RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

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HELLO

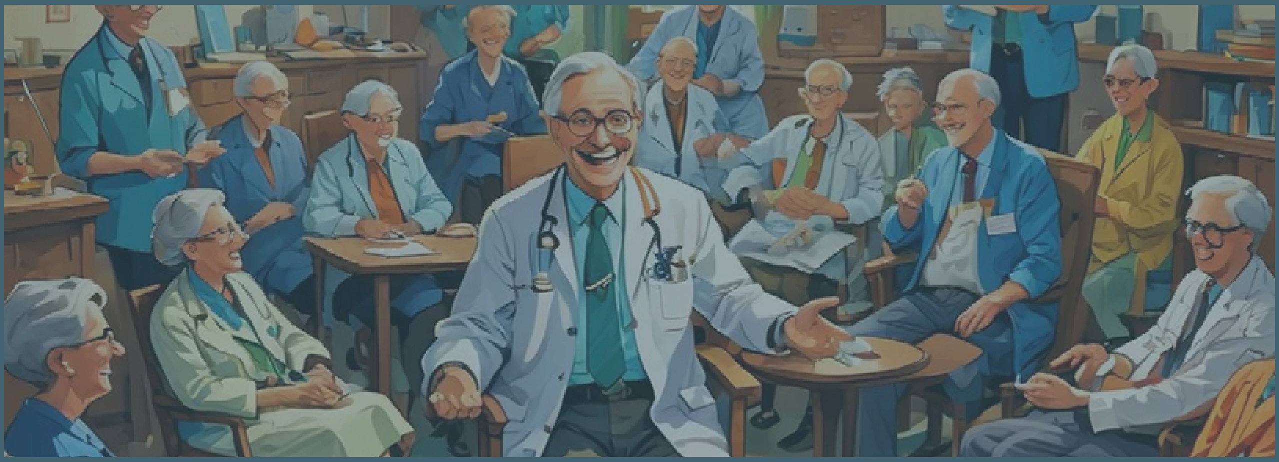
Welcome to Issue 90, September 2024, of the RCPsych Old Age Faculty Newsletter

Editorial Team

Shaheen Shora - Lead Editor
Curtis Osborne - Trainee Editor
Jennifer Parker - Trainee Editor

Correspondence email: oldage@rcpsych.ac.uk

Cover Information



‘Artificial Intelligence(AI) and the Old Age Psychiatrist

The cover of this issue is a collage of images created by Artificial Intelligence, and you’ll see more AI images throughout. We asked a variety of AI image generators to depict an Old Age Psychiatrist and were amused by the rather psychedelic and white coat-heavy results. We were saddened, too, not to encounter much diversity in what the machine believes an Old Age Psychiatrist looks like: a reminder that we must continue to champion our diverse workforce online. We hope some of you are encircled by colleagues in rapturous appreciation of your work, or working from beautiful light-filled conservatories as these AI psychiatrists are.

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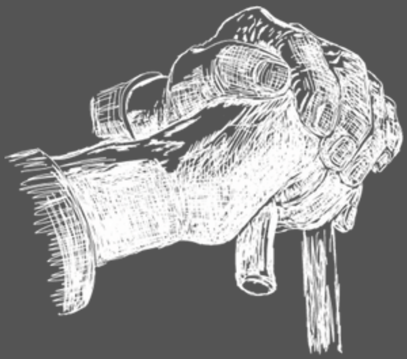


UPDATE FROM THE EDITORIAL TEAM

I hope you all had a lovely summer and were able to spend some quality time with your families and friends. A lot has happened since our last newsletter – we have a new government in the UK, NHS 111 is offering crisis mental health support for the first time and NHS in England is one of the first countries in the world to offer access to a 24/7 mental health crisis support through one single phone line to people of all ages. We are in exciting times for Old Age Psychiatry.

Congratulations and a warm welcome to Dr Mohan Bhat as Chair and Dr Ben Underwood as the Vice Chair of the Old Age Faculty. Mohan has in his write up set the vision and 'Focus for the next 4 years' with 5 clear strategic aims for the Old Age Faculty.

The editorial team would like to express our deepest sympathies to Prof Dave Jolley's family and friends. Prof Jolley sadly passed away in May this year, and Prof Susan Benbow has penned a heartfelt tribute in his memory.

We have some interesting articles in this edition, including one on 'Sustainability in Old Age' by Katherine Witter, a 'Dementia Support Initiative in Egypt', and 'Infectious diseases and Cognitive Impairment' by Alex May and Jennifer Parker to name a few.

Dr Sujoy Mukerjee has written a succinct update on European association of Geriatric Psychiatry (EAGP) and Anitha Howard has sent us a valuable book review on the fascinating topic of ethics relating to dementia care.

The impact of technology barriers in Old Age by Curtis Osborne is another great read.

I want to take this opportunity to thank Jennie and Curtis, our 2 amazing higher trainee editors for their tremendous input to this edition. I also want to thank all of those who contributed by sending us interesting case reviews and articles & made this edition varied and enriching, which I hope you all will enjoy reading. A final thanks goes to our faculty manager, Kitti Kottasz for her unwavering support.

Do consider sharing your interesting pieces of work and case reviews for the newsletter by emailing kitti.kottasz@rcpsych.ac.uk or oldage@rcpsych.ac.uk. For the January edition, we have chosen the theme of 'Equity, Diversity and Inclusion' in Old Age services and any articles in this area would be very welcome.

On a personal front, I was honoured to receive the fellowship of the college from our President, Dr Lade Smith CBE, in June '24.

With best wishes

Dr Shaheen Shora
Lead Editor

VIEW FROM THE CHAIR

Dr Mohan Bhat

Chair of the Faculty of Old Age Psychiatry

Dear Colleagues and members of the Faculty of Old age psychiatry,

I hope you all had a restful break during the summer. This is my first message to you as the Faculty Chair, a role I assumed in July 2024. I would like to extend my heartfelt thanks to Dr. Mani Santhana Krishnan, affectionately known as Krish, for his tireless work and excellent leadership as the previous chair, especially for navigating the faculty during the challenging times of COVID. I also want to express my gratitude to Dr. Josie Jenkinson, our outgoing vice chair, for her significant contributions, particularly in advancing the cause of Liaison Old Age Psychiatry and enhancing our faculty's presence on social media.

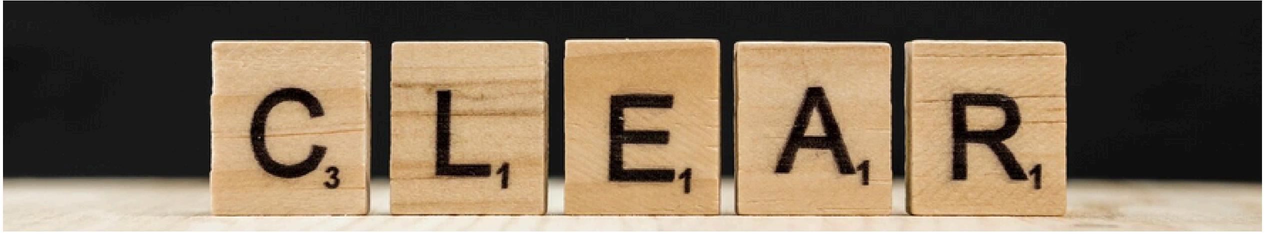
I am pleased to welcome Dr. Ben Underwood, who joins me as the new vice chair, and Bob Barber, who takes on the role of finance officer. Together with our elected and co-opted faculty members and Dr.Chineze Ivenso, our academic secretary (About the old age psychiatry faculty (rcpsych.ac.uk),we look forward to engaging with all of you. Our goal will be to promote the mental health and well-being of older people and their families by supporting and providing opportunities of continuous professional development for old age psychiatrists, preparing our trainees for future service and leadership roles, and collaborating with other stakeholders to share and promote best practices.

A bit about me

I began my UK journey in psychiatry as an international medical graduate from India, starting my training in Liverpool in 1994. After completing my specialist training in East London, I took on my consultant role there in 2002. As a clinician, educator, and medical manager, I am passionate about enhancing and delivering evidence-based practices, with a strong focus on promoting the early translation of research and adoption of it into clinical settings. I've been involved with the faculty for the past six years, serving as both the academic secretary and finance officer before stepping into my current role.

What will be my focus for the next 4 years?

Our faculty executive team had productive meeting at the end of June, and we agreed our strategic aims for the next four years. In keeping with the overall College goals, we came up with 5 "CLEAR" strategic aims that will guide us moving forward.



Here's what "CLEAR" stands for:

****C: Clinician Engagement****
We're all about connecting with our practicing clinicians. We will aim to keep them updated with the latest information and best practices and thus support and enable them to provide best care to our patients. Continuous professional development is key!

****L: Leadership Development****
Our goal is to develop our members into effective leaders in service development. We want to empower them to be able to contribute to local and national policy development and be role models for the future medical workforce.

****E: Educational Activities****
Education and Training is at the heart of what we do. We aim to promote, provide, and support educational activities for clinicians, trainees, patients, and carers. Whilst our aim will be to provide various opportunities for Continuous professional development of our members , we also recognise the need to prepare our workforce of future to meet with the challenges of the delivery of health care in the future.

****A: Advocacy and Ambassadorship****
We're committed to advocating for our patients at every opportunity that arises either locally or nationally. We also recognise the need for us as faculty to work collaboratively with voluntary agencies in areas like promoting research, developing policies and increasing the profile of the health care needs of our patient population. We want to shine a spotlight on old age psychiatry and expand our international influence

R: Research Network*
We're looking to build a robust research network in the UK. Our aim is to promote and influence in the time it takes for research to translate into clinical practice and to promote evidence-based practice.

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What We Have started So Far?
I am excited to announce that, as part of our initiative to engage more effectively with our higher trainees, we will be launching a quarterly webinar series tailored to their needs. This series will be led by the trainees themselves working with the faculty exec representatives, in collaboration with the college's CALC team, ensuring that it carries the credibility of the college.

Additionally, I am working on establishing a new consultant group in old age psychiatry aimed at fostering mutual support and nurturing future leaders in our faculty. We are also planning a webinar to support this group, which will take place next year.

We are in the process of updating the CPD modules related to our clinical practice within the College CPD resource. Furthermore, we will strive to provide our members with summaries of literature reviews on relevant topics, utilizing the resources available through the college library. Please do visit our faculty website Faculty of Old Age Psychiatry (rcpsych.ac.uk) for information on regular updates.

Dr Kallur Suresh and Dr Alex Bailey have been actively developing an international diploma in old age psychiatry, which the college is launching in September 2024. The RCPsych International Diploma in Older Adults' Mental Health will be a new knowledge enhancement program designed for overseas doctors seeking to upskill or refresh their understanding of the most common mental disorders in older adults, including their presentation and management. IInternational Diploma (rcpsych.ac.uk).

What to look out for?

I am pleased to announce that Dr Chineze and Dr Barber are organizing our winter conference, scheduled for December 13th. This will be an online event, and I encourage you to keep an eye out for the program on our faculty website which is currently being finalized.

I am also excited to share that the next annual faculty conference will take place in Liverpool in March 2025.

This will be a hybrid conference and will be my first faculty conference as chair. I am looking forward to meeting our faculty members in person at this face-to-face conference.

Additionally, please be on the lookout for the report from the National Audit of Dementia, published in August 2024 Layout 1 (rcpsych.ac.uk). This report examines various aspects of memory service delivery standards in England. Key findings indicate an overall increase in waiting times from referral to assessment and diagnosis, as well as significant variations between services. The report includes four sets of recommendations for implementation from local to national level. I urge all of you to provide leadership locally to enhance the standards of memory assessment services.

Furthermore, the faculty is actively collaborating with NICE and has submitted comments regarding various disease-modifying treatments. We are currently awaiting the outcome of their appraisal.

Finally

I want to thank Dr Shaheen Shora who has taken on the role as the Editor of our faculty news letter. I take this opportunity to request you all to submit articles /notes/ experiences for our faculty newsletter. Also please feel free to contact me if you have any ideas relating to any of our strategic aims that you want to share with me for consideration.

Mohan.bhat1@nhs.net.

WHAT'S NEW IN OLDER ADULTS' MENTAL HEALTH

Dr Amanda Thompsell - amanda.thompsell@nhs.net, National Speciality Advisor for Older people's Mental Health NHSE&I

As ever, my focus will be on new developments or resources that have been published since the last newsletter.

As some of you may have noticed, we have a new government, and it has new ministers who will decide on the direction of travel. Having outlined their 5 key missions it is good to see "improving the NHS" is one of them. We have already seen that Wes Streeting has made several comments such as "anyone who works in or uses the NHS can see it is broken" and that CQC is "not fit for purpose". It is fair to assume that more change will be on the agenda. It seems there is a commitment to reforming the Mental Health Act — and to expand the mental health workforce with an additional 8500 mental health staff .How/if these plans will be funded will depend on the finances. Whilst it is clear change is coming, the shape of that change remains unclear. As a result the content in this newsletter is less than normal.

What's new in Older Adults' Mental Health

A small pot of money has been allocated to develop more of the OPMH competencies training for Tier 1 and 2 individuals (ie those needing a general awareness of OPMH and those who regularly work with older people) although it is likely to be at least a year before this comes through.

NHSE is looking are aiming to try to get the names of the leads for Dementia and OPMH leads in the Integrated Care Boards(ICBs). This will improve communication with and between ICBs. Whilst this is not the first attempt at getting this information this time there is a far greater enthusiasm to have this information . If you know who are the leads for your ICB, please send their contact details to me at the address below and I will make sure that this goes to those who need to know.

Following the tragedy in Nottinghamshire in July 2024, NHS England asked all ICBs to review their policies and practices regarding the care of people with severe mental illness who require treatment but where engagement is a challenge (see NHS England's publication NHS England » Guidance on intensive and assertive community mental health treatment.) This guidance covers the following:

- Themes and lessons for services from severe untoward incidents;
- The features of intensive and assertive community care; and
- How ICBs should undertake local reviews.

Whilst older adults are not specifically mentioned in this document, it does definitely apply to them as well so older adult services should be reviewing their intensive and assertive community care.

Given the long-standing focus by the government on improving discharge from acute hospital inpatient beds, there is currently a piece of work looking at providing suggestions of changes that can be made that will have a high impact. It is already clear that getting discharge right for older adults will have a disproportionately high impact on the whole system. We expect the recommendations to be available by the time of the next quarterly newsletter.

In my role with NHSE, I am continuing with Jeremy's support to increase our link with frailty services which I see as especially important as there is a drive for even greater integration .It will be essential that mental health is not left out when physical health and social care work more closely together-one of the themes emerging from the College Report on Frailty in 2020 which outlines the value of older adult mental health input into frailty services (ps02_20.pdf (rcpsych.ac.uk)

We all know that talking therapies are an important element in supporting people back into work, but as the Centre for Ageing Better has recently pointed out by 2030, there will be an additional 1.2 million people aged 50-64 in the UK, but only another 500,000 people aged 15-29. The future of UK growth and productivity depends on mobilising the 50+ workforce . There is therefore a strong case to be made for improving the access to older adults, including those who have retired, to benefit from these services.

What's new in Dementia

The National Audit of Dementia's Audit Spotlight Audit 2023 National Report Layout 1 (rcpsych.ac.uk)was released in August 2024. This paints a picture of memory services across England and Wales that is less than flattering. There are considerable delays, which have increased substantially over the last few years, in accessing Memory Assessment Services (MAS) . The delays range from 13 to 268 days and are at the higher end in the most deprived areas. There is a similarly wide and worsening variation across regions in the time taken between referral and obtaining a diagnosis. It was also noted that there was wide variation in the frequency of particular subtypes of dementia being recognised. Whilst there may be many potential reasons for all of these variations it is also important that we interrogate our data to ascertain the potential reasons in our particular service. I know that the Executive of the Old Age Faculty of the RCPsych are keen to support MAS services .

The so-named Dementia Profile was developed originally to support the work of the Dementia Intelligence Network in providing health intelligence withwhichto inform the provision of care of people in England who have dementia. There has recently been update of the Dementia Profile. This can be accessed via the Dementia Surveillance Factsheet on the Fingertips platform Dementia Profile - 2. Dementia new indicators factsheets | Fingertips | Department of Health and Social Care (phe.org.uk).(Aug 2024) The data used for the Dementia Profile is based on the statistics taken from primary care settings. The new data includes localised information on new diagnoses; dementia incidence rates ;on the numbers of people with dementia who also appear on primary care palliative and end of life care registers; as well as the numbers of those with dementia and cardiovascular comorbidities recorded in the primary care system. It also provides the numbers of those recorded with mild cognitive impairment and people with the diagnosis prior to 65 years of age.

At long last the updated Right Care scenario that I have been repeatedly mentioning has been published (Aug 2024) NHS England » RightCare dementia scenario .The various scenarios describe a fictional person living with dementia and his wife (Tom and Barbara) to show the difference between a suboptimal, but realistic, pathway of care compared to an optimal one.

The aims of these scenarios are to help those on the ground to understand how patient outcomes and quality of life can be improved through shifting the care pathway from a suboptimal journey to an optimal one. It has a range of useful links as well as some suggested questions systems should ask themselves. Supporting summaries of the scenarios and summary dementia data packs can be found on the RightCare FutureNHS site. It is well worth a look.

Just a quick reminder that the dementia pathway data is set out under policy priorities in the Model Health System dashboard.

As you will have noticed I have deliberately omitted to discuss the decisions of NICE and MHRA decision concerning lecanemab as I see this as an ongoing issue and by the time you read it whatever I have said will be out of date

If you have any questions please do not hesitate to contact me amanda.thompsell@nhs.net and I will try and answer them or find the right person to contact.

IN MEMORANDUM: PROF. DAVE JOLLEY: PHYSICALLY QUITE SMALL, A GIANT IN ACHIEVEMENTS

Dr Susan Mary Benbow, Consultant Old Age Psychiatrist

Dave Jolley (died 17 May 2024 aged 79)

I can only give a flavour here of the Dave Jolley that I knew and his many achievements but many people in old age psychiatry will know of Dave and his remarkable career. I first came across Dave when I was on the psychiatry rotational training, working in South Manchester. At that time, he was a consultant at Withington Hospital, having been appointed consultant with responsibility for older people in November 1975. One late afternoon, when I was on call, I took a call from someone who started by asking: “are you the duty shrink?” I bristled but then discovered it was one of the consultants – it was Dr Jolley asking me to admit one of his patients and I had just been introduced to his irreverence and humour.

Later, as a Senior Registrar, I was offered the choice of an old age psychiatry placement or a psychotherapy placement. One of the other Senior Registrars, who bizarrely became an old age psychiatrist, warned me that if I specialised in old age everyone would shout at me! Instead, I believed Sue Hodgson (now Sue Jolley) who said: “it’s great, you’ll love it!” And I did, thanks to Dave, his enthusiasm and commitment.

Dave had trained at Guy’s at a time when he saw enormous advances in understanding and treating mental disorders, sadly alongside scandals in the care of older people with mental illness. Eventually he migrated to the North West and Withington Hospital. There was no specialist training in old age psychiatry at that time, it wasn’t a speciality, but Dave got sponsorship from the North West Region for a year training with pioneers in the developing field, including Tom Arie, Felix Post and John Brocklehurst. These experiences prepared him to develop services, teaching and research initiatives once he became a consultant.

So, I was lucky to train with Dave – the home visit model, working with families, caring, following up and supporting people living with dementia to the end. I saw how he connected with his patients as real people with important and unique histories, experiences, and opinions; how he didn’t stand on ceremony; how he stood up for them and their families when that was needed. I saw how his model worked, and how Dave’s patients, their families and his work colleagues in the older adult service loved him. He was an early pioneer in old age psychiatry who catalysed developments in services across the Region and more widely, and who became a renowned developer of services. He introduced his trainees to the Section of Old Age Psychiatry – later the Faculty of Old Age Psychiatry - at the Royal College of Psychiatrists. He served as Chair of the Section and spoke powerfully in favour of old age psychiatry becoming a specialty, which it did.

Thus, he made the most of opportunities, showed the rest of us how to do it, and inspired the generation that followed. After training with Dave, I worked next door - him in south Manchester and me in Central. My patients remembered him warmly and made it clear that they missed him, wondering whether he would agree with my proposed treatment plans.

When he moved to Wolverhampton (a city close to his heart and where he grew up) to apply his prodigious energy to developing services there, I followed him, and, when he developed an innovative memory clinic in a GP practice, I took on the clinic following one of his retirements. I learned so much from Dave, including how to be a serial retiree, watching him retire from one role and move on to another. I think of him as being irreverent in the best possible way. He didn't feel the need to do things the way other people had always done them - he had the courage to do things his own way, always in the interest of the people using services. He was a leader who spoke his mind - I've seen him stand up, speak and sway a room full of psychiatrists at the Royal College of Psychiatrists and that is quite an achievement. I've never met anyone who retired so many times yet never stopped working in the interests of people who needed him.

Alongside developing services, Dave developed academic activities, taught, trained, and wrote. He established the West Midlands Dementia Centre (Dementia Plus) in Wolverhampton and published a series of journal articles about the primary care memory service at Gnosall that attracted national interest. He went on to work in a Hospice developing a palliative care service for people with dementia and his interest in spirituality and life-long Methodism led to him joining and chairing Christians on Ageing. We wrote together over many years - I loved writing with him: we could chew things over together. He had the knack of identifying an apt and eye-catching title, and his facility with adjectives was incomparable. His philosophy was that it didn't really matter that we should publish in a first-rate journal - what mattered was to get findings and ideas out there, to contribute to debate, and so that other people could draw on them in their own way. Over time Dave had become a friend, and he continued to be my mentor after I too retired. I knew Sue Jolley from our time both working at Withington Hospital: she had been Senior Registrar when I was a registrar.

JOHN LEIGH PARK, ALTRINCHAM, FROM: HTTPS://JOHNLEIGHPARK.ORG.UK/

Friends of John Leigh Park was a project outside medicine. I didn't know, until I read Dave's own account of his life, that he had cared for chickens and budgies in an outside aviary when he was growing up, so perhaps it's not surprising that he (with others) resisted the closure of the aviary in the park. The park has grown from strength to strength and I was privileged to see Dave doing his rounds in the park. The park has grown from strength to strength and I was privileged to see Dave doing his rounds in the park, speaking to people walking dogs, meeting up with parents bringing their children to play, and encouraging volunteers, while enthusiastically describing developments in the pipeline.

One of the honours that meant a lot to Dave was being Honorary Professor at Wolverhampton, his home town. Another was bestowed by the Steward of the Court Leet on 11 May 2024, six days before he died, when Dave became a Freeman of Altrincham for his work in the community and in John Leigh Park. The rights and privileges within the Lordship of Dunham Massey include walking sheep through Altrincham and getting free ale! A life well lived.

Physically Dave may have been quite small, but he was a giant in his achievements and a giant as a friend.

THE DIGITAL DIVIDE: THE IMPACT OF TECHNOLOGY BARRIERS ON THE ELDERLY IN THE UK

Dr Curtis Osborne, Trainee Editor

Introduction

The rapid development of technology has transformed many aspects of daily life, from communication to accessing services and information. However, not all demographics have benefitted equally from this digital revolution. In the UK, a significant proportion of elderly people struggle to use technology, including apps, websites, and smartphones, leading to digital exclusion that exacerbates social isolation, limits access to essential services, and hinders their ability to participate fully in modern society. This article explores the challenges faced by the elderly in navigating technology, the implications of these challenges, and potential solutions to bridge this digital divide, drawing on recent scientific research

The Extent of Technology Use Among the Elderly

Digital inequality remains a significant issue for the elderly in the UK, particularly those aged 75 and over. According to the Office for National Statistics (ONS), around 54% of individuals in this age group had not used the internet within the past three months as of 2020 (ONS, 2020). This reflects a broader trend of digital exclusion among older adults. Research indicates that older adults are less likely to use digital technology, with many citing a lack of confidence or interest in engaging with online platforms (Helsper & Reisdorf, 2017). The Age UK Charity highlights that 3.8 million people aged 65 and over have never used the internet, largely due to technology being perceived as too difficult or irrelevant to their lives (Age UK, 2021).

The digital divide is particularly pronounced among the oldest segments of the population. While younger elderly individuals (aged 65-74) have increasingly adopted technology, those aged 75 and older continue to lag behind, often due to physical and cognitive limitations (Bevis & Reardon, 2019). Despite growing internet usage among the elderly, many still lack access to essential devices such as smartphones, tablets, or computers. The complexity and cost of these devices further exacerbate the barriers to digital inclusion (Good Things Foundation, 2021).

Barriers to Technology Adoption Among the Elderly

Several factors contribute to the low levels of technology adoption and proficiency among the elderly in the UK. One of the most significant barriers is a lack of digital literacy. Research indicates that many older adults struggle with digital skills, particularly those who have limited prior exposure to technology (Bevis & Reardon, 2019). According to the Lloyds Bank UK Consumer Digital Index, 52% of people aged 65 and over have very low digital capability, meaning they lack the basic skills required to navigate the internet, use apps, or manage their online presence (Lloyds Bank, 2021). This lack of digital literacy can be attributed to the fact that many older adults did not grow up with technology and may find it challenging to learn new skills in later life.
Physical and cognitive limitations further exacerbate these challenges. Age-related conditions such as arthritis, poor vision, and hearing loss can make it difficult for older adults to use devices that require fine motor skills or involve reading small text on screens (Charness & Boot, 2016).

Cognitive decline, which affects a significant portion of the elderly population, can also make it difficult to remember passwords, follow complex instructions, or understand how to navigate digital interfaces (Bevis & Reardon, 2019). This combination of physical and cognitive barriers contributes to the digital exclusion experienced by many elderly individuals.

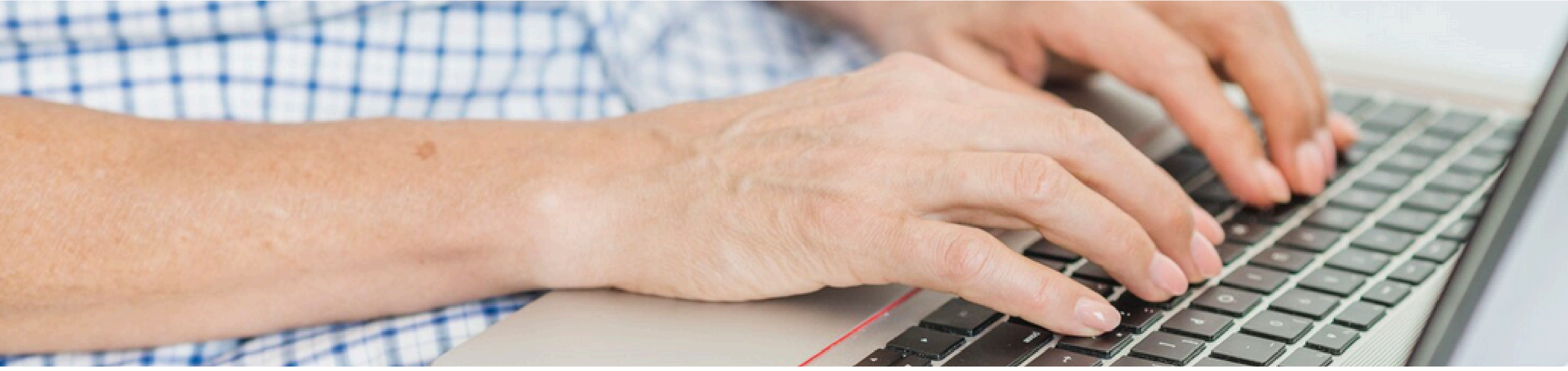
Another barrier is the perception that technology is not relevant to their lives. According to a study by the Centre for Ageing Better (2021), 61% of non-internet users over 50 felt that technology was not useful or relevant to them. This perception is often reinforced by negative experiences with technology, such as encountering poorly designed websites or apps that are not user-friendly for older adults (Helsper & Reisdorf, 2017). These experiences can leave elderly users feeling frustrated and discouraged, further diminishing their willingness to engage with digital tools.

Cost is also a significant factor that deters older adults from adopting technology. Many elderly individuals live on fixed incomes and may struggle to afford the upfront costs of purchasing a device, as well as the ongoing expenses of internet access and data plans. Age UK reports that nearly two million pensioners were living below the poverty line in 2020, making technology seem like an unaffordable luxury rather than a necessity (Age UK, 2021). This financial barrier further compounds the digital divide, preventing older adults from accessing the benefits of digital technology.

Disadvantages Faced by the Elderly Due to Technology Barriers

The inability to effectively use technology puts elderly individuals at a significant disadvantage in many areas of life. One of the most pressing concerns is access to essential services. In recent years, many services that were once delivered in person or over the phone have shifted to digital platforms, making it more difficult for those who are not digitally literate to access them. According to a study by Yeandle and Henz (2021), digital exclusion among older adults can significantly impact their ability to access public services, including healthcare and social services. The shift to online systems means that elderly individuals who lack digital skills may struggle to claim the benefits they are entitled to or access important health information.

Healthcare is another area where the digital divide is particularly impactful. The NHS has increasingly moved towards digital-first services, with many appointments and consultations now taking place via video calls or online forms. While these innovations can improve efficiency and reduce waiting times, they also create barriers for those who are unable or unwilling to use technology. Research by the Health Foundation (2021) found that one in four people aged 65 and over had difficulties accessing healthcare during the COVID-19 pandemic due to the reliance on digital platforms. This lack of access can have serious consequences for the health and well-being of elderly individuals, particularly those with chronic conditions who require regular medical attention.



The digital divide also affects elderly individuals' ability to manage their finances. As online banking becomes the norm, those who are not comfortable using the internet may find it increasingly difficult to manage their money. A survey by Age UK (2020) found that 27% of people aged 65 and over felt that managing their money had become more difficult due to the move towards online banking. Without access to digital banking tools, elderly individuals may struggle to pay bills, monitor their accounts, or protect themselves from fraud. This digital exclusion can leave them vulnerable to financial difficulties and exploitation.

Social isolation is another major issue exacerbated by the digital divide. Technology plays an increasingly important role in maintaining social connections, with many people using social media, messaging apps, and video calls to stay in touch with friends and family. For elderly individuals who are not comfortable using these tools, this can lead to increased feelings of loneliness and isolation. Research by Priest and Williams (2020) highlights how digital exclusion limits older adults' ability to maintain social connectedness, particularly during periods of social distancing, such as during the COVID-19 pandemic. This isolation can have a significant negative impact on mental health and well-being, further marginalizing older adults.

Finally, the inability to use technology limits the elderly's ability to participate in the modern economy. With more and more businesses moving online, from retail to entertainment, those who are not digitally literate may find themselves excluded from a growing range of products and services. This can result in elderly individuals missing out on savings, loyalty programs, or convenient shopping options that are only available online (Helsper & Reisdorf, 2017). In some cases, this exclusion can even lead to increased costs, as those who cannot access online-only deals may be forced to pay more for goods and services.

Addressing the Digital Divide for the Elderly

Addressing the digital divide for the elderly requires a multifaceted approach that includes education, accessibility, and support. One of the most important steps is to provide digital literacy training specifically tailored to the needs of older adults. Programs that offer hands-on, one-on-one training can help build confidence and skills, making technology more accessible. For example, initiatives such as the "One Digital" program, run by Age UK and the Good Things Foundation, have provided digital skills training to thousands of older people across the UK, helping them to navigate the internet, use apps, and stay connected with loved ones (Good Things Foundation, 2021).

In addition to digital literacy, accessibility is a key consideration. Research suggests that technology needs to be designed with older users in mind, taking into account the physical and cognitive limitations that can make it difficult for them to use devices and apps (Charness & Boot, 2016). This includes making websites and apps more user-friendly, with larger text, simple navigation, and clear instructions. The UK Government has introduced guidelines for making digital services more accessible, but more needs to be done to ensure that these standards are consistently applied across all sectors (UK Government, 2018).

Providing affordable access to technology is also crucial. For many elderly individuals, the cost of devices and internet access is a significant barrier to digital inclusion. Government and private sector initiatives that provide low-cost or subsidized devices and broadband services to older adults could help bridge this gap. For example, some local authorities and charities have begun offering free or discounted tablets and smartphones to older people, along with support in setting them up and learning how to use them (Centre for Ageing Better, 2021).

Finally, it is important to recognize that not all elderly individuals will be able or willing to adopt digital technology. For those who remain digitally excluded, it is essential that alternative methods of accessing services and information remain available. This includes maintaining in-person and telephone services, as well as ensuring that printed materials are available for those who prefer not to go online (Yeandle & Henz, 2021).

Conclusion

The digital divide presents significant challenges for the elderly in the UK, affecting their ability to access essential services, manage their finances, stay connected with loved ones, and participate in the modern economy. While efforts to address these issues through digital literacy programs and accessible design are underway, there is still much work to be done. A comprehensive approach that includes education, accessibility, affordability, and ongoing support is essential to ensure that older adults are not left behind in the digital age. By addressing these barriers, society can help to reduce the social isolation and inequality experienced by many elderly individuals, improving their quality of life and enabling them to participate more fully in the modern world.

References available upon request

THE AI REVOLUTION AND THE OLD AGE PSYCHIATRIST

Dr Chloe Harrison, Core Psychiatry Trainee (CT3), Avon & Wiltshire Mental Health Partnership NHS Trust

Since OpenAI's 'ChatGPT' was released in November 2022, Artifical Intelligence (AI) has gone mainstream, prompting much speculation about how it might revolutionise our lives. Concurrently, old age psychiatry faces increasing pressures as the global population ages. AI and machine-learning (ML) technologies are proposed solutions to increasing healthcare efficiency and effectiveness. But what does AI have to offer the old age psychiatrist – and is it more hype than substance?

AI – The Promise

What are AI and ML?

AI involves creating systems that perform tasks usually requiring human intelligence. Key techniques include machine learning and deep learning, where algorithms analyse data, identify patterns, and make predictions or carry out tasks without explicit programming for each one. These methods help find insights missed by human experts. With iterative training, AI systems can improve and learn over time.

Pathophysiology and Risk Prediction

ML excels at finding complex non-linear patterns in very large datasets, offering new insights into the intricate physiology and environmental interactions in neurodegenerative and psychiatric conditions. ML has already been applied to refining our understanding of pathophysiology and disease constructs in old age psychiatry – identifying accurate models of the ageing brain(1), neural correlates of psychiatric symptoms(2), and genetics of dementia(3), for example.

Much AI research has also focussed on risk factor identification, and risk prediction. Previous work has shown ML as useful in identifying novel risk factors and improving individual risk prediction for the development of Alzheimer's disease(4); for evaluating risk factors for developing depression(5,6); and for risk of suicide(7).

Improving Diagnosis

AI can also augment psychiatric diagnosis, with promise again in dementia. ML algorithms have been studied to both improve diagnosis(8), identify biomarker-led approaches(9), and to aid in subtype identification(10). Image analysis is also an area of relative strength and maturity. Studies have shown that ML techniques applied to neuroimaging may improve the accuracy of dementia diagnosis(11), and potentially detect subtle changes in brain structure and function that precede clinically apparent symptoms, to enable earlier diagnosis(12).

AI-aided diagnostics based on multimodal models have also shown early potential in other conditions, such as depression(13), anxiety(14) and delirium(15). The use of novel data sources is an interesting possibility: EEG in functional conditions; social media data to identify loneliness(16); natural language analysis to identify later-life depression(17); speech analysis in Parkinson's Disease(18); driver data to identify early cognitive impairment(19); and even GPS location data in negative symptoms of schizophrenia(20).

Precision Pharmacology and Personalised Care

In psychiatry, where new drug discovery has slowed due to disappointing results, AI might help identify candidate targets and molecules more cheaply and accurately. AI has been used in this way again to identify molecular targets for new dementia treatments(21). Additionally, ML has been applied to repurposing older drugs in psychiatry(22), and to identifying drug responder sub-groups(23), which might offer new pharmacological options tailored to older people, with well-characterised safety profiles.

AI could also support precision psychiatry: by analysing high-volume individual data (like neuroimaging, functional connectivity, individual genetics, health records, and biomarkers) to give a personalised phenotypic understanding. ML algorithms have been used to tailor personalised first-line treatments for depression, with the aim of improving response(24). ML models have also been developed which can predict disease course: for example, mortality for people with dementia, which might help to identify high-needs cohorts(25), and treatment resistance in depression for older adults(26). In later life cohorts particularly, atypical presentations, physiological variability, comorbidities, and polypharmacy make predicting treatment tolerability and response in future particularly desirable.

Improving Care

AI applications have been used to enhance non-pharmacological aspects of care too. AI chatbots using large language models have shown efficacy in reducing loneliness and depression in older adults(27); personalised AI music therapy has been shown to reduce agitation and anxiety in BPSD(28).

AI approaches have also been used to better understand the improvements seen during psychotherapy(29). Research is underway on integrated home-sensor data to identify warning signs of deterioration in people with dementia, to facilitate early intervention, reduce hospital admissions and supporting independent living(30).

Perhaps more prosaic and less science-fiction, AI administration tools supporting dictation, clinical note writing might free up clinician time and enable more direct patient contact. This is particularly relevant in old age psychiatry when recruitment is a growing problem.

AI – The Hype

“Rubbish in, rubbish out”

This phrase highlights a key issue: poor quality data leads to poor quality results, even with sophisticated ML approaches. Psychiatric data often faces restriction due to well-founded security and privacy concerns. High quality longitudinal data-gathering is often expensive and difficult to sustain. Electronic heath records can be incomplete, erroneous, and inconsistent.

AI relies upon large, high-quality datasets, which are lacking in old age psychiatry, with older people under-represented in clinical research and in registry data(31). Our clinical variables are more like to be subjective, and this can limit advances compared with more categorical or image-based specialities like radiology. This is likely reflected in the relative interest in dementia.

Generalisability

More concerning than obvious underperformance due to data quality, are misleading results due to systemically biases data. AI models are vulnerable to biases in training data, potentially replicating and amplifying existing inequalities (such as ageism, racism and sexism) experienced within healthcare.

Acceptability, Regulation and Logistics

Even advanced AI tools have error rates and people often find mistakes from humans more acceptable than those from computers. A significant challenge to adopting AI may be whether patients and families are willing to accept it, especially among older adults who may be less familiar digital technologies.

Adjunctive tools alongside clinical judgement might also face barriers from clinicians, with uncertainty about liability and responsibility for decision making. Alongside this is navigating complex regulatory frameworks that are cautious around new technologies, and the logistics of integration into an NHS landscape where fax machines and pagers remain common.

Current Examples

Perhaps the most compelling argument against an ML-guided future in old age psychiatry, is the relative infancy and limited penetrance into even the best-suited specialities. FDA approvals have broadly been for devices and algorithms than analyse categorical or image data with relatively restricted indications – such as detecting atrial fibrillation, or image recognition of cancers. Notably, less exciting but more widely used technologies – such as automated dictation, or notes summarisers – still lack evidence to show that they increase efficiency.

Conclusion

In conclusion, while AI holds enticing potential for old age psychiatry, its actual impact remains uncertain. Research shows early promise in diagnostics and personalized treatment, particularly in dementia care where more extensive and appropriate datasets exist. Issues like poor-quality data, inherent biases, and resistance from both patients and clinicians pose serious challenges, however, and few approaches have shown real-world effectiveness. As the field evolves, a balanced approach will be needed - leveraging AI's potential benefits while ensuring rigorous evaluation and genuine clinical utility.

References available upon request

SUSTAINABILITY IN OLDER ADULT PSYCHIATRY

Dr Katherine Witter, ST6 Psychiatrist, Hertfordshire Partnership University NHS Foundation Trust and RCPsych Green Scholar 2022-23.

What does sustainability mean to you? For all of us, it is likely we recycle or think about our travel and what we eat at home, but for many we might be less likely to think of this at work. For our team, we wanted to bring all the things we do at home to our workplace.As a Green Scholar for the College of Psychiatrist's (RCPsych) Planetary Health and Sustainability Committee (PHSC), and an Older Adults trainee, I have had a great opportunity to put this into practice and would like to share. All of us can make a difference whatever our interest in this topic, even the smallest things will make a difference.

NHS England has set a target to achieve NetZero by 2024 and to be the world's first net zero national health service. It's a daunting task! And for lots of clinicians the feeling may be its too big a challenge, or "its estates job" or it "won't make a difference anyway". But we can all make a difference, and, in the NHS, we are in a privileged position that the public respect and will listen to.

Like many Trusts, Hertfordshire Partnership Foundation Trust (HPFT) has an active Sustainability Steering Group and "Green Plan" in place. Within the group we aim to establish a coordinated approach to managing the environmental impact of the Trust's activities, promote sustainable healthcare, support delivery of greener models, involve staff and the public in our goals, develop communication with wider organisations and advise on developments which may impact the environment.

Whilst this has historically been a non-clinical group, we have been increasingly including clinicians, pharmacists and allied healthcare professionals to join. Through this, we have new innovation relevant to clinicians with ideas everyone can include take forward. Why not find out if your Trust has a Sustainability group or similar and join a meeting? And have a look too for the Green Plans, which might have some ideas your team can easily implement, or you may be doing already, and can share your great practice.

As psychiatrists, our College is committed to sustainability. The RCPsych's SPHC takes a broad view on what sustainability means, and recognises it's not just carbon counting, climate and environmental issues but also looking at social justice and the sustainability of the workforce that is important.

The SPHC endorses that the core principles of practising sustainable psychiatry are 1) prioritising prevention, 2) empowering patients, communities and staff, 3) delivering high value care and 4) considering carbon.These are all good practices that demonstrate sustainable care is also great care, and we can both deliver greener mental health services and simultaneously improve the quality of our services to our patients.

For example, as clinicians in Older Adults we can pay more attention to what might prevent both mental and physical illness, prevent carer burnout, prevent falls and relapse and also reduce staff burnout. Looking after our own wellbeing and that of our colleagues is both a personally rewarding and "green" thing to do! A sustainable workforce is one that feels supported and fulfilled by their work and not exhausted and undervalued. Building a strong team that lasts and cares for each other prevents high staff turnover, prevents the need for training new members, enables resilience to challenges and increases productivity.

To promote patient and community empowerment in our day-to-day practice we can all do simple things such as encouraging service users and their carers and family to ask questions, help them become involved in their loved-ones care, promote self-management and provide excellent communication. The "Choosing Wisely" international campaign aims to embed a culture in which patients and clinicians regularly discuss the clinical value and effectiveness of interventions and medications, with the ambition of reducing the amount of inappropriate clinical activity. This also supports empowering service do what works for them and work collaboratively with their treating team.

As teams, we can think about delivering high value care by prioritising holistic patient-centred care, considering individual needs and using our own time and resources carefully. A part of our services can involve nature and green care – encourage engaging with nature, valuing exercise outdoors, looking after our workplaces' green spaces and recognising the benefits to physical and mental wellbeing of nature to all of us,

And of course, our carbon footprint. Think of the carbon footprint in relation to work travel, requesting investigations and prescribing, for example. Procurement - the purchase of medication and medical equipment- accounts for 60% of the carbon footprint of the NHS in England. The sustainable use of resources, such as choosing wisely when prescribing, rationalising medication and reducing clinical waste, play an important role in supporting sustainable mental health services. This is recognised in the RCPsych position statement on our planet's climate and ecological emergency.

Specifically for Older Adults, The National Institute for Health and Care Excellence (NICE) guidelines also recommend deprescribing in elderly patients using structured instruments. An example of such an instrument that is user-friendly and appropriate for many frail older people is STOPPFrail (Screening Tool of Older Persons Prescriptions in Frail Adults with limited life expectancy), which we have used effectively across our Trust in dementia units.

Medicines have a huge carbon footprint and contribute massively to our carbon footprint with all their plastic packaging, production and delivery costs, in addition to the cost of disposing those that aren't taken and the treatment of iatrogenic harm.

Giving just an extra thought to what and how much we are prescribing, and to the alternatives that might be an option, might not only benefit our patients but also the planet.

So finally, a thank you for everything you are doing. We can all contribute to a greener NHS, achieve the NetZero target and deliver high quality of care in excellent teams whatever our roles or experience! I believe in Older Adults we can lead the way and leave a better planet for the next generation.

EUROPEAN ASSOCIATION OF GERIATRIC PSYCHIATRY (EAGP) -UPDATE

Dr Sujoy Mukherjee - Consultant Psychiatrist, West London NHS Trust and Secretary, EAGP

EAGP BOARD MEETING AT PASTEUR UNIVERSITY HOSPITAL, NICE (FRANCE), 30TH JUNE TO 1ST JULY 2024

European Association of Geriatric Psychiatry (EAGP) was founded over 50 years ago in Dusseldorf, Germany. It is an umbrella organisation with sole aim of promoting Old Age Psychiatry Across Europe. Currently the national organisations (Old Age Psychiatry) of Netherlands, Germany, Belgium, Portugal, Spain, Norway, Sweden, Denmark, Ireland, France, Switzerland, Romania and the UK(Faculty of Old Age Psychiatry) are members. EAGP provides high quality trainings – Summer school for trainees in Old Age Psychiatry that takes place in University of Lausanne, Switzerland alternate years, usually in September.

Also, refresher course in Old Age Psychiatry is taking place in Leuven, Belgium from 26th to 28th September, 2024. Both courses are residential, face to face and has a highly rated faculty from across Europe. We are also running webinars over last few years and they are free to join and we get highly rated speakers from across Europe and beyond.

EAGP has been collaborating and taking part in national conferences of its member organisations over the years and our faculty also took part in collaborative events with EAGP and AAGP in the past. We hope to have many more such collaborative events in the future. EAGP is also exploring strategic partnership with Old Age Section of EPA (European Psychiatric Association) at present.

Many board members of EAGP are leading academics in their own country and there are also opportunities for research collaborations and presentation in our webinars.

Please do not hesitate to contact me if you are interested. Also, please check our website for further details – eagp.com.

INFECTIOUS DISEASES AND COGNITIVE IMPAIRMENT: WHAT DO OLD AGE PSYCHIATRISTS NEED TO KNOW?

Dr Alex May, Consultant in Infectious Diseases and Microbiology, North Bristol NHS Trust
Dr Jennifer Parker, ST6 in Old Age & General Adult Psychiatry, Avon & Wiltshire Mental Health Partnership NHS Trust

Old age psychiatrists are often tasked with ordering and interpreting HIV and syphilis blood tests as part of a confusion screen. Here we provide a practical summary as to when, why and how to carry out these tests, and what to do with the results.

Infection screening to consider

For a standard dementia diagnostic workup, NICE guidelines recommend screening with appropriate blood and urine tests to exclude for reversible causes of dementia, but do not specify which tests to perform (1). The associated NICE Clinical Knowledge Summary (CKS) recommend beginning with a full blood count and CRP, before considering a chest radiograph, urinary microscopy and culture and HIV and syphilis serology where appropriate (2). This set of investigations provides a solid initial screen for common infections that may precipitate a delirium, whilst also screening for some specific infections that can have longer term impact on cognition. When there is a history of rapid cognitive decline, the NICE guidelines recommend referral to a neurological service with access to tests including cerebrospinal fluid (CSF) examination.

HIV

Neurocognitive dysfunction is a well-recognised complication of HIV infection. HIV enters the Central Nervous System early in infection and can cause neurocognitive dysfunction through a variety of mechanisms including direct inflammation and disruption of host glutamate homeostasis (9). It is estimated that 6% of people living with HIV in England are unaware of their diagnosis (10).

Testing considerations:

Particular circumstances in which to consider HIV testing include:

- Subcortical dementia: The expected prevalence of undiagnosed HIV in subcortical dementia is 1 in 1000, and thus British HIV Association (BHIVA) recommend testing for HIV in anyone presenting with subcortical dementia(11).
- Living in major urban centres in the UK**:** BHIVA recommends HIV testing in any individual accessing health care and undergoing venepuncture in an area where the HIV prevalence is greater than 2 in 1000, which includes most major cities in the UK - see https://www.hiv-lens.org/ for local prevalence rates.
- Global considerations: HIV testing is recommended in people who have immigrated from a country with high diagnosed seroprevalence (>1%) - UNAIDS provides annual updates on global HIV prevalence (12).

Diagnosis and treatment:
Serum blood tests are used to screen for HIV that identify both HIV antigens and antibodies. These tests have a typical 3-day turnaround time. A new diagnosis of HIV will need referral to specialist HIV service for further assessment and treatment. HIV is treated with combination Antiretroviral Therapy (cART) typically with 3 drugs targeting 2 different stages of the viral replication cycle. In the UK, 97% of individuals on treatment for HIV fully supress the virus (10). Developments over the last 3 decades in HIV treatment with combination antiretroviral therapy have dramatically reduced the mortality and morbidity in HIV, with individuals on treatment now having a normal life expectancy.

Syphilis
Syphilis is caused by the bacteria *Treponema pallidum* and is typically transmitted through sexual exposure. Primary syphilis classically presents with a painless, often inconspicuous, chancre at the site of inoculation. Without treatment, the disease progresses to secondary syphilis, classically presenting with a symmetrical rash involving the trunk and palms, before entering a symptomatic latent stage that can last decades prior to developing into tertiary syphilis. Tertiary syphilis has a wide range of manifestations across the body including neurosyphilis, which presents symptomatically with chronic meningitis, meningovascular stroke-like syndromes, tabes dorsalis (paraesthesia, ataxia and Agryll Robertson pupils), and neuropsychiatric manifestations (historically known as general paresis). These neuropsychiatric manifestations include gradual decline in memory and cognitive functions, emotional lability, personality change, psychosis and dementia. Neurosyphilis, as well as being a late manifestation, may also present earlier in the disease course with milder symptoms (3).

Testing considerations:
Rates of syphilis in the UK have been increasing over the past decade, and in 2023 reached the highest level since the 1940s. Anyone who has been sexually active is at risk of syphilis. The highest risk groups are men who have sex with men. Rates of infection are also higher in individuals from major urban centres, more deprived regions, and of Black Caribbean backgrounds (5,6). One centre that routinely screened for syphilis as part of their cognitive impairment screen found 1% of patients to have positive serology and 0.12% warranting treatment (6).

Diagnosis and treatment:
Evidence of syphilis infection can be screened for on a serum blood test. This typically involves a screening test looking for total antibodies to syphilis. If this is positive further confirmatory testing through a secondary Treponemal test and Rapid plasma regain (RPR) titre is performed. Typical laboratory turnaround times for these tests are 3 days for the initial screen and up to a further 7 days for confirmatory testing. Interpretation of syphilis serology can be a challenge particularly in differentiating chronic and past infection - have a low threshold for discussing positive serology with an infection specialist. CSF testing is also indicated when there is a concern about neurosyphilis. Syphilis is primarily treated with intramuscular penicillin, or alternative antibiotics in specific circumstances. The duration and number of treatments depend on the stage at which syphilis is diagnosed.

Conclusion

In conclusion, NICE recommends consideration of screening for infections including HIV and syphilis as part of the investigation of a suspected case of dementia. The recommendation for HIV testing is supported by BHIVA with undiagnosed HIV expected to be present in more than 1 in 1000 individuals with subcortical dementia. Studies of routine syphilis screening in individuals with cognitive impairment have demonstrated a similar rate of 1 in 1000 individuals screened requiring treatment. Initial screening for both conditions is on a serum blood test that can be taken alongside other routinely recommend screening blood tests. On this basis, routinely screening for both HIV and syphilis as part of dementia workup seems reasonable in most circumstances.

Whilst other infections such as Hepatitis C and Lyme Disease can be implicated in cognitive impairment, these should not be routinely tested for by old age psychiatrists. If in doubt, seek specialist advice.

References: Available upon request

A CASE REPORT: NAVIGATING THE INTERPLAY - CHALLENGES OF PSYCHIATRIC DIAGNOSIS IN AN OLDER ADULT WITH PHYSICAL HEALTH PROBLEMS

Dr Faquiha Muhammad - Core Psychiatry Trainee, **Dr Shigore Job -** Consultant psychiatrist, and **Dr Harshani Yapa Bandara -** Core Psychiatry Trainee, Northamptonshire Healthcare NHS Foundation Trust

We report on a complex patient presenting with atypical behavioural and psychiatric symptoms and multiple physical health issues.

Case History:
The case history of our patient was obtained from e-records and MDT meetings. Mr X, a 67-year-old gentleman was first referred to the mental health team in 2016, presenting initially with recurrent symptoms of low mood, poor sleep and appetite. He was subsequently diagnosed with Depression for which he was given SSRIs. This patient also reported auditory hallucinations of God talking to him, along with nihilistic thoughts of his organs being stripped away and these were accompanied by odd behaviours like pacing around the room, repeated vacant episodes and walking backwards. In 2017, he was given a diagnosis of recurrent episodes of moderate to severe depression with psychosis; with 7-8 such episodes over the course of the next 6 years. He was treated with multiple psychotropics, including risperidone, sertraline, and mirtazapine, as well as being referred to the young onset Dementia clinic and first fit clinic where both dementia and epilepsy were ruled out. CT head was also done to rule out organic pathology.

During this period our patient was investigated for poor appetite, weight loss, abdominal pain, back pain, and haematuria with CT abdomen and OGD which were negative, as well as being treated for recurrent UTIs.

In January 2022 he underwent a 2-month inpatient stay at a psychiatric facility due to a gradual decline in mental state with an increase in self-harming behaviour. Mr X was convinced he had an ongoing physical illness causing his back, neck, and abdominal pain. His medications were reviewed several times including the addition of lithium, and he was eventually discharged, with some improvement in his condition.

By November 2022, he was re-admitted to the general hospital in status epilepticus. Examination revealed fluctuating GCS, unequal pupils with twitching of his arms, and he was intubated and transferred to critical care.

CT Head and MRI ruled out brain metastasis at this time, and EEG revealed no abnormality. Neurology advised screening for syphilis; Treponemal Ab Screen EIA and Syphilis 2nd Line Immunoassay were positive with 2.3 RPR units, but the Treponemal IgM ELISA was negative and Lumbar puncture was normal.

Considering the neurological findings and ambiguity in test results, the team decided to treat him with a course of antibiotics to cover the possibility of Neurosyphilis and Encephalitis and to rule out Delirium.

Unfortunately, Mr. X then developed intestinal obstruction while in ITU requiring a Laparotomy. Investigations at the time revealed elevated PSA levels, suspicious pelvic lesions on CT Abdomen, multiple osteoblastic lesions on bone scan, and lung imaging suggestive of metastasis with bilateral Pulmonary Emboli. Based on these findings, he was diagnosed with Metastatic Carcinoma of Prostate, and started on hormonal therapy.

Following this, he was managed in a rehabilitative setting, where our team reviewed him for his ongoing mental health issues. We considered the possibility of Neurosyphilis contributing to his past challenging behaviours along with comorbid psychiatric illness and continued to regularly review his psychotropic medications.

Reflections on this case:

This case describes a 67-year-old male with a long history of mood disturbance, personality changes, and psychosis followed by seizures, abnormal neurology, positive syphilis serology and metastatic prostate carcinoma. This proved to be a challenge in the context of a layered diagnosis; with the possibility of the interplay of a pre-existing psychiatric disorder, probable historical syphilitic infection and his comorbid physical health problems contributing to his current presentation.

his case illustrates the significance of the context in which investigations are interpreted, along with the importance of a thorough history, mental-status examination, physical examination, and collateral information-gathering, which remain of paramount importance in psychiatric diagnosis.

Discussion about syphilis:

Syphilis is a major global health issue caused by Treponema pallidum. Neurosyphilis occurs in up to 30% of people with untreated syphilis and may occur at any stage of the infection, and it has a wide spectrum of neurocognitive symptoms that are also found in many other neurologic and psychiatric disorders. The incubation period can vary from less than 2 years up to 20 years [2]. The presence of syphilitic anti-lipid antibodies in serum and plasma can be used in conjunction with other investigations and clinical findings to diagnose syphilis.

Take home message:

Mr X’s story clearly demonstrates the challenges of psychiatric diagnosis in the midst of serious ongoing physical health problems in older adults. We are always taught to rule out organic causes of psychiatric illness, as various medical conditions can manifest with psychiatric symptoms, and yet the interplay between them remain a challenge.

Physical health and mental health influence each other bidirectionally, and those with comorbid physical and mental health conditions can struggle to access appropriate and integrated care as these conditions are often treated separately within the healthcare system.

Did this patient have a primary psychotic illness, or did we see the end results of a previous syphilitic infection? How much of his presentation was caused by metastatic cancer, simmering away in the background? Could it be a little bit of everything? We may never know.

It is likely that with such complex presentations, we may never fully determine the extent of the impact of each condition on the other, and these patients will continue to challenge clinicians both in diagnosis and in management.

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DEMENTIA SUPPORT INITIATIVE IN EGYPT: COMMUNITY ENGAGEMENT ACTIVITY IN EGYPT

Mariam Alwerdani - CT1, Psychiatry trainee, Southern Health NHS Trust
Mariam.alwerdaniAbouelmaati@southernhealth@nhs.uk

Working as a doctor in Egypt's old age medicine wards, I have often found myself at the front lines of a silent struggle—a battle fought daily by dementia patients and their families. These individuals face not only the debilitating effects of the disease but also the reality of limited services and widespread ignorance, both among the public and, regrettably, within the medical community. This double-edged sword of neglect and misunderstanding leaves dementia patients and their families marginalized, grappling with countless unanswered questions. This harsh reality inspired me to take action, leading to the creation of the "Dementia Support Initiative in Egypt (DSIE)." Alongside a team of dedicated doctors from various specialties, we set out to raise public awareness and enhance the capacity of junior health professionals in understanding and managing dementia.

This article aims to shed light on the current state of dementia in Egypt and the work being done by DSIE to address this pressing issue.

Aging and Dementia in Egypt

By 2050, it's expected that over 20% of the global population will be aged 65 and above (1). This demographic shift presents significant challenges, particularly in developing countries like Egypt, where managing age-related mental disorders, including dementia, becomes increasingly complex.

The prevalence of dementia in Egypt has been reported to vary across studies, ranging from 2.01% to 5.07%, with a higher incidence in women across all age groups (2). However, comprehensive data from Egypt's major cities, like Cairo and Alexandria, are lacking, leaving the true prevalence of dementia in the country largely unknown.

A recent study assessed dementia knowledge among Egyptians and found that one-third had poor knowledge, particularly in the treatment and life impact domains (3). While efforts to improve geriatric care in Egypt are increasing, these services are mostly concentrated in tertiary healthcare centers in larger cities. Public awareness about dementia remains limited, with many still mistakenly believing that memory loss is just a normal aspect of aging.

The Importance of Dementia Awareness

Imagine trying to navigate through a foggy road. Without a clear view, you can’t see where you’re going or what obstacles lie ahead. In the same way, lacking awareness about dementia is like driving in the fog—it hinders our ability to understand and address the needs of those affected.

Stigma significantly impacts the quality of life for both dementia patients and their families. According to Dementia UK, this stigma can begin affecting individuals even before a formal diagnosis is made.

Fear of social judgment often delays people from seeking medical help, worsening their condition over time. The stigma surrounding dementia can also lead to isolation, with some patients and families feeling too embarrassed to acknowledge the disease publicly (4).

In Arabic, the term for dementia, "Marad Al-Kharaf," translates to "the disease of confusion," which further burdens patients and their families by implying a complete loss of mental capacity. This misinterpretation often results in people normalizing memory issues as just another aspect of aging, delaying crucial medical intervention.

Caregiving for dementia patients presents its own set of challenges. In Egypt and the broader MENA region, caregivers are typically informal—often the patient’s daughter or wife. A recent review highlighted high levels of stress and burnout among these caregivers, who face long hours, societal pressures, and minimal support. In Egyptian culture, it is seen as shameful for children to place their parents in a residential home, even in the late stages of the disease. If they do, they risk being labelled as ungrateful. Formal caregivers, who are usually from lower socioeconomic backgrounds, also face difficult working conditions with little training, long hours, and inadequate pay.

he Dementia Support Initiative in Egypt

The Dementia Support Initiative in Egypt (DSIE) is a community-based effort, driven by Egyptian health professionals and medical students, with the goal of improving the health and social conditions of dementia patients in the country. Our mission is to bridge the gap between patients, caregivers, healthcare workers, and the general population by raising awareness, building healthcare capacity, and fostering a supportive environment for dementia-related professions.

DSIE Activities: A Journey of Empowerment and Collaboration

The Dementia Support Initiative in Egypt (DSIE) was officially launched during the Global Brain Awareness Week in March 2022. We organized a series of workshops aimed at junior physicians and medical students, covering essential topics such as dementia facts in Egypt, dementia research, caregiver support, and clinical approaches to memory problems. Each session attracted around 50 participants, and we employed pre- and post-workshop surveys to assess the effectiveness of our training. The results were encouraging participants' knowledge improved by 20% following the sessions.

To extend our reach, particularly to the elderly and those in rural areas, we partnered with other community NGOs to conduct dementia awareness campaigns in small villages as part of broader medical outreach efforts.

Understanding the struggles caregivers face, we also arranged targeted sessions for them, covering practical aspects of daily care, communication strategies, nutrition, and mobility. These sessions were led by senior health professionals from various fields, including geriatrics, psychiatry, nursing, physiotherapy, and clinical nutrition.

he response to DSIE's activities has been overwhelmingly positive. We’ve received valuable feedback from both colleagues and participants, identifying numerous challenges and generating a wealth of new ideas. Building on this momentum, we recently launched the "Dementia Ambassadors Program" in collaboration with the American University in Cairo's

Institute of Global Health and Human Ecology. This program is designed to empower individuals—includingprogram is designed to empower individuals—including healthcare professionals, students, and community leaders—to develop and lead their own dementia support projects across different sectors and regions in Egypt. The ambassadors have already completed their training, which received highly positive feedback, and the next phase will see them apply their training by leading their own community-based projects.

Collaboration has been a cornerstone of DSIE's work. We have established partnerships with key organizations, including the International Brain Research Organisation (IBRO), the American University in Cairo (AUC), the Egyptian Red Crescent (ERC), the General Secretariat of Mental Health, and the Mental Health Research Network in Egypt (MHRNE). Our efforts have been recognized internationally, with a poster on DSIE's activities presented at the IBRO annual congress in 2023 and the RCPsych Old Age Psychiatry Faculty conference in 2023.

Looking Ahead: The Future of Dementia Care in Egypt

The Dementia Support Initiative in Egypt (DSIE) is dedicated to creating a dementia-friendly community through future projects focused on early diagnosis, establishing a clear referral pathway, and creating a national dementia patient registry.

By expanding clinical training for healthcare practitioners, advocating for a national screening program, and developing a structured referral system, DSIE aims to improve early detection and patient care across Egypt. Additionally, the initiative plans to establish a patient registry to enhance service quality, support research, and inform future healthcare strategies.

Conclusion

The journey to improve dementia care in Egypt is challenging, but with initiatives like DSIE, there is hope for a brighter future. By raising awareness, empowering healthcare professionals, and establishing a supportive network for patients and caregivers, we are working towards a community where dementia is understood, and those affected are cared for with dignity and compassion.

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The author has acknowledged the contribution of other professionals.

RESEARCH UPDATE

Dr Curtis Osborne, ST4 in Old Age Psychiatry, and **Dr Jennifer Parker,** ST6 in Old Age and General Adult Psychiatry, Trainee Editors of *The Old Age Psychiatrist*

Original Research:
Analysis of clozapine prescribing in the over-65s: 5-year retrospective study
Barclay J et al, BJPsych Bulletin

Introduction:
Clozapine is the only evidence-based treatment for treatment-resistant schizophrenia, as reflected in clinical guidelines. However, its prescription is limited due to a range of adverse effects, which include serious medical concerns like myocarditis, seizures, and agranulocytosis, as well as more common issues such as metabolic syndrome, hypersalivation, sedation, and constipation. These side effects are particularly concerning for elderly patients, who are more susceptible to the adverse effects of antipsychotic drugs due to age-related physiological changes. The elderly also face an increased risk of falls and cognitive impairment, especially when co-prescribed medications like anti-hypertensives, opioids, and benzodiazepines. Despite these challenges, there is limited research on the use of clozapine in this age group.

Method:
Barclay et al. (2024) conducted a retrospective study to assess the side effects of clozapine in patients over 65 years within Hertfordshire Partnership NHS Foundation Trust (HPFT) over a five-year period. The study aimed to evaluate the burden of side effects, concurrent medication use, and the relationship between side effects and clozapine dosage. Data were collected from electronic patient records and the Denzapine Monitoring Service.

Results
Results from this study of 69 elderly patients on clozapine revealed that 61% were stable in mental state, but 94% experienced side effects in the past year, with constipation being the most common (65%).

Conclusion
Clinical implications suggest a significant side-effect burden, especially clozapine-induced gastrointestinal hypomotility (CIGH), which can be fatal. Despite age not being a recognized risk factor for constipation in clozapine patients, this study raises concerns about increasing health risks as patients age and highlights the need for better monitoring of CIGH.

Full article available: *https://www.cambridge.org/core/journals/bjpsych-bulletin/article/analysis-of-clozapine-prescribing-in-the-over65s-5year-retrospective-study/2689438ED7E0DC732DF6C2EDFDBC6D7E*

Cognitive testing and the hazards of cut-offs

Series H, Burns A, BJPsych Advances

Cognitive tests are essential in diagnosing, tracking, and managing cognitive impairments, especially dementia. These assessments are widely used in various medical settings, including primary care, accident and emergency, and memory clinics, to detect cognitive issues like dementia, delirium, and cognitive impairments in conditions such as multiple sclerosis and Parkinson’s disease. Cognitive tests help differentiate between normal aging, mild cognitive impairment, and dementia, providing critical insights into the severity and progression of cognitive decline. This information guides diagnosis, treatment, and advice, helping ensure patients receive appropriate care.

However, cognitive tests have limitations. Results can fluctuate due to factors like patient anxiety, fatigue, and test conditions. Test accuracy can also be impacted by variations in the test procedure and scoring. This variability highlights the need for using normative data when interpreting results, considering factors such as age, education, and cultural background. Accurate interpretation relies on comparing a patient's results to an appropriate normative dataset to ensure that the score's significance is properly assessed.

The use of cut-off scores is a common approach to determine whether a patient's cognitive function is significantly impaired. These cut-offs, however, need to balance sensitivity (correctly identifying those with the condition) and specificity (correctly excluding those without the condition). For example, while the Montreal Cognitive Assessment (MoCA) is a useful tool with a suggested cut-off score, research shows that adjusting for age and education can improve test accuracy. Therefore, the choice of cut-off scores and interpretation should consider the context of the test’s purpose, whether for screening or diagnosis. In conclusion, cognitive tests are powerful diagnostic tools, but their effectiveness depends on careful consideration of individual patient factors and the use of appropriate normative data.

Full article available:
https://www.cambridge.org/core/journals/bjpsych-advances/article/cognitive-testing-and-the-hazards-of-cutoffs/94003DB9AE601FA3D51EC428BF602CD9

Pet ownership and psychosocial outcomes among the oldest old in Germany during the Covid-19 pandemic.

Introduction: The study by Hajek et al. (2024) aimed to explore the impact of pet ownership on psychosocial outcomes among Germany's oldest adults during the Covid-19 pandemic. Using data from the "Old Age in Germany (D80+)" study, which included 2,867 individuals aged 80 and above, researchers conducted telephone interviews from May to October 2021. The study utilized established tools like the "Short Form of the Depression in Old Age Scale" (DIA-S4) to assess outcomes such as loneliness and depression.

Method: Participants were categorized into five groups based on their pet ownership status: (1) no pets, (2) at least one dog, (3) at least one cat, (4) other pets (excluding dogs and cats), and (5) at least two different types of pets. Multiple linear regressions were used to analyze the data.

Results: The results revealed that owning at least one dog was associated with significantly lower levels of loneliness compared to those without pets ($\beta = -0.21$, $p < 0.01$). In contrast, other forms of pet ownership, including cat ownership, did not show a significant impact on loneliness or other psychosocial outcomes in the fully-adjusted models.

Conclusion: The study concluded that owning a dog is particularly effective in reducing loneliness among the oldest old in Germany. This was thought to be related to Dogs usually encouraging regular social interaction through walks and interactions with other dog owners, neighbours or other people who stop to admire the pet or children who want to pet the dog in addition to the companionship provided by a dog. For individuals in this age group, who may face increased social isolation, having a dog could be a viable strategy to enhance well-being and reduce feelings of loneliness, provided it aligns with their personal preferences and attitudes.

Full article available:
https://onlinelibrary.wiley.com/doi/10.1002/gps.6127

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REVIEW SECTION: DEMENTIA AND ETHICS RECONSIDERED BY JULIAN C. HUGHES

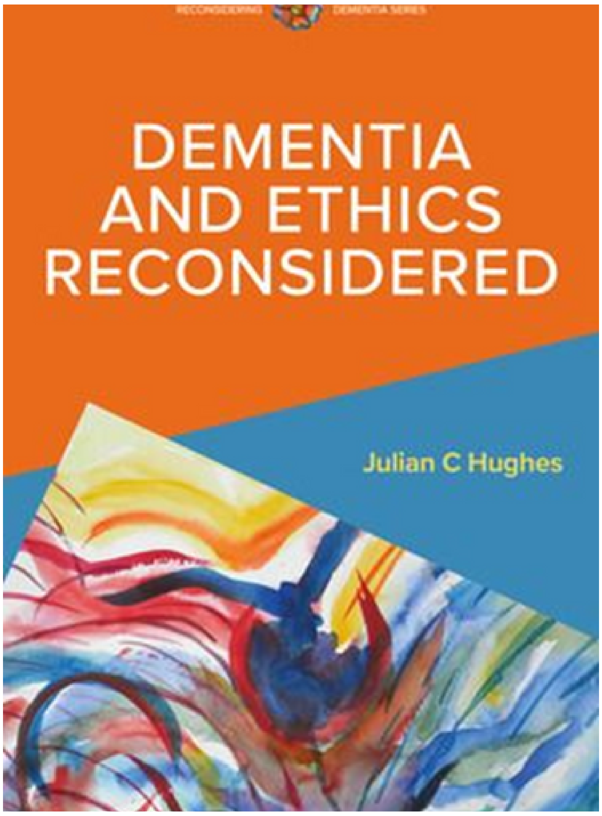
Dr Anitha Howard, Consultant Psychiatrist, Bensham Hospital, Gateshead

This book is a fascinating dive into the sometimes neglected world of ethics relating to dementia care. Dementia and Ethics Reconsidered covers a wide range of ethical dilemmas that professionals working with dementia come across in their daily work. The book reviews these issues through an ethical framework and includes discussions about ethical theory to the application of ethical thoughts in our day to day practice.

Dr Hughes writing is engaging, with a touch of humour but with a strong sense of compassion and practicality. There are number of case vignettes that help illustrate the clinical problems that many of us will recognise. He does not shy away from difficult and potentially contentious topics such as covert medication, very early diagnosis, resource allocation and end of life care.

The book balances the person with dementia’s autonomy with every day challenges of proving care and treatment. I found the chapters on capacity and consent useful and will be using some of the flowcharts when teaching junior doctors. Dr Hughes writing makes ethical theories accessible, easy to understand and applicable to normal clinical practice and is also a useful taster into the world of values based philosophy.

This is a book is a valuable resource for anyone working with older people with dementia but would definite recommend this book to any Older Adult Psychiatrists who wish to add a more ethical depth to their practice.



WINNER OF THE RCPSYCH OLD AGE FACULTY 'NATIONAL OLD AGE TRAINEE ESSAY PRIZE' 2023: 'UNMASKING MASCULINITY'

Dr Amy Fulker, CT2 , Southern Health NHS Foundation Trust

Introduction

In a world marked by evolving societal norms and shifting gender dynamics, the intersection of feminism, social support, and mental health in older men is an area of burgeoning significance. While feminism has often been associated with women's liberation, it has an equally vital role to play in challenging traditional, stereotypical masculinity and promoting the well-being of men, particularly as they age. This essay aims to explore this multifaceted relationship, drawing on the experiences of a real patient to provide context and depth to the discussion. It is important to note that this essay focuses primarily on heterosexual couples, as the scope of this work does not allow for a comprehensive discussion of more diverse couples.

The Real Patient's Journey: A Case Study

I attended a home visit to an 88-year-old gentleman, who I will call Mr A. He had been experiencing delusions and auditory hallucinations. These centred around a financial scam that he was the victim of. The voices would threaten him and say he needed to give them money. This was on a background of his wife passing away after a long battle with colon cancer, just as the COVID-19 pandemic was starting. He had support from a grief counsellor following this with weekly phone contact. He had a good relationship with this counsellor and found speaking to them very helpful. Unfortunately, the funding for this was cut and he no longer had access to this. He felt it was from that point onward that he deteriorated.

The delusions and hallucinations started about one and a half years ago. He felt that he couldn't confide in any of his friends and family. He would ruminate on his wife's final moments in the early hours of the morning. He had lost his confiding relationship leading to a deterioration in his mental health. He deteriorated to the point that his friends and family became aware that something was wrong. Once they realised, he was able to start talking about what was going on. His family were able to talk to him about his delusions. Over time these became less fixed, and he finally realised that they were delusions, and the voices were not real. This really highlighted to me the importance of having a confiding relationship.

Mr. A's Struggle with Traditional Masculinity

Mr. A's upbringing and societal expectations, rooted in the era in which he was born, compelled him to suppress his emotions and maintain a stoic façade. Men of Mr. A's era were often raised in an environment that expected emotional restraint and stoicism. Expressing vulnerability or seeking help for mental health concerns was viewed as a sign of weakness. Older adults with mental health problems are especially unlikely to seek professional mental health services.[1] A systematic review found that stigma, negative beliefs about mental health professional services, and cost were the most reported barriers.[2] They concluded that older adults are in need of interventions normalizing mental health help seeking. Generally speaking, men exhibit lower levels of emotional expression compared to women, often hesitate to reveal vulnerability, and are notably less inclined to seek professional assistance when compared to women.

This reluctance to seek help is a shared characteristic that transcends factors like age, race, ethnicity, and nationality.[3]

This internalization of traditional masculinity came to the forefront when he faced the sudden and overwhelming challenges of delusions and auditory hallucinations. He didn't reach out to friends or family about these issues. It wasn't until he could no longer hide his symptoms that he finally divulged what had been going on.

Older adults are less inclined to actively seek assistance for symptoms of depression or anxiety unless their social support circle promotes a positive mindset toward seeking help.[4] If present this leads to positive help-seeking intentions and subsequently utilizing mental health services. This was certainly shown in this case. Once Mr A's family and friends were involved, they supported him to access mental heath services. His friends actively encouraged him to delay his prior commitments and prioritise seeking help for his mental health. This lead to a very positive interaction between myself and Mr A. He felt less alone, less anxious, and had his experiences validated and normalised.

The Importance of Confiding Relationships: A Glimpse into Mr. A's Struggles

Mr A's wife sadly passed away in early 2020 during the peak of the COVID pandemic. This was the loss of his closest relationship. As we age, we are more likely to rely on spouses for social support.[5] In particular older men are more likely to confide in a spouse, whereas older women chose friends and children, usually daughters, as their confidants.[6] This highlights just how important this relationship, and the emotional support it provides, can be for older men. Lower levels of social and emotional support are associated with increased mental distress, depressive symptoms, anxiety symptoms and insufficient sleep.[7]

Not only did Mr A lose his closest confidante, but he also suffered emotional turmoil relating to the circumstances of her passing. Mrs A had a long battle with colon cancer, and she wanted to fight this cancer until the bitter end. She didn't accept that there were no more treatment options. She did not want to go into the Hospice at the end of her life. The Hospital team and Mr A had to put pressure on Mrs A to get her into the Hospice. Their biggest concern was that she would be stuck on a general hospital ward for her final days.

Mr A was called in to be with his wife whilst she passed away at approximately 4am. He describes watching the person you love most in the world pass away as a harrowing experience. Since then, he often awakens at 4am and will be overwhelmed by anxious thoughts. He calls this is 4am demons.

Thankfully, with encouragement from the Hospice, he sought support from a grief counsellor with whom he developed a trusting and confiding relationship. Due to COVID 19 these sessions were 1 to 1 and held over the phone. Mr A reflects how well these sessions suited him. He felt that he could really open up, in comparison to the in-person group session which was run prior to COVID 19. He felt able to truly share his thoughts and feelings, in a way that he couldn't with his friends and family. This appeared to have a positive effect on Mr A's mental health and he initially coped well.

The Descent into Delusions and Hallucinations

While he initially had support from a grief counsellor, this lifeline was severed when funding was cut. The abrupt cessation of counselling left Mr. A feeling isolated. After this, Mr. A's mental health began to deteriorate. He was no longer to speak to anyone about his '4am demons'. He was overwhelmed by guilt.

Mr. A's experiences were marked by auditory hallucinations and delusional beliefs. He recounted hearing voices, sounds, and music, often linked to a delusion that he was the target of a financial scam. These voices, he believed, belonged to the perpetrators of the scam, and he would sometimes conduct searches around his house for hidden speakers and microphones or relocate to different rooms, attempting to locate the source of the voices. Additionally, he endured persistent, hours-long episodes of singing that severely disrupted his sleep. The voices consistently revolved around the trust fund for fellow residents in his apartment building, involving requests for money or conspiratorial plots against him.

Mr. A's experiences highlight a poignant moment where he felt he could no longer confide in anyone. The grief that haunted him in the early hours of the morning, coupled with the tormenting voices, became unbearable.

The Importance of Rekindling Confiding Relationships

The importance of Mr. A's relationship with his daughter in his journey towards recovery cannot be overstated. As Mr. A's mental health continued to deteriorate, his friends and family began to sense that something was amiss. They noticed the distress and confusion that had taken hold of him, and their concern prompted them to intervene. It was during this crucial phase that Mr. A's relationship with his daughter came to the forefront as a lifeline for his healing process. His daughter's involvement in his struggle marked a significant turning point. She recognized the depth of her father's suffering and the torment he was enduring due to the delusions and auditory hallucinations. Her willingness to engage in open and empathetic conversations with her father about his experiences proved to be transformative. Through their discussions, Mr. A began to share the distressing details of his delusions, and this sharing of thoughts and emotions was instrumental in breaking down the barriers that had isolated him for so long.

One particular moment stood out as a breakthrough in Mr. A's path to recovery. His daughter suggested a novel approach—recording the voices on his phone. This method allowed them to listen together to the recordings, and to their surprise, there was nothing on the clip. This powerful evidence provided by the recorded voices challenged the delusions that had tormented Mr. A for so long. Instead of doubling down on his beliefs, as is often seen in individuals experiencing psychosis, Mr. A was able to trust his daughter's perspective. This marked a significant turning point in his recovery, as he began to question the authenticity of the voices and delusions, gradually releasing their grip on his life.

While Mr. A's journey underscores the importance of maintaining regular contact with a trained professional, as exemplified by his positive relationship with his grief counsellor, it also highlights the unique role that his daughter played in his healing process. Her unwavering support, compassionate listening, and innovative approach to addressing the delusions became a source of strength for Mr. A.

Through her encouragement and her role in challenging his distorted perceptions, Mr. A came to appreciate the profound benefits of confiding relationships, particularly within his own family. It was his daughter who rekindled the flicker of hope and recovery, emphasizing that these connections within the support network are invaluable in the mental well-being of older individuals like Mr. A.

Conclusion to The Real Patient's Journey

Mr. A's narrative demonstrates how older men who came of age in the 1930s navigated the treacherous waters of emotional expression and mental health within the confines of their societal norms. His journey vividly underscores the vital role of confiding relationships in the lives of older men. His narrative demonstrates how the loss of such relationships can precipitate a mental health crisis, while their restoration can be instrumental in the path to healing. His story serves as a poignant reminder of the evolution of masculinity, the importance of shedding the constraints of traditional gender roles, and the pressing need to foster open, empathetic connections within society, regardless of one's generation.

The Intersection of Feminism and Men's Mental Health

Feminism, often perceived as a women-centric movement, fundamentally seeks to break down gender-based stereotypes and eliminate structural barriers that limit the potential of any gender. An essential aspect of this is dismantling the rigid constructs of traditional masculinity, which can be particularly detrimental to men's mental health. This is where the intersection between feminism and men's mental health becomes evident.

Gender Disparities in Grief: The Profound Impact of Spousal Loss on Men

Notably, the loss of a spouse is one of the most profoundly impactful life events that men undergo. This significant event is associated with notable increases in in morbidity and mortality for individuals of all genders. However, during the initial grieving period, the impact on men is relatively more pronounced than on women, underlining the distinct emotional challenges that men face during these times.[9] In the realm of grief, Bennett eloquently articulates the impact of masculinity, stating, "As well as being forced to confront cultural notions of what is 'masculine', widowers find themselves up against conventional ideas (both academic and popular) about what it is to grieve." Bennett goes on to emphasize that societal expectations for those grieving the loss of a spouse can be particularly challenging for men. Western society prescribes a set of norms for grieving individuals, which include the display of emotion, a temporary withdrawal from society, and cautiousness in forming new relationships. These expectations often clash with the traditional ideals of masculinity, marked by emotional restraint and a focus on public life. In this complex landscape, widowed men often find themselves navigating a delicate balance between demonstrating their grief while adhering to masculine norms. Bennett's insights shed light on the intricate challenges men face in the grieving process.[10]

Traditional Masculinity: A Barrier to Emotional Expression

Traditional masculinity, marked by the expectation that men remain emotionally reserved, often poses a barrier to their willingness to confide in others regarding their emotional challenges. This emotional stoicism is a common characteristic of men, as women typically are more confrontive and expressive of their emotions than men. [11] Practices of masculinity include neglect of social networks and avoidance of any self-report of emotional strain.[12] Qualitative studies have revealed gendered pressures to maintain expectations of leadership and protection attached to fatherhood roles, leading to reluctance to reveal vulnerabilities.[14] The real patient's experience can serve as a prime example, illustrating how societal pressures have played a pivotal role in suppressing his emotions.

In his influential 1976 book, Brannon delved into the themes of masculinity and the male sex role. He outlined how men are socialized to distance themselves from behaviours traditionally associated with girls, to be cautious about expressing their emotions or revealing vulnerability, and to become adept at concealing their feelings.

This socialization demands that men uphold a 'stiff upper lip,' even in situations where they've lost a life partner and are in dire need of emotional support.[15]

Attempts to adhere to these masculine ideals seem to have a detrimental effect on men’s psychological wellbeing.[16] Abandoning this role can lead to better outcomes. It has been found that men who coped better with bereavement were more likely to talk to other people about their feelings. This was not necessarily their feelings about the bereavement, but feelings in general. It seemed that it is was the willingness to talk that was the most important factor.[8]

Challenging Stereotypes: Embracing a Balanced Emotional Landscape

Bennett's perspective sheds light on the challenges that older men often face as they confront the later stages of life. These challenges, he contends, include the loss of traditionally masculine attributes such as autonomy, physical strength, and unwavering mental resilience. As men age, there can be a gradual erosion of these stereotypical qualities, leaving them grappling with societal expectations and personal identity.[8]

In this context, feminist principles offer a refreshing perspective. They advocate for a re-evaluation of traditional gender roles, highlighting the value of emotional openness and vulnerability for men. The overarching idea is not to negate masculine qualities but to expand the definition of masculinity, allowing men to be more emotionally attuned without compromising their sense of self.

The real patient's journey, as illustrated in their experiences, offers an illuminating case study. Through their story, we witness a transformation—an older man who, through the act of opening up to his friends and family, particularly his daughter, took the initial steps toward embracing a more open and authentic relationship with his emotions. His journey serves as a testament to the power of challenging stereotypes and evolving notions of masculinity, ultimately contributing to improved mental well-being in older men. By seeking this balance, men like Mr A. are breaking free from the constraints of traditional masculinity and embracing a more holistic, emotionally fulfilling path as they age.

Conclusion to The Intersection of Feminism and Men's Mental Health

In summary, the connection between feminism and men's mental health is all about challenging traditional views of masculinity to create a more supportive environment for men, especially during difficult times like grief. Feminism, which is often associated with women's issues, is actually about breaking down old ideas about what it means to be a man, allowing them to express their emotions and seek help when needed. This intersection helps men, especially older ones, deal with their feelings in a healthier way, which is essential when they go through significant life changes, such as losing a spouse.

Feminist principles encourage redefining masculinity to allow emotional openness without compromising a man's identity. This transformation is exemplified in the patient's journey as he embraced emotional authenticity, particularly through open conversations with his family, especially his daughter.

The intersection of feminism and men's mental health envisions a society where older men can face life's challenges with resilience and well-being, free from the constraints of traditional masculinity. It promotes authenticity and thriving for all, regardless of gender.

Relationships: Social Dynamics and Emotional Well-Being in Older Men.

Confiding relationships, where individuals can openly discuss their feelings and thoughts without judgment or stigma, are pivotal for maintaining good mental health. In the context of older men, these relationships become crucial as they navigate the complexities of aging, life transitions, and emotional well-being.

Friendship and Community

Robust friendships and a nurturing community often serve as the cornerstone of an enriched quality of life. Research consistently finds that people with strong social networks have better health outcomes – both mental and physical.[17] Mr A. reported feeling lonely often, despite having people to reach out to. He was initially very reluctant to share his feelings and emotions. The patient's journey shows how his friends and family supported him and encouraged him to seek further mental health support.

Loneliness, a prevalent issue among older men, has been closely linked to adverse health outcomes. When it comes to seeking help and opening up about their feelings of isolation, studies have revealed that ingrained notions of masculinity and societal expectations related to traditional male roles can pose significant barriers for older men.[14]

Discussing emotions is widely regarded as something associated with women, and, for certain men, it's considered a sign of "feminine weakness".8 These societal expectations significantly influence how they approach seeking assistance and cope with the emotional challenges of loneliness in their daily lives.[18]

Discussions with older men indicated a significant emphasis on personal autonomy and self-reliance. Many of these men expressed ambivalent attitudes about core aspects of what is often considered a traditional "female script," including the necessity for intimacy and social interaction.[19] Another qualitative study reaffirms this sentiment, with older men consistently expressing a pervasive sense of social disconnection during interviews. They conveyed feelings of isolation and detachment from their social circles, perceiving a growing disconnect between themselves and the broader society as they advanced in age. [20]

The Role of Partners and Spouses

The presence of intimate partners and spouses is instrumental in offering emotional support and encouraging men to confide in them. In a qualitative study focusing on loneliness in older men, it was revealed that significant life events, particularly the death of a spouse or partner, were frequently cited as triggers for feelings of loneliness.
Notably, over a third of all study participants highlighted this event, underscoring the profound emotional impact experienced by men in such situations. These findings emphasize the crucial role that intimate relationships play in men's emotional well-being. [14]
Additionally, it's important to recognize that men's broader social networks are often intertwined with their spouse or partner.

When a partner or spouse is lost, older men can face considerable challenges in maintaining connections and companionship with others, resulting in a decline in their overall social relationships. [21] Studies have shown that women tend to have larger social networks and receive support from many sources, whereas men tend to rely exclusively on their wives.[22]

Men's dominance within the family unit results in women being primarily responsible for domestic activities, which include managing familial and social connections. This division of domestic labour favours men in their professional careers, enabling them to channel their efforts into work and secure their financial stability in their later years. Nevertheless, this arrangement also means that women tend to cultivate broader social support systems.[10]

Empowering Older Men: The Role of Gender-Based Social Interventions in Promoting Mental Health and Well-Being

When considering the intricate relationship between feminism, social support, and the mental health of older men, it becomes evident that gender-based solutions are crucial. Social interventions must address the specific needs and challenges that older men face, particularly in the context of traditional masculinity and societal expectations.

Older men often encounter greater difficulty than women in establishing new friendships during their later years. This can be attributed to various factors, including the lifelong socialization into traditional masculine roles that encourage emotional restraint and self-sufficiency.

Furthermore, they may be less inclined to participate in social organizations within their communities, which frequently have a female majority, possibly due to the clash between their own identity and the predominantly female environment.[23],[24]

Elderly men's underutilization of community health resources and their lower engagement in preventive healthcare activities can also be linked to traditional masculinity's influence. The pressure to conform to masculine ideals, which discourage openness and vulnerability, might discourage them from seeking help or engaging in activities typically associated with women. [11]

Gender-based solutions recognize these challenges and aim to develop programs and interventions that not only acknowledge but actively address the impact of traditional masculinity on older men's mental health and social well-being. By fostering environments that encourage emotional openness, deconstructing rigid gender norms, and creating support networks tailored to the specific needs of older men, we can work to overcome these barriers and promote better mental health outcomes for this demographic. Such gender-sensitive interventions represent a critical step in ensuring that older men can access the support and resources they need to thrive, regardless of societal expectations related to masculinity.

Men’s Sheds: Fostering Social Inclusion and Well-Being Among Older Men

One way to try and address these issues is with gender-based social activities. One obvious example of this is Men’s Sheds. "Men's Sheds" is a global movement that provides a unique and supportive space for older men to come together, socialize, work on practical projects, and promote their overall well-being.

The concept of Men's Sheds originated in Australia in the early 2000s. It was developed as a response to social isolation and mental health issues that older men often face, especially after retirement or significant life changes. Men's Sheds are based on a simple yet powerful philosophy: "Shoulder to Shoulder." The idea is that men come together in a communal space to work on projects, have conversations, and support one another.

It provides an opportunity for men to engage in meaningful activities while reducing social isolation. Men's Sheds are typically set up as community workshops or shared spaces equipped with tools and resources for woodworking, metalworking, gardening, and other practical projects. These activities offer a sense of purpose and achievement to participants.

A review of both Men’s Sheds and other gender-based activities found that engaging in these activities led to improvements in self-reported mental health. A consistent theme was one of a greater sense of belonging and purpose.

There was also evidence of beneficial effects on social wellbeing. Men's Sheds addressed social isolation and loneliness by enhancing self-esteem and offering social support through the cultivation of friendships and a strong sense of companionship among male participants.[25]

Key Success Factors in Men's Sheds and Gender-Based Interventions

Successful Men’s Sheds had a good location, provided a diverse range of activities, had extended operating hours, strong local support and a proficient co-ordinator who facilitated smooth running.[26]

t's worth emphasizing that individuals involved in Men's Sheds typically perceive themselves as volunteers or members (as opposed to clients or patients), gathering to engage in hands-on activities they find enjoyable. Their primary focus is often contributing to the community rather than being the target of an intricate social intervention aimed at enhancing their health and well-being.]21] Framing these activities in this way allows men to maintain the ‘manly air of toughness, confidence, and self-reliance’ as proposed by Brannon11, while still engaging in social groups aimed at combatting loneliness. These are spaces where older men can perform and reaffirm their masculinity.[22]

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There was recurring theme of finding a sense of identity and purpose in other successful interventions. This could be achieved either through formal volunteering or learning new skills. The strong bonds and feelings of camaraderie that can develop among elderly men participating in meaningful, voluntary social engagements form the foundational building blocks for the effectiveness of initiatives like Men's Sheds and similar interventions.[21]

Conclusion to Empowering Older Men: The Role of Gender-Based Social Interventions in Promoting Mental Health and Well-Being

In conclusion, the role of social interventions in the context of older men's well-being is of paramount importance. The challenges older men face in establishing new friendships, their reluctance to engage in female-dominated social organizations, and their underutilization of community health resources and preventive healthcare activities underscore the pressing need for gender-sensitive solutions.

"Men's Sheds," a global movement born out of the recognition of these challenges, offers a unique and supportive environment for older men to come together, foster social connections, and embark on meaningful projects.

This section has shed light on how these gender-based social activities can significantly enhance older men's mental health by providing a sense of belonging, self-esteem, and social support.

Importantly, the participants perceive themselves as volunteers or members, emphasizing their role in contributing to the community while maintaining their traditional masculinity.

In addressing the multifaceted relationship between feminism, social support, and the mental health of older men, social interventions like Men's Sheds serve as exemplars of how older men can find camaraderie, purpose, and emotional support while preserving their sense of self. By recognizing and promoting such initiatives, we move toward a more inclusive and supportive society where older men can thrive in their later years.

Conclusion

The intersection of feminism, social support, and mental health in older men is a fascinating area to explore. It's clear that traditional masculinity can have a profound impact, as demonstrated in the real patient's journey. However, recognizing these challenges allows us to help older men overcome these barriers effectively. As we conclude our exploration, it's crucial to understand that masculinity is not a fixed concept; it evolves, just like society does. Traditional notions of masculinity, often centred around emotional restraint and stoicism, can create significant hurdles for older men when it comes to seeking help and opening up to others. Mr. A's story is a compelling illustration of these challenges and how transformative it can be when individuals break free from the confines of traditional gender roles.

As we conclude our exploration, it's crucial to understand that masculinity is not a fixed concept; it evolves, just like society does. Traditional notions of masculinity, often centred around emotional restraint and stoicism, can create significant hurdles for older men when it comes to seeking help and opening up to others. Mr. A's story is a compelling illustration of these challenges and how transformative it can be when individuals break free from the confines of traditional gender roles.

Additionally, we've highlighted the significance of social relationships and the role of intimate partners in older men's emotional well-being. The loss of a spouse, in particular, can trigger feelings of loneliness and emotional distress. This underscores the importance of fostering stronger social connections, especially as men navigate the complexities of aging. Importantly, these connections should be provided in a way that preserves and respects the sense of masculinity older men hold dear.

References available upon request

WINNER OF THE RCPSYCH OLD AGE FACULTY ‘OLD AGE PSYCHIATRY MEDICAL STUDENT PRIZE ESSAY’ 2023: ‘POSTERIOR CORTICAL ATROPHY IN YOUNG ONSET DEMENTIA’

Jessica Pellumbaj, Medical Student, University of Nottingham

Introduction

Posterior cortical atrophy (PCA) is a progressive neurodegenerative disease of the parietal, occipital, and occipitotemporal lobes resulting in a decline in visual processing and other cognitive dysfunctions (Crutch et al., 2012). The age of onset of PCA is typically <65 years, the syndrome of which is recognised as a rare cause of young-onset dementia (YOD). PCA was first recognised as a distinct disorder by Benson et al., in 1988 who understood a pattern of dementia characterised by an initial decline of high-order visual functioning, with preserved memory, insight and judgement until advanced disease. PCA, accordingly, is also known as Benson's syndrome. This paper covers existing literature on what is currently known and understood of PCA, and talks of my experience in understanding this disease as observed in clinics throughout my 4-week placement with the University of Nottingham’s YOD team.

Epidemiology

It is difficult to comment on the incidence and prevalence of PCA given historical discrepancies in defining and classifying the disease, its relative rarity, and a general lack of research. It is impossible to evaluate geographic information on the distribution and rate of occurrence between countries due to a lack of literature. PCA normally presents between the ages of 50-65 years. A study evaluating genetic risk factors for PCA found the mean age of onset across a group of 302 patients to be 58.9 years, with 82.5% of patients presenting at <65 years of age (Schott et al., 2016). It is estimated PCA may be responsible for roughly 10% of all YOD diagnoses (Koedam et al., 2010).

While some studies report a higher incidence of PCA in women, it can be argued the findings represent a correlation between Alzheimer’s disease (AD; a common cause of PCA) and sex rather than PCA itself, and the general consensus seems to follow that there is no real difference in incidence between sexes (Renner et al., 2004; Schott et al., 2016).

Aetiology

Studies proving the presence of amyloid plaques and neurofibrillary tangles in the parietal and occipital lobes argue PCA to be an atypical visual variant of AD (Bokde et al., 2001; Levine et al., 1993; Ross et al., 1996). Similarities in neuroimaging showing regional overlap in atrophy of areas such as the posterior cingulate gyri, pre-nucleus, and inferior parietal lobes further argue AD as the underlying trigger for PCA in the context of YOD (Galton et al., 2000; Migliaccio et al., 2009; Ross et al., 1996). Comparisons of amyloid burden in PCA show little differences across the cortex compared to typical AD (Tang Wai et al., 2004). This close relationship in the distribution of pathology between AD and PCA is further proven at autopsy where there is no denying the AD pattern of decay predominantly found in cases of patients with PCA (Crystal et al., 1981; Ross et al., 1996). Whilst AD remains the predominant neuropathy of PCA, conversations concerning other neurodegenerative conditions such as Lewy body dementia, Creutzfeldt-Jakobs disease, and gliotic syndromes suggest other causative aetiologies also play a role (Galton et al., 2000; Renner et al., 2004; Yerstein et al., 2021). Corticobasal degeneration can also manifest with symptoms synonymous with PCA including visuospatial dysfunction concurrent with posterior cerebral decay (Tang-Wai et al., 2003). PCA, however, can also present independent of underlying pathology. An evaluation of the clinical differences between patients presenting with PCA and typical AD highlighted important comparisons of the two patient groups and argued PCA to be its own distinct clinical syndrome rather than an AD variant (Mendez et al., 2002). Discrepancies and differences in opinion regarding these different aetiologies lead to establishing a consensus criterion in diagnosing and classifying PCA as its own distinct pathology. In 2017, Crutch et al. created a framework of classification to help better understand PCA and its different presentations and aetiologies where factors such as biomarker evidence, neuroimaging, and criteria of exclusion all come into play when deciding on appropriate PCA classifying.

Clinical and cognitive features

On examination, for a patient to be considered for a diagnosis of PCA they must first demonstrate three principles of any neurodegenerative disorder – their condition must: (1) be insidious in onset, (2) gradually progress/degenerate, and (3) have no other identifiable cause like tumour or vascular disease. More often than not, the first symptom patients with PCA complain of is a change in their vision and visuospatial awareness. A typical history may describe recent troubles with tripping over and bumping things, as well as new difficulties with surface and depth perception – mistaking a dirty top on the floor as a hole in the ground (Alzheimer's Research UK, 2021). The nature of these presentations often means patients with PCA become first known to the secondary care services of ophthalmology before redirection to YOD.

Patients with PCA also commonly report features of Gertsmanns syndrome (acalculia, fingers agnosia, agraphia, and left-right disorientation) and Balints syndrome (triad of optic ataxia, oculomotor apraxia, and simultagnosia) as well as alexia and apraxia (Benson et al., 1988; Crutch et al., 2012). Reading issues are especially apparent in the initial presentation of PCA, where patients may recall losing their place on a page, letter crowding and finding it hard to follow lines on a page (Catricala et al., 2011; Crutch et al., 2009; McMonagle et al., 2006). Picture agnosia, the inability to recognise photographs of an item compared to its real-life object, though seen in YOD-AD, is also characteristically found in early-stage PCA (Sugimoto et al., 2012).

Here, picture-naming cognitive testing plays a role in supporting diagnosis. Colour desaturation and abnormal hues may be described in patients with AD-PCA in relation to visual cortex involvement in understanding colour and its eventual dysfunction in disease (Alzheimers Research Uk, 2021; Chan et al., 2001). Due to the retro-chiasmal pattern of disease in PCA, patients can sometimes present with homonymous hemianopia visual field defects (Formaglio et al., 2009; Pelak et al., 2011). In fact, any insidious onset homonymous hemianopia should raise suspicion of possible PCA and ideally testing to rule out neurodegenerative pathology should follow. Other signs of PCA can include language impairment and anomia, where a linguistic profile similar to that of patients with typical AD is seen where phonologic word retrieval especially presents with prominent difficulties, though is usually noticed in later-stage disease unless specifically searched for (Crutch et al., 2013). A classical feature in the differential diagnosis of PCA is the sparing of episodic memory at the onset of disease.

Though this preservation is not seen in terms of working memory, it is usually enough to direct suspicion of a diagnosis of PCA over other YOD aetiologies (McMonagle et al., 2006). Up to 24% of patients with PCA can experience visual hallucinations (Tang Wai et al., 2006). One study comparing the clinical and imaging features of PCA patients with and without hallucinations found associated parkinsonism and myoclonic jerks in patients with hallucinations, suggesting there may be thalamocortical dysfunction involvement responsible for these symptoms (Josephs et al., 2009). Motor symptoms of dyspraxia and limb rigidity generally reflect an underlying pathology causing both the motor features as well as PCA therefore it is important to remain aware of differential diagnosis in this context, as Lewy body dementia, Huntington's disease, and Corticobasal degeneration can present similarly (Ryan et al., 2014; Suarez-Gonzales et al., 2016). When considering personality and behavioural changes in the context of PCA, early anxiety, though difficult to discern in origin, is another clue to be conscious of. While insight and personality, for the most part, are preserved in the early stages of disease, many patients report unfamiliar new onset panic-like symptoms. This anxiety can sometimes be traced to their new cognitive troubles, but sometimes it can present non-specifically (Everhart et al., 2012). On the contrary, anosognosia is typically observed among patients with AD.

Management

The prognosis for PCA is poor as with any neurodegenerative disorder. Pharmacological treatment options are typically dictated by whether or not there is an underlying concurrent pathology. One study observing anticholinesterase inhibitors in the treatment of a patient with PCA-AD reported a degree of response (Kim et al., 2005) however no further reports or trials on the effectiveness of these drugs in PCA have been published since.

Treatment is therefore generally supportive and catered towards optimising the quality of patient life and function. The diseases' progressive nature means deterioration of visuospatial and cognitive symptoms will invariably and inevitably worsen and patient expectations must be managed. While insight is generally retained, awareness of their increasing dependency and imminent deterioration can lead to significant mental health problems. Many patients become functionally blind and must surrender their driving licences. Those in work face early termination of their careers which can impact their emotional wellbeing. Mood is generally managed through primary care services and supportive talking group therapies can be useful in tackling the social isolation that comes with a diagnosis of a rare condition like PCA, and it gives patients the space to share their experiences with people who not only understand but are able to provide personal advice on their own coping strategies. Practical tips and tricks, like switching to audiobooks in the absence of fluency, can help manage smaller obstacles. Unable to work, a lack of structure and daily routine can feel further disorientating for patients and so families are educated on the benefits of timetabling with little tasks and activities for their loved ones to help provide daily purpose for the patient. Occupational therapies are important in exercising a patient's physical and cognitive skills, helping to maintain and preserve some control and independence with their day-to-day activities of looking after themselves. This input also provides some much-needed respite for the family themselves.

Case study

During my time with the YOD team, I observed a consultation of a patient in the early stages of PCA. The patient had positive features of PCA; she had a background of progressive visual difficulties, especially problems with her peripheral vision, as well as anxiety and aphasia.

When prompted to talk about the development of any new symptoms or worsening of any established ones, the patient described increasing dinner-time difficulties. Over recent months, her ability to use cutlery when eating had steadily declined and she was no longer able to co-ordinate the task of cutting up food or bringing a fork to her mouth. She also talked about feeling ‘lost’ in not knowing what to do throughout the day. Her hopelessness, she described, felt worse by the fact she was no longer allowed to drive, shop independently, or work. I was able to pick up on elements of aphasia where the patient’s partner would help guide the conversation by telling their account of her symptoms when she struggled to find the words. The patient's episodic memory remained relatively intact and her insight was striking as she demonstrated self-awareness in understanding the nature of her condition and even expressed anxiety in knowing her cognition was deteriorating. The consultant demonstrated the value of a good collateral history by using the partners account to create a timeline of the patient’s symptoms and used this to assess the patient's change in cognition. A collateral history can also guide treatment planning by recognising struggles the patient themselves may not be aware of, and it provides a voice and opportunity for the family of the patient to express areas of support they may feel they need. It was discussed the benefits of help from occupational therapy in supporting the patient and her partner and they were educated on practical tips like keeping a weekly task calendar to help structure the patient’s day. This was an important point in the consultation where the clinician set realistic standards for the patient and her partner, in that they would likely benefit from external help. I reflected on this practice and thought of ways I may manage patient expectations in the future. Preparing before a difficult consultation by reading the patient's notes beforehand is an appropriate start. Delivering information gradually using simple but direct language so the patient is not overwhelmed all at once is good practice that makes for a successful consultation.

It is also always helpful to plan for time to allow for questions the patient and their family may have and to stay sharp and identify moments in which you, as a clinician, can offer support and build the relationship. While it was a difficult consultation to observe, it was an educational experience in learning about PCA from its clinical presentations to the challenges of a consultation in assessing, diagnosing, and managing dementia. It was a useful opportunity to further my understanding of this condition and the way in which the YOD team runs its services in order to optimise patient care.

Conclusion and key points

PCA is a rare neurodegenerative disorder characterised by atrophy of the parietal and occipital lobes resulting in visuospatial decline and is a leading cause of YOD. Recognising patients with YOD have unique considerations is critical in identifying areas for practical and psychological support. Consultations which assess and manage dementia are especially challenging so it is important to understand ways in which clinicians can optimise patient care.

References available upon request

WINNER OF THE RCPSYCH OLD AGE FACULTY ‘OLD AGE PSYCHIATRY MEDICAL STUDENT PRIZE ESSAY’ 2023:
‘HOW A PATIENT WITH DEMENTIA CAN BE MANAGED AND SUPPORTED, AND HOW THE PROCESS AFFECTS THE INDIVIDUAL, THE FAMILY AND SOCIETY’

Harmanleen Singh, Medical Student, Brighton & Sussex Medical School

Dementia is a chronic and progressive syndrome caused by various diseases affecting the brain, characterised by a deterioration in memory, behaviour, and executive function, with no curative treatment. Whilst people living with dementia can live many years after their diagnosis, it has a significant physical, psychosocial, and economic impact on the individual, their families, and the wider society. Around 50 million people around the world have dementia, and this figure is expected to nearly triple by 2050 (1). The increasing number of people living with dementia and the challenges they face emphasise that dementia is a public health priority; actions must be taken to appropriately manage and support them (2). Using a case study, this essay will explore the experience of patients living with dementia, the challenges they face, and their interactions with healthcare through the process of diagnosis and management to highlight things that may help or hinder the patient’s overall well-being.

Case description

I had a chance to meet A and his wife as part of the ‘Time for Dementia’ programme in a non-clinical, longitudinal setting over multiple online virtual meetings from 2020 to 2021 (3). A is a 66-year-old man diagnosed with early-onset Alzheimer’s disease in 2013. He has recently become hard of hearing but doesn’t like wearing hearing aids. He has a past medical history of hypothyroidism, for which he is on low-dose levothyroxine. He is also prescribed donepezil, which is a cholinesterase inhibitor indicated for mild to moderate dementia (4). He currently lives with his wife, who supports him as an informal carer. He has two adult sons who live in Kent and New Zealand. In recent times, his neighbours have also supported him with shopping, while he has to shield at home due to COVID-19.

Prior to his diagnosis, A used to work full-time with a non-government organisation helping refugees. He subsequently had to drop the number of hours he worked and then eventually retired. Nevertheless, he is fiercely independent and enjoys driving, dog walking and bowling.

Diagnosis, support, and management of a patient with a chronic disease.

The diagnosis of Alzheimer's disease is made using the NIA (National Institute of Ageing) criteria. This diagnostic process can be lengthy as it involves clinical assessment to test cognition and memory, referral to a memory clinic, neuropsychological testing, further tests for biomarkers and neuroimaging to look for evidence of protein aggregation and regional brain atrophy (4).

A was diagnosed with Alzheimer's disease three long years after the onset of his first symptom: his wife noticed that something was wrong when A could not do measurements and calculations correctly.

A feels that it took so long because doctors are afraid to diagnose someone with dementia because it is incurable. In fact, a review analysing missed and delayed dementia diagnoses cited eighteen studies that identified the physician's attitudes towards dementia as a major barrier, particularly the perceived burdens of diagnosis in the early stages of dementia (5). This is significant because earlier diagnosis can provide long-awaited answers and an opportunity for patients to make important decisions about their future life, care, and support whilst they still have the physical, mental and financial capacity to do so. It can allow patients to stay independent at home for longer and allow carers more time to adjust to their new role, resulting in a better quality of life for both the person living with dementia and their carer (6).

As shown in Figure 1, NICE guidelines recommend that people living with dementia should be encouraged to be involved in decision-making during the management of their condition (7). There is overwhelming evidence that shared decision-making improves patient outcomes (8). Despite this overwhelming evidence, shared decision-making can often be overlooked by clinicians, especially when working with patients with dementia, due to misconceptions and underestimation about the individual's ability to understand, communicate and make decisions.

A stated that almost immediately after he had been officially diagnosed, health professionals would simply ignore him, and they would speak almost exclusively to his wife to relay any information. He felt invisible as if his emotions and opinions did not matter.

In fact, the World Alzheimer Report 2019 also revealed similar findings: 85% of respondents living with dementia reported that their opinions were not taken into consideration (9). Furthermore, information about Alzheimer's disease should be provided to the patient by their primary care provider (figure 1). This information can be helpful for patients to understand their condition and how it is expected to progress. However, it is important that this information is communicated with an appropriate level of sensitivity; A recalls his GP saying, “Of course, you know it is only going to get worse”, which A perceived to be condescending and rude.

This can result in the breakdown of rapport between the patient and the clinician, hindering the patient's ability to access support. A's experience highlights those negative attitudes, assumptions and misconceptions, especially when propagated by health professionals, can hinder the overall well-being of people living with dementia. This can be addressed by providing staff training to healthcare providers about patient-centred care for people living with dementia, as suggested by the NICE guidelines in Figure 1 (7).

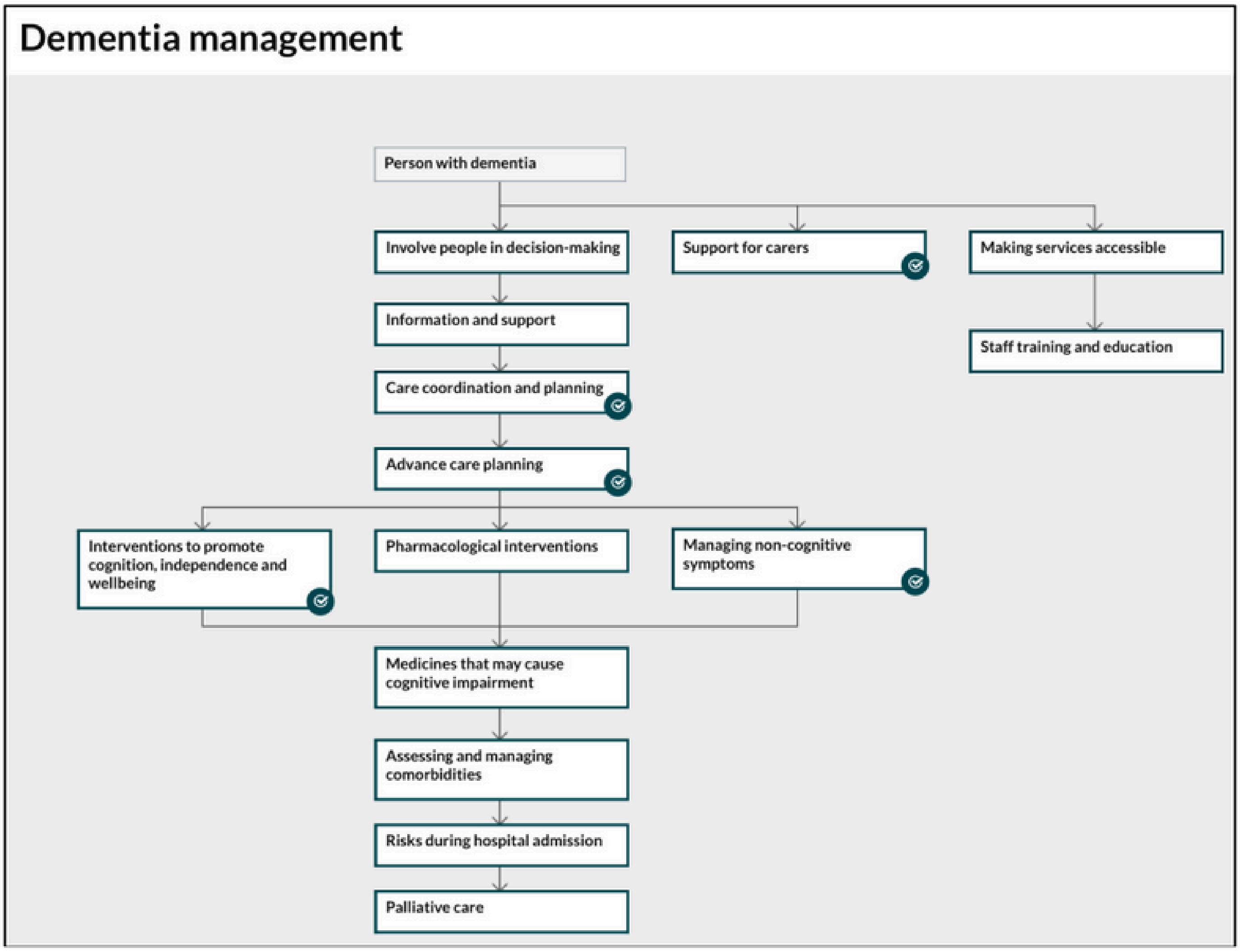


Figure 1: NICE (National Institute for Health and Care Excellence) guidelines for managing dementia presented as an interactive flowchart (7)

Whilst advances have been made in the understanding of the pathophysiology of Alzheimer's Disease, the management is still symptomatic. A was prescribed donepezil, a cholinesterase inhibitor, which increases the availability of acetylcholine to help improve and stabilise memory and cognitive function. Cholinesterase inhibitors, including donepezil, are first-line treatment for mild to moderate dementia. However, it is important to regularly review the patient using the Montreal Cognitive Assessment to assess their response to the medication (10). Since these medications are not disease-modifying, they should be stopped if the patient doesn't seem to have any symptomatic improvement; in this situation, alternative drugs such as memantine may be considered depending on the severity of Alzheimer's disease.

Furthermore, the side effects of the drugs and their impact on the patient's life should be discussed with the patient. For example, donepezil can cause muscle pain; for A, this meant that he could not go for longer dog walks, which he really enjoys. On balance, he decided to continue using donepezil after discussing it with his GP. For patients with multiple co-morbidities, other considerations must be taken into account, such as any medications they are taking should be reviewed and replaced if there are any severe drug interactions or contraindications. Non-pharmacological treatment options such as group cognitive stimulation therapy should also be offered to patients.

Management also involves treating non-cognitive symptoms that are associated with Alzheimer's disease, such as agitation, distress, anxiety, and depression. Pharmacological treatment for these symptoms should generally be avoided, except in specific cases, for example, pre–existing mental health problems. Instead, patients should be offered psychological treatment, or environmental and psychosocial interventions should be considered (7).

The goal of management is to slow down the progression of symptoms to allow the patient to maintain as much independence as possible for as long as possible. Nevertheless, patients normally require some support even in the early stages of Alzheimer's disease; this support is provided by a family member who takes on the role of an informal carer for up to 90% of patients (11). Caring for the needs of a patient with dementia can be challenging or even overwhelming, especially as the condition progresses and patients require support with activities of daily living. Patient’s needs should be assessed to develop a care and support plan to address these needs, for example offering professional caregiving services to those who need extra support. In addition, informal carers should also be offered more support, including education, training and advice, so that they are able to provide care effectively whilst maintaining their own physical, social and mental well-being (7).

The relationship between healthcare, social service, and voluntary service workers.

A and his wife both expressed frustrations about the barriers to accessing care. It is very difficult to navigate care services unless “you know the system”. For example, people living with dementia and their families can be offered support by social services, including providing carers, meals on wheels, aids and adaptations. The eligibility is evaluated by a needs assessment to develop a care plan. A’s wife admitted that initially she was not even aware that this support was available, and it was very difficult to request a needs assessment. She reported that the social worker was very empathetic but explained that they were not eligible for any support because A was deemed to be too young. Care Navigators are an excellent alternative to combat the lack of support that caregivers get. Care Navigators have the expertise to guide caregivers who in contrast do not have a substantial understanding of the system (12).

Another key barrier to accessing care is the cost; dementia care for one person can cost £100,000 or more. Social workers can also help families access financial support such as a Carer’s Allowance and contribution towards the cost of formal care. However, as in the case of A, many dementia patients and their caregivers are not awarded this allowance due to their ineligibility. As a consequence, carers are left without the necessary guidance or support to provide the appropriate care for dementia patients. Indeed, figures from Alzheimer’ society report that up to 50,000 hospitalisation of dementia patients could have been avoided had they received the suitable care (12). This highlights the need for integrated care in the management of patients with chronic condition to provide better outcomes for patients as suggested by the Chronic Care Model. A systematic review found that integrated care not only benefits patient health but also consistently generates potential savings for healthcare systems (13).

Healthcare worker often refer to voluntary service support and social group to improve the psychosocial wellbeing of the patient. A was offered several groups but he found that majority of them were targeted at older people living with more advanced dementia, so he felt that he did not fit in.

However, through Alzheimer's society, A got involved in a local community group called Rusty Brains which offers various dementia-friendly activities including walks, bowling and gardening. A really enjoys being a part of this group as it gives him an opportunity to socialise, make new friends and learn more about dementia. It allowed him to discover a new hobby in bowling whilst enjoying a pre-established hobby in gardening, which he was no longer able to do by himself. In the last year, however, none of these activities have been possible due to lockdown restrictions. The only alternative he was offered was a group phone call organised by Alzheimer' society, but A did not find this helpful as he prefers face to face conversation. Nevertheless, with 120,000 people with dementia living alone in the UK, this service might have been appreciated by those who felt isolated (14). A's quality of life was improved by his interactions with people outside of medical care which is significant when we consider that his main anxieties were related to how dementia would affect his occupation and his social life.

The impact of dementia upon the individual, family, and society.

The diagnosis of a chronic condition such as dementia affects all aspects of life of the individual, including their relationships with friends and family. A reflected that his post diagnosis experience was one of isolation as he lost his friends and his job; he spent the day sitting idle, watching television. Feeling of isolation along with neurochemical changes could lead to depression in up to 50% of patients with Alzheimer disease (15). A's coping strategies include finding different things to get involved in to keep himself busy such as the Rusty Brains society.

A also expressed that he really enjoys taking part in various clinical trials as he likes the idea of contributing to help others. This has given him a sense of purpose and helped him come to terms with his diagnosis.

A's condition has also prevented him from doing things he used to enjoy.

A used to be an avid reader, but now he loses track of what sentence he is reading. He has adapted by watching film adaptations of his favourite books instead. Fortunately, he has retained his ability to drive, which has allowed A to stay relatively independent and not rely on his wife to drive him everywhere.

A's wife had to travel to different countries for work on a frequent basis. Prior to A's diagnosis, A would often travel with her as he enjoyed visiting different countries and learning about different cultures. This was no longer possible after A had been diagnosed; A's wife had to stop working so she could stay with A as she adopted the role of an informal carer. She described that this had been a drastic change to her life, but she was willing to do so for A's health. Another big change for A's wife is that now she has to cook everything for A and herself, whereas A used to do all the cooking before. Many caregivers, especially women, for patients with dementia have to reduce the number of hours they work, with one-fifth providing unpaid care for more than 20 hours every week (12). The burdens and strain of providing care often have a negative impact on the carer's own physical and mental health for the majority of dementia carers (10).

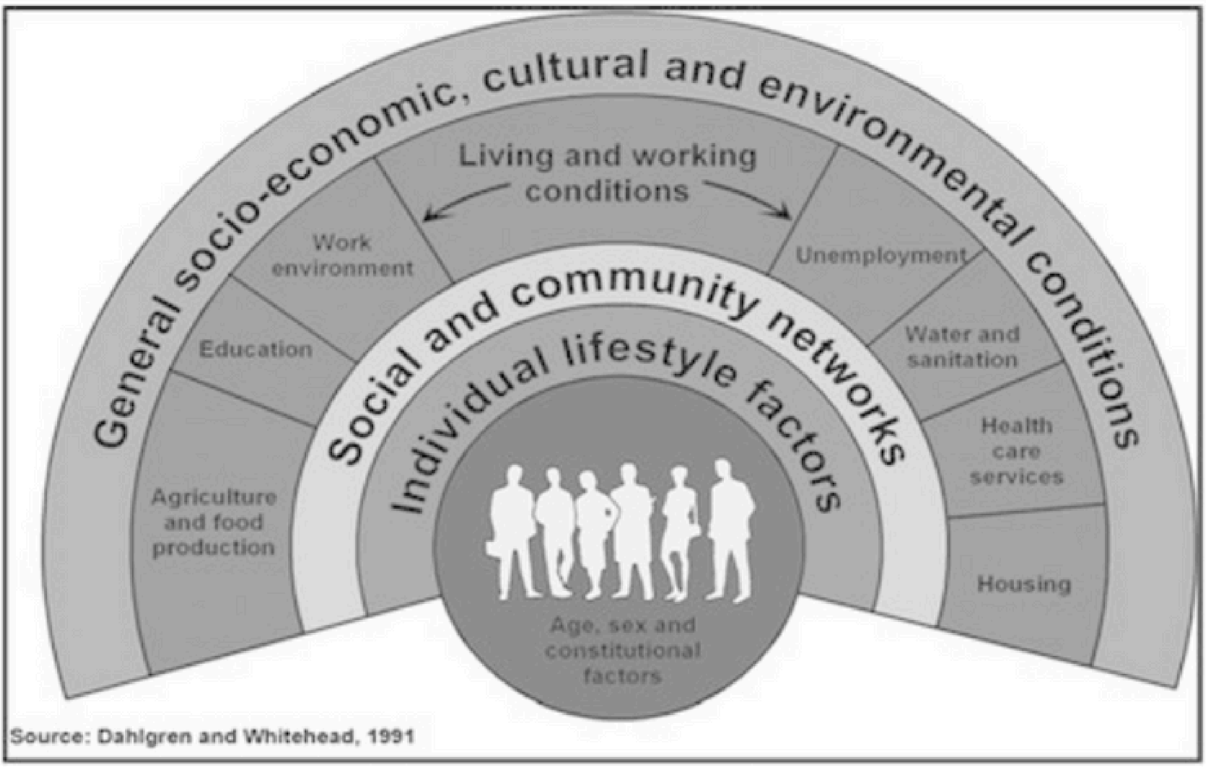
The global societal cost of dementia is around US$ 1 trillion, and this is expected to double by 2030 (1). In the UK, a significant proportion of this cost is paid by NHS and local councils. Undoubtedly, the population in the UK and many other developed countries is ageing, with one in five people in the UK over the age of 65 by 2030. This will result in a higher economic burden for taxpayers (16).

Identification and communication of key health promotion recommendations.

Dementia is becoming a key public health priority as its prevalence increases. Figure 2 illustrates that at the centre of the Social Model of Health are non-modifiable factors that affect a person's health (17), including age which is the biggest risk factor for developing dementia is age, but there are several modifiable lifestyle factors such as smoking, diet and exercise that could help prevent or delay the onset of dementia. However, 75% of people are unaware that they can affect their risk of developing dementia. Therefore, people should be informed about how their risk of developing dementia can be reduced.

Several studies have provided evidence for a link between cardiovascular disease and the risk of developing Alzheimer's disease or vascular dementia, which account for around 80% of all cases of dementia (18). Public health campaigns to educate the general public have adopted this messaging: 'what's good for your heart is good for your head'. It is important to note low educational level, low socioeconomic status, and higher levels of air population, represented on the outer two layers in Figure 2 (17), have also been linked to the development of Alzheimer's disease (19).

A stays physically active as he enjoys walking the dog. A Cochrane review of 17 trials revealed that physical activity can help improve the ability to perform activities of daily living in patients with dementia, allowing them to stay independent for longer, which in turn results in less strain on the carer (20).



Source: Dahlgren and Whitehead, 1991

Figure 2: The Social Model of Health (17)

A stays physically active as he enjoys walking the dog. A Cochrane review of 17 trials revealed that physical activity can help improve the ability to perform activities of daily living in patients with dementia, allowing them to stay independent for longer, which in turn results in less strain on the carer (20). A believes that this boosts his physical and mental well-being. A has also been supported through his strong social and community networks, including his neighbours and friends from Rusty Brains, which has improved his psychosocial well-being. There are still, however, misconceptions and barriers to accessing health and social care that hinder the overall well-being of patients living with dementia and their carers (21).

Reflection

My experience in the Time for Dementia programme gave me a unique insight into the numerous challenges experienced by people living with dementia and their families and carers. I believe this experience has been really instrumental in allowing me to understand and empathising with the perspectives of the patients and their families and carers, recognise some of my own unconscious biases, allowing me to be more aware and challenge myself on some of these misconceptions not only about people with dementia but many other chronic medical and mental health conditions. I learnt the importance of empathy when communicating with patients and their families about the diagnosis of dementia, as a simple interaction can have a profound impact on their lives and future engagement with healthcare services. I was able to appreciate the frustrations of patients throughout the long journey of getting a diagnosis and the difficulties in accessing further care to address their medical and psychosocial needs.

Overall, I have learnt that providing holistic, integrated, and accessible care for patients living with chronic conditions can drastically improve their well-being as well as the well-being of their carer.

References available upon request

TRAINEE FOCUS: NAVIGATING YOUR FINAL YEAR IN TRAINING AND PREPARING FOR CCT

Dr. Rebecca Fitton, Higher Trainee Representative of the RCPsych Old Age Faculty

For many of us August marked the start of a new training year. For those of you starting ST6 you might be wondering what things you need to think about during your final year in preparation for CCT and beyond. This year requires some organisation so we have summarised the key things you need to be aware of.

Applying for your certificate of completion of training (CCT)

You can start your application anytime from 6 months before your completion of training date (though it will not be completed until you have received an outcome 6). The process can take several weeks particularly at peak times (coming up to February and August), so be sure to plan ahead and apply no later than 4 weeks before your completion of training date, ideally at least 8 weeks.

The application form can be found on the RCPsych website (within "Apply for certification" in "Your Training" section. The application form will be reviewed alongside your ARCPs on your online portfolio. All being well, the college will then submit a recommendation to the GMC, who will invite you to apply through your online GMC account. The fee for joining the specialist register is £489, so be sure to have this saved. Once you have reached the date of your CCT you will be sent a certificate of CCT and included on the specialist register on the GMC website.

Final ARCP

The final ARCP process is similar to previous ARCPs you have had in training and you will be familiar with the paperwork required. You have met at least the minimum requirements for WPBAs as well as have evidence regarding psychotherapy competences, quality improvement and research activities, leadership and management activities and special interest sessions.

You need to ensure you have covered all aspects of the old age curriculum (as well as any other curriculums that are relevant to you – for example if you want an endorsement in liaison or are dual training in general adult) over the course of training. Ensure you map your activities to the curriculum to help assessors see that you have covered all areas. It can also help to organise your portfolio by summarising and grouping evidence from different areas (for example leadership and management) together in folders.

Period of Grace and Applying for consultant posts

You can start applying for consultant posts up to 6 months before your CCT date, but you will want to start discussing with trusts about potential posts before this.

"My advice would be to seek out leadership opportunities at work, leading in meetings and on complex cases. If you can do placements, special interest sessions or projects with clinical leaders and make a name for yourself as a considerate colleague then it helps to keep you in consideration for new posts as they are coming up. It helps to let people know in clinical leadership roles that you will be interested in a consultant post when you are in your final year of training"
Dr Alex Graham, ST7 dual old age/general adult (acting consultant)

If you think you will need a little bit more time before taking up a consultant job, then you can apply for a Period of Grace to continue in a training post (though you would no longer be in training) for a further 6 months. You would need to discuss this with your TPD well in advance as any posts would be subject to availability within your training scheme.

Applying for AC approval (England and Wales only)

Most consultant jobs in England and Wales require you to have Approved clinician (AC) status under the mental health act. This is relatively straightforward to achieve but requires some prior planning. You will need to attend an AC induction course, which you can attend up to 2 years before your CCT. You will then need to apply for AC status via your local approval panel, providing them with the course certificate, your most recent ARCP outcome form, an up to date CV and two references. The application needs to be submitted in good time as it can take up to three months.

Acting up

You might want to consider acting up during your final year if an opportunity becomes available. It is not mandatory but allows you to experience working as a consultant whilst still having additional support and is likely to give you plenty of useful experience to draw on when answering consultant interview questions!

There are several rules around acting up: It can only be for a maximum of three months (or whole time equivalent for LTFT trainees). It needs to be an approved post and generally must be within the region you are training - if not then an out of programme for training OOPT application will need to be submitted to the college). It must be supported by an appropriate clinical supervisor, and you should still be receiving weekly supervision.

"Acting up taught me the hidden curriculum if training. It enabled me to test my readiness for consultant position and my ability to manage interdisciplinary working...it was rewarding and it built my confidence in my overall abilities. I participated first hand in discussions pertaining to team performance, serious incidents, recruitment challenges and resource management. The only challenge I faced was the difficulty in influencing change in the short time frame I had with the team"
Dr Kemi Okopi, new consultant

TRAINEE FOCUS: CPD CORNER

Dr Rebecca Fitton and **Dr Jennifer Parker**

We're always on the look out for great courses and events aimed at old age psychiatry trainees - Please send us any reviews of courses or conferences that we can feature in the next edition. Email Rebecca.fitton1@nhs.net or oldage@rcpsych.ac.uk

Upcoming conferences and courses:

- **Royal College of Psychiatrists Annual ECT and Neuromodulation Course 2024**

28-29 November 2024, RCPsych/ Livestream

This two-day conference does what the name suggests, and provides an annual update on ECT and neuromodulation – which may be of interest to some old age trainees. More information is available here.

- **British Neuropsychiatry Association Teaching Weekend- The Essentials of Neuropsychiatry'**

13-15 December 2024, St Anne's college, Oxford

This residential in-person weekend course is aimed primarily at trainees in neurology and psychiatry and lectures and seminars cover a broad swathe of neuropsychiatry topics. More information is available here.

- **The British Geriatrics Society Delirium in Older People E-Learning**

Open access, online

The British Geriatrics Society have developed a Delirium eLearning course which can be accessed here for a fee. There are also frailty (free) and perioperative medicine modules available.

CALL FOR ARTICLES: SPOTLIGHT ON DIVERSITY & EQUALITY IN OLD AGE PSYCHIATRY

Are you passionate about advancing mental health care for older adults from diverse backgrounds? We're on the lookout for insightful articles for our upcoming January 2025 issue on Diversity & Equality in Old Age Psychiatry.

We believe in the power of inclusive and equitable care, and we're seeking thought-provoking articles that shed light on this critical topic.

We're interested in exploring topics like:

- **Cultural nuances:** How do different cultures and backgrounds impact mental health in older age?
- **LGBTQ+ experiences:** What unique challenges do older LGBTQ+ individuals face?
- **Social and economic disparities:** How do factors like income and social status affect mental health?
- **Intersectionality:** How do multiple marginalised identities intersect in the context of older adults?
- **Best practices:** What are effective strategies for providing culturally competent and inclusive care?
- **Policy and advocacy:** How can we advocate for policies that support mental health equity for older adults?

By contributing to this issue, you will:

- Share your expertise and experience of old age psychiatry.
- Contribute to raising awareness and improving the lives of older adults.
- Educate others on the mental health care landscape.

Don't miss this opportunity to be a part of something meaningful.

Submit your article by 09/12/24 by emailing oldage@rcpsych.ac.uk

For more information and submission guidelines, please visit [OAP Psych Newsletter Submission Guidelines].