 1.4 billion[2].

You want to see further in the future? Ah, yes, the year is now 2050 and the world's population of people aged 60 years and older has doubled, that's a whopping 2.1 billion. The number of persons aged 80 years or older has tripled during the last three decades and is now at 426 million people[2].

ORIGINAL ARTWORK, DR MAROULLA ANDERSON

'PLEASE, WE ARE AND NEVER HAVE BEEN A "ONE SIZE FITS ALL" SOCIETY'

As we are now living longer it continues to present the same challenges and pressures around economy, services, and society.

I have been referred for a memory assessment and I see I am not the only one and as the population has increased so has the need of those requiring older adult psychiatry services and please do not assume we have the same issues because of our age. Please, we are and never have been a "one size fits all" society and we need to remember each person comes with their own health needs, capabilities, independence, disability, our own care responsibilities and we may still be contributing to society through jobs/volunteering, and we may need support from the state. As we are such a diverse group of people, let us remember that we were young once and we are still the same person (just a bit more mature). I know that later life is diverse and complex, and we should be treated as such.

We are seeing more people reaching 100 years old and as such we need to be prepared and talk about life in later years as I still would want to work (if I can) and not stereotyped as "old and unable". Let us start the conversation and start tackling the very real challenges of pensioner poverty, shortages in housing and inequalities in health and life expectancy.

What do I want from my psychiatrist? I would encourage them to ask me to use my voice, include me in discussions, do not talk around me and let me have a good later life. To my younger self, be an advocate for your patients, treat those like how you want to be treated in 2059 (if/when you get here).

To keep well, it is important to have the opportunity to talk to other people and socialise in groups. Encourage us to keep our mind and body active. As we get older, we may have more time and this can make us lose focus, encourage us to get creative and do the activities we enjoy doing.

What I am trying to say is: Ageism is discrimination against your future self and that makes no sense.

Let me finish by reciting a poem:

'Please do not forget me' – An original poem by Dr Maroulla Anderson

I have lived a good life, my face and body are a map to the life I have lived, the wrinkles are deceiving for I am young, the mirror is tricking me to thinking I am old. Please do not forget me, for I am still here.

I have greying hair, a trick to show that my age is going higher, but I am still young at heart. Please do not forget me, for I am still here.

I cannot remember as well as I used to and my mind is a strange place for, I am young, but the evidence says that I am not. Please do not forget me, for I am still here.

I need more tablets than I used to. My body giving the game away to my real age, I have plenty of doctors to see but never know if they see the real me. Please do not forget me, for I am still here.

I live alone now, the home is quiet, but my mind is busy. All my children have children, and I am still alone. My husband is with me in spirit, but he and I cannot stop the march of time. Please do not forget me, for I am still here.

I see people but can never remember their names, I sometimes forget where I have put something just knowing it must be somewhere. How can I get home when I do not know the way? Will somebody help me? Please do not forget me, for I am still here.

My children are worried that my memory is going but how can that be? When all my memories live in my heart and theirs? Please do not forget me, for I am still here.

I am in a different home now, I am not where I should be, my family come to see me but I feel invisible. I want to go home this is not where I should be. Please do not forget me, for I am still here.

So, before I disappear and depart from this life, I beg you to reach out to me and hold on with all your might. For somewhere in my bewilderment, I still linger here. Please do not forget me, for I am still here.

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HIGHLY COMMENDED (2): WHO NEEDS AN OLD AGE PSYCHIATRIST?

Dr Bharat Velani
ST4 Psychiatry Higher Trainee in dual old age and general adult psychiatry, North Central London Partnership Mental Health Foundation Trust

Autumn's Diary

21st-August-2023

My first memory of grandad is his smell, my fondest his smile, my most comforting his touch. He would arrive at my school, exchange a box of raisins for my hand, and wouldn't let go until we were home. He was a tactile person, maybe that's why he became a mechanic. His hands were always covered in soot when I visited the garage.

It was lovely to spend time with you today. Mum and dad's presence was deeply missed.

Happy 80th birthday grandad. I love you so dearly.

13th-October-2023

The doctor has referred to the memory service. My suspicion was aroused when grandad forgot the name of that book he's been trying to get me to read - something about Buddhism and maintaining a motorcycle...

24th-December-2023

I don't want grandad to suffer. What if he forgets the moments we shared together?

Like that time in the Grand Canyon when Autumn broke down. Grandad named her after me, an off-yellow 1976 Volkswagen T2 Combi. Mum was losing her mind! Every family holiday was peppered with arguments between them, "I don't understand why we must keep taking this dying van everywhere!"

Grandad would always fix it. He jumped out, opened the front bonnet, and within an hour we were off again. Maybe this is why I became an intensive care nurse – I just wanted to be like grandad, fixing things, making everyone happy again.

6th-January-2024

Hours of assessments then the psychiatrist dropped the bombshell. He has been prescribed donepezil.

We held hands. Clammy. I think the sweat was mine.

Grandad broke out into an anecdote going home,

"Do you remember when Autumn broke down in the Grand Canyon? I realised then she was dying. I had known for a while, but I allowed myself to feel it then. Her colour had always reminded me of the autumn leaves; and that day I decided to let her die with dignity and beauty, like those leaves. I stopped taking her on holiday, but drove her weekly and tended to her in the garage.

There was no need for everyone, her included, to go on suffering. I stopped trying to fix her but continued to care for her the best I could.

I had always been afraid of being afraid of dying. After that day, I was just afraid, but contented."

3rd-May-2024

Grandad is insisting on stopping donepezil. Studies show that it reduces MMSE at 24 weeks by 1-2 points. I've done my research! Why won't he listen!?

'GRANDAD IS INSISTING ON STOPPING DONEPEZIL... I'VE DONE MY RESEARCH! WHY WON'T HE LISTEN!?'

16th-March-2025

GP started him on amlodipine, statin, vitamin D and metformin. He says he feels well and doesn't see the point. I offered no choice this time!

10th-October-2026

The dreaded daily chore of giving him his pills.

"I am perfectly happy with my books!".

I've moved him in so I can monitor compliance. I need to take him to the cardiologist for his leg swelling next week.

12th-December-2026

Visited him in hospital. They started Risperidone. His chest is clear now, but he is still agitated.

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19th-June-2027

Things have been awful. I don't know what to do anymore. Amlodipine switched to ramipril due to leg swelling - hospital for UTI - another admission with AKI - ramipril switched back to amlodipine but the doctors wouldn't listen about the leg swelling!

I have to take him to the geriatrician tomorrow

25th-March-2028

He has been admitted to a dementia ward. It was my fault I didn't lock the door. I'm meeting with the old age psychiatrist tomorrow. Worried they are going to suggest a care home.

26th-March-2028

The old age psychiatrist is Dr Rubelk-Ross. Name seems familiar...

She focussed on things not related to Psychiatry, like stopping the statins, metformin, anti-hypertensives and vitamin D. She seemed to know her stuff. Must have been a medical consultant before!

She explained that statins are given to prevent 10-year-risk of cardiovascular events and that life-expectancy from dementia diagnosis is not usually more than ten years. I had never really thought of it like that...

20th-April-2028

They put a picture of Autumn next to Grandad at around sunset each day – it seems to sooth him. Dr Rubelk-Ross stopped his Risperidone because it wasn't working. They sometimes use promethazine which settles him.

8th-May-2028

Grandad is steadier on his feet now. He is enjoying the walking-chess they play with the OTs.

Dr Rubelk-Ross spoke to me about what we would do if grandad declined in health and discussed ceiling of care.

22nd-May-2028

Dr Rubelk-Ross kindly met with me. I wanted to say that I felt "end-of-life planning" was a bit premature. I actually did most of the talking, she just made a few comments here-and-there. We ended up talking about my parents and "Thanatophobia".

I have never had a conversation with a doctor for more than 20 minutes, even at work! I feel lighter somehow.

8th-June-2028

Grandad and I talked about the Grand Canyon today. He didn't remember why mum was angry that day, but he quipped, "Jenny is more highly strung than Pinocchio.... with OCD!". I don't know who Jenny is, but I was crying of laughter.

Saw Dr Rubelk-Ross on the way out and she recommended a book, "Staring at the Sun – by Irvin D Yalom".

'I HAVE NEVER HAD A CONVERSATION WITH A DOCTOR FOR MORE THAN 20 MINUTES, EVEN AT WORK! '

19th-June-2028

Something spooky happened today.

Dr Rubelk-Ross and I were talking about care homes but ended up talking about life. Reflecting on her own experience as an old age psychiatrist she said,

"I was once afraid of being afraid of dying.... now I am just afraid, but contented".

I had to double check, but those were the same words grandad had used!

I have goose bumps writing it, but I think everything has just clicked. I understand what grandad was talking about the day he was diagnosed. Come to think of it, that was the last time I spoke to an old age psychiatrist until I met Dr Rubelk-Ross...

Grandad, I will stop trying to fix you, but I will continue to care for you as best I can. Like you said, why go on suffering.

TRAINEE FOCUS: WHAT SHOULD I DO WITH MY SPECIAL INTEREST TIME?

Joanne Hew and **Rebecca Fitton,** Higher Trainee Representatives of the RCPsych Old Age Faculty

How to begin:

Setting up a special interest may be daunting as a new trainee – it is difficult to know where to start with all the opportunities on offer. The amount of special interest time varies by deanery. For less than full time trainees, the entitlement is pro-rated. These sessions are now becoming known as *professional development sessions*.

Here are some tips:

1. Identify any interests and look for opportunities in those areas.
2. Speak to your educational supervisor and fellow trainees to see if there are any opportunities you haven't thought about.
3. Try to cover the different aspects (clinical, teaching, leadership, research) over the time of your training. This will give you an idea of what you might enjoy developing further as a consultant.
4. Plan your special interest time with your supervisor and reflect on the skills/knowledge you'd like to develop during this time.
5. Discuss with your clinical supervisor about which day/time you can take as special interest – ensure your clinical workload does not encroach on this time.

1. Clinical

Opportunities:

Addictions, Neuropsychiatry, Forensic, Liaison, ECT, rTMS, Psychotherapy and others.

Physical health experiences - Geriatrics ward rounds and clinics, Stroke clinics, Neurology clinics (eg Parkinson's Disease clinics)

How?

Identify your area of interest and then identify a suitable supervisor. If in doubt, ask your fellow trainees or your educational/clinical supervisor – they should be able to point you in the right direction.

Gaining a qualification

Consider undertaking the Diploma of Geriatric Medicine qualification by the Royal College of Physicians. This could help increase your confidence in managing the care of older people.

'I found it really useful to attend an ECT clinic for a few months, and thanks to the knowledge, training and support of colleagues in the ECT department I gained both confidence and competence to administer ECT and lead a list. I anticipate this will be very useful throughout my career, in all sorts of ways. In my current old age liaison psychiatry post, for example, I have been involved in the care of a number of patients who have needed ECT but have been deemed inappropriate to undergo a General Anaesthetic in the ECT clinic, which is in a standalone mental health hospital. Alongside my liaison colleagues, we have been able to administer lifesaving ECT on the emergency theatre list in the general hospital on a number of rare occasions.' - Jennifer Parker, ST5

'I took a year out of training to undertake a role as a Teaching Fellow. When I returned to training, I continued studying for the Postgraduate Certificate in Medical Education. The theories and skills I learnt from this qualification allowed me to reflect and improve on my teaching practice, using different techniques and novel ways of teaching to engage my students. I have actively sought teaching opportunities in my trust, and devised teaching programmes for my team when I identified a gap in knowledge. I feel much more confident when teaching and am motivated to continue to learn and improve. I would recommend pursuing the qualification if you have a strong interest in medical education, as this will improve your practice as a clinical teacher.' - Joanne Hew, ST6

2. Teaching

Opportunities:

Clinical lectures, OSCEs, simulation based learning, CASC practice, developing teaching materials etc.

How?

Keep a lookout for mailers from your local medical school or speak to the medical education department – they will be more than happy to let you know what opportunities are available.

Gaining a qualification

Consider undertaking a Postgraduate Certificate in Medical Education. These courses are available part time in many universities, and some can be done virtually.

3. Leadership

Opportunities:

Local representative roles, Royal College leadership roles e.g. Psychiatric Trainee Committee roles, trainee representative roles on the various faculties and special interest groups, other organisational roles e.g. BMA.

Conducting serious incident investigations in your trust.

Shadowing clinical/medical directors in your trust.

How?

Look out for advertisements for roles locally and on the RCPsych website/mailers.

Approach a senior medical leader to find out about opportunities in your local trust.

Contact the serious incident investigations team to find out more.

Gaining a qualification

The Royal College runs a yearly Leadership and Management Fellow Scheme. This allows the development of your leadership skills, supported by senior leadership in your trust.

I used my specialist interest time in part for the role of higher trainee rep for the RCpsych old age faculty committee. This is a co-opted role alongside another trainee rep and vacancies are advertised usually on an annual basis. It involves representing trainees in quarterly meetings with members of the faculty. We also organise the Old Age Trainees' Annual Conference as well as contributing content new Trainee section of the Old Age Faculty Newsletter. It has been useful for developing management skills and "seeing inside" how the RCPsych runs. I have enjoyed seeing how the faculty develops policies and pioneers new treatment developments, for example in its work updating members on advances in disease modifying drugs in Alzheimer's disease". - Rebecca Fitton, ST6

'II approached a Consultant Psychiatrists working in palliative care liaison who put me in contact with the academic unit of a local hospice. The clinical nurse specialists and doctors working within the community palliative care team wanted an evidence based resource when caring for those who are dying with dementia so I have been developing a dementia toolkit for them. This involved carrying out an initial literature search for preexisting evidence, shadowing the palliative care clinical nurse specialists and carrying out focus groups with palliative care and CMHT colleagues. I then pulled together a comprehensive clinical resource that addresses things like; What is dementia vs cognitive impairment, what are the subtypes of dementia, dementia vs. delirium, symptom assessment in dementia, mapping out of other services and evidence-based prescribing in dementia. This year has afforded me a great opportunity to learn more about palliative care, develop relationships with my palliative care colleagues whilst working together to improve patient care, quality of life and dignity in dying for a shared patient group" - Eimear Devlin, ST5

4. Audit/ Quality Improvement

Opportunities:

Preexisting local audit and QIs, or develop your own.

How?

Discuss with your supervisor/team leader about local opportunities.

Your trust may have a QI team, who can help with setting up the QI, giving you advice and access to materials and tools – link in with them!

Improving your skills

Your local trust may run QI workshops.

The RCPsych website has links and online training modules regarding QI.

5. Research

Opportunities:

Collecting or analysing data in preexisting studies, conducting initial assessments for participants, assessing treatment response.

Writing up an interesting case report, writing an opinion piece on a contentious topic, conducting a systematic review.

How?

If you have a particular interest, look for supervisors who conduct research in that area.

Speak to your educational/clinical supervisor/research leads who can point you in the right direction.

Join a Cochrane authorship team to contribute to a review of interest.

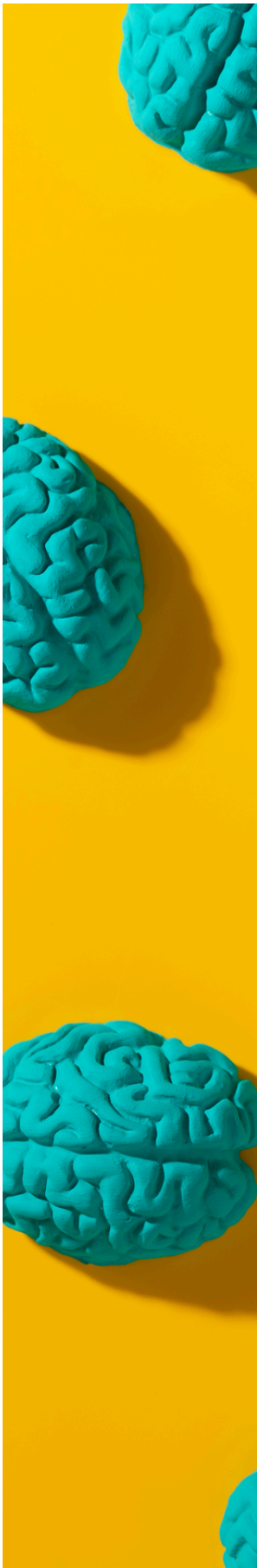
If this is your first time writing a paper, seek advice and supervision from someone who has experience in this!

Conclusion

This guide hopefully gives you an idea of what opportunities are available. However, the possibilities are endless. Speaking to your educational supervisor to find out what local opportunities are available can be very helpful in planning your special interest time. It is also possible to pursue a special interest out of your trust – you may be able to get an honorary contract to enable you to access notes etc, so do not be afraid to look for opportunities a little further afield.

TRAINEE FOCUS: CPD CORNER

Joanne Hew 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 including a "CPD corner" in the trainee section of the newsletter. Each edition, we will have a round up of any upcoming courses or conferences that might be useful. We invite any short reviews of any courses or conferences you have attended which could be added.

Upcoming Courses:

European Association of Geriatric Psychiatry (EAGP) "Refresher Course"
27-29th September 2024, Leuven (Belgium)

This intensive three-day course in old age psychiatry will provide an in depth review of selected topics, guided case discussions and will update you with the latest high quality research relevant for clinical practice.

Cambridge dementia course
5-6th December 2024 Hybrid online/in-person course at Homerton college, Cambridge

2 day in-depth course aimed at neurology and psychiatry registrars and new consultants covering Alzheimer's Disease, Frontotemporal Dementia, Lewy Body Dementia, Prion Disease and rarer forms of Dementia.
Places book up fast, and it is worth getting your name on the waiting list sooner rather than later.

British Association for Psychopharmacology Certificate Course: Drug Treatments in Old Age Psychiatry
October 2024 (dates tbc), The Royal Station Hotel, Neville St, Newcastle upon Tyne

This two day course will provide an update on current thinking in the drug treatment of an array of old age focused psychiatric conditions, including dementia.

Please send us any reviews of courses or conferences that we can feature in the next edition!
Email Rebecca.fitton1@nhs.net or joanne.hew@doctors.org.uk