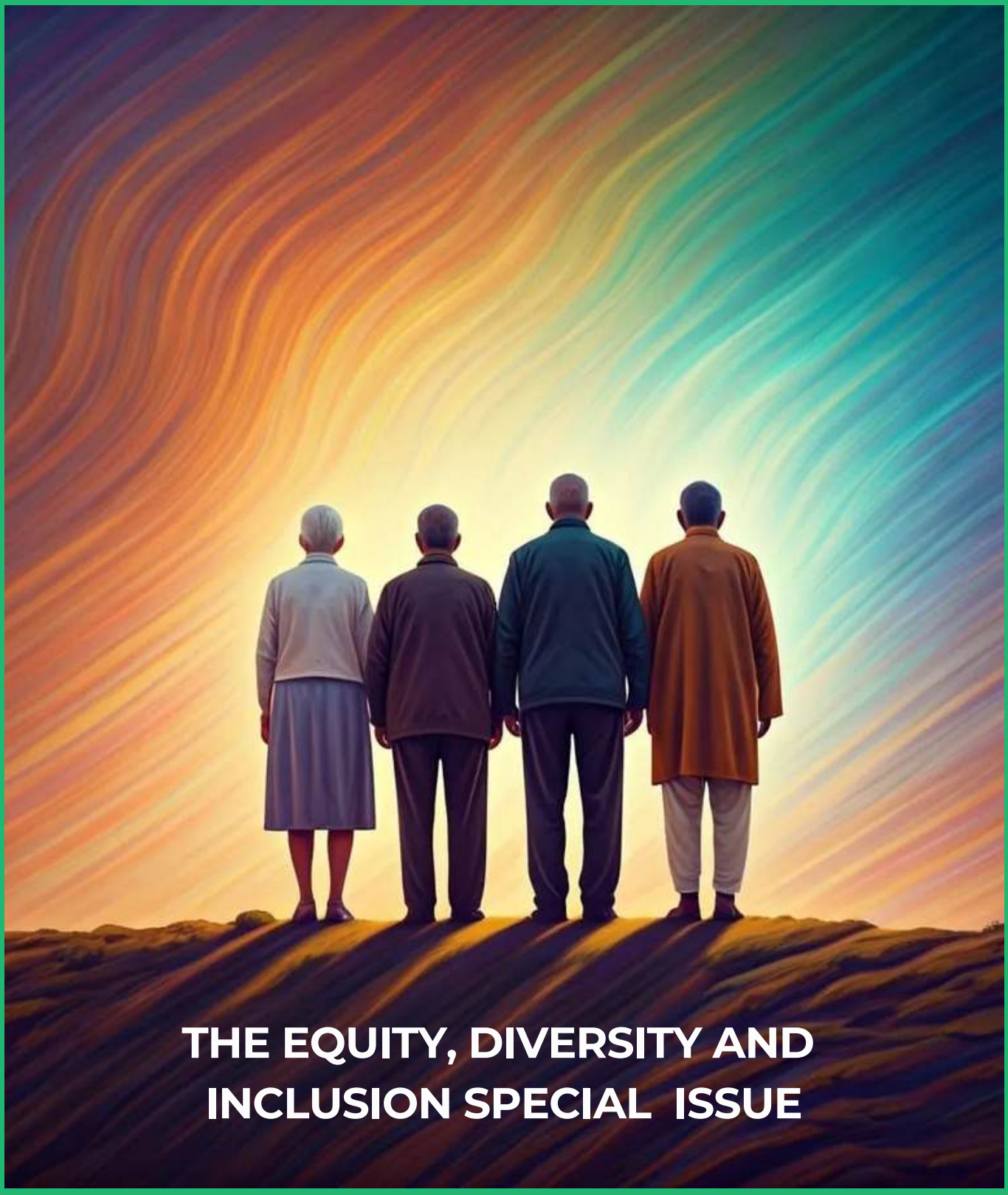
RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

Issue 91

January 2025



THE EQUITY, DIVERSITY AND INCLUSION SPECIAL ISSUE

HELLO

Welcome to Issue 91, January 2025, of the RCPsych Old Age Faculty Newsletter

Editorial Team

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

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Cover Information

The theme of this issue is Equity, Diversity and Inclusion (EDI) in old age psychiatry. The cover depicts a multicultural group of older adults looking towards a sky brightened by the colours of the rainbow.

IN THIS ISSUE

Issue 91, January 2025

Editorials

Focus on Equity, Diversity & Inclusion

Features

IN THIS ISSUE

Issue 91, January 2025

Review Section

Trainee Focus

Essay Competition Winners

UPDATE FROM THE EDITORIAL TEAM

Happy New Year to you all from Jennie, Curtis and I. It is hard to believe that we are already 3 weeks into 2025, time seems to fly by!

The first edition of this year is a special issue on 'Equity, Diversity and Inclusion', a hugely important subject both for our patients and our workforce, that our College is leading with passion and commitment through various initiatives.

Some of this issues' highlights include a comprehensive piece for this special issue from Ruth Adams, Head of EDI Strategy, Royal College of Psychiatrists and a sensitive and powerful write-up by Jonathan Olds highlighting the struggles of the LGBTQIA+ community. Bob Barber has written a very useful piece on 'Resources to support prescribing monoclonal antibodies therapies in Alzheimer's dementia'.

Once again, Jennie and Curtis, our higher trainee editors, have produced a very interesting and useful issue. Thank you to them both and all of you who contributed by sending us interesting articles, case studies & CQI work making this edition diverse and enriching.

The Faculty of Old Age Psychiatry Annual conference 2025 'Future Challenges' takes place on 27th and 28th March '25 in Liverpool and is a hybrid conference with an exciting line up of great speakers. Do look on the college webpage for booking information and further details.

A huge thank you to our faculty manager, Kitti Kottasz for her unwavering support. Please consider sharing your interesting pieces of work and articles for the newsletter by emailing kitti.kottasz@rcpsych.ac.uk or oldage@rcpsych.ac.uk.

We would encourage you to enter our newsletter's annual creative writing competition which is now open – the theme this year is 'Stories in Old Age Psychiatry' - there is more information on p.5.

In the next edition, in May '25, we would welcome your stories and would love to hear your experiences of working in old age psychiatry.

With best wishes
Dr Shaheen Shora
Lead Editor
Old Age Psychiatrist, HPFT
Equity Champion, RCPsych

VIEW FROM THE CHAIR

Dr Mohan Bhat

Chair of the Faculty of Old Age Psychiatry

Dear Colleagues

I would like to begin by wishing you all a very happy and prosperous New Year. I hope you managed to enjoy a restful break and spent quality time with family and friends during the festive season, and that your year is off to a great start.

Time flies and its already been 6 months that I took on the role as the Chair of the Faculty of Old age psychiatry. We in the faculty are very fortunate to have very committed executive members who have all been busy contributing to the work of faculty and ensuring that they effectively voice and represent the needs of the older adults and also of the teams providing the various services to older adults with mental health needs at various forums that they attend on behalf of the faculty of old age psychiatry.

I would like to take this opportunity to acknowledge the invaluable contributions of our previous chairs, whose leadership and steer has guided the faculty over the years. Below is the list of esteemed leaders from whom I draw inspiration to fulfil my responsibilities as Chair:

- In 1976-1978 Dr Felix Post was the Chairman of the Group for the Psychiatry of Old Age (Group became a Section.)
- 1978-1982 – Dr R.A Robinson
- 1982-1986 – Prof. Tom Arie
- 1986-1990 – Prof. Brice Pitt (Section became Faculty in 1988)
- 1990-1994 – Dr David Jolley
- 1994-1998 – Dr J.P. Wattis
- 1998-2002 - Dr Andrew Fairburn
- 2002-2006 - Prof. Susan Benbow
- 2006- 2010 - Dr David Anderson
- 2010 - 2012 Dr Peter Connelly
- 2012-2016 Dr James Warner
- 2016-2020 Dr Amanda Thompsell
- 2020-2024 Dr Mani Santhanakrishnan

As I mentioned in the last newsletter we at the faculty have agreed a set of CLEAR strategic aims to drive and guide our work:
C: Promoting clinical engagement,
L: Providing leadership and developing new leaders,
E: Promoting education and training,
A: Advocating for older adults needs and being Ambassadors for them and
R: Promoting research and supporting embedding of the evidence-based practices.

In the last 6 months we at the faculty have been working on a few areas:

1. Higher Trainee Engagement

With our aim to improve our clinical engagement with our Higher trainees, we have launched a new webinar series titled Engaging Minds: Webinars for Old Age Psychiatry Higher Trainees. I want to congratulate our higher trainee representatives Rebecca Fitton, Ayana Hazu, and Harleen Birgi for getting this off the ground.

This series will be run by our higher trainees and is specifically designed to provide clinical updates, networking opportunities, and engagement with experts and our faculty executive team.

The inaugural session was held on November 21, 2024, with over 180 trainees participating. The next session is scheduled for January 16, 2025. Engaging Minds: Webinars for Old Age Psychiatry Higher Trainees . More information about the series can be found here..

2. Winter Conference

We hosted our Faculty Winter Conference on December 13, 2024, focusing on neuroimaging, specifically updates on CT scanning and MRI, as well as psychological therapies for older adults. The event attracted over 480 delegates from various countries, including Australia, Bulgaria, Canada, India, Ireland, New Zealand, Nigeria, Singapore, and Spain. I am very pleased to note that our faculty conferences now have started attracting global interest. I would like to extend special thanks to Dr. Chineze Ivenso, our Academic Secretary, and Dr. Bob Barber, our Faculty Finance Officer, along with Catherine Ayres from the conference team for their efforts in organising this successful event.

3. Disease Modifying Treatments

We are all aware that Couple of New Disease Modifying Treatments (DMTs) Donanemab and Lecanemab received MHRA approval recently. We have responded to a NICE request for our faculty views on the guidance that they produced for these treatment options. Our Faculty issued press statements following the NICE guidance for these medications was issued. We at the faculty are currently working on producing some guidance/FAQs about these treatments for patients and their carers.: College welcomes approval of first ever license for disease modifying drug for Alzheimer's disease
Approval of second medication for Alzheimer's disease welcomed by RCPsych.

4. Assisted dying bill

I also want to bring our members attention to the debate and the recent vote on the Assisted dying bill in England and Wales. The college issued its statement about this and committed to continue to work closely with parliamentarians and other stakeholders on this important issue..

I also want to thanks Dr Feena Sebastian who is representing the old age faculty at the College group looking at issues arising from the proposed Assisted dying bill.
RCPsych comments on vote for assisted dying Bill in England and Wales

5. 10-year Health Plan

There is a proposal to develop a new 10 year health plan for NHS in England. NHS England » Creating a new 10-Year Health Plan. We at the Faculty of Old Age Psychiatry have been proactive and have submitted the priorities pertaining to our area of work and expertise as part of the overall Royal college of Psychiatrists response to the 10 year health plan.

Dr Mohan Bhat and Prof Liz Sampson at the EMBED-Care reception

6. EMBED-Care

I am also pleased to share that I recently attended a reception hosted by Baroness Finlay of Llandaff: "Policy Recommendations for Palliative Dementia Care - The Empowering Better End of Life Dementia Care Programme (EMBED-Care)" at the House of Lords. This was a culmination of a 6 year programme which was led by Prof Liz Sampson and Prof Catherine Evans. The Policy brief summarises the evidence developed from the EMBED-Care programme and endorses a step change in dementia care to improve the comfort and quality of life of those affected by dementia that draws on a model of integrated palliative dementia care whilst prioritising a holistic and person-centered approach.

7. Old Age CPD Modules

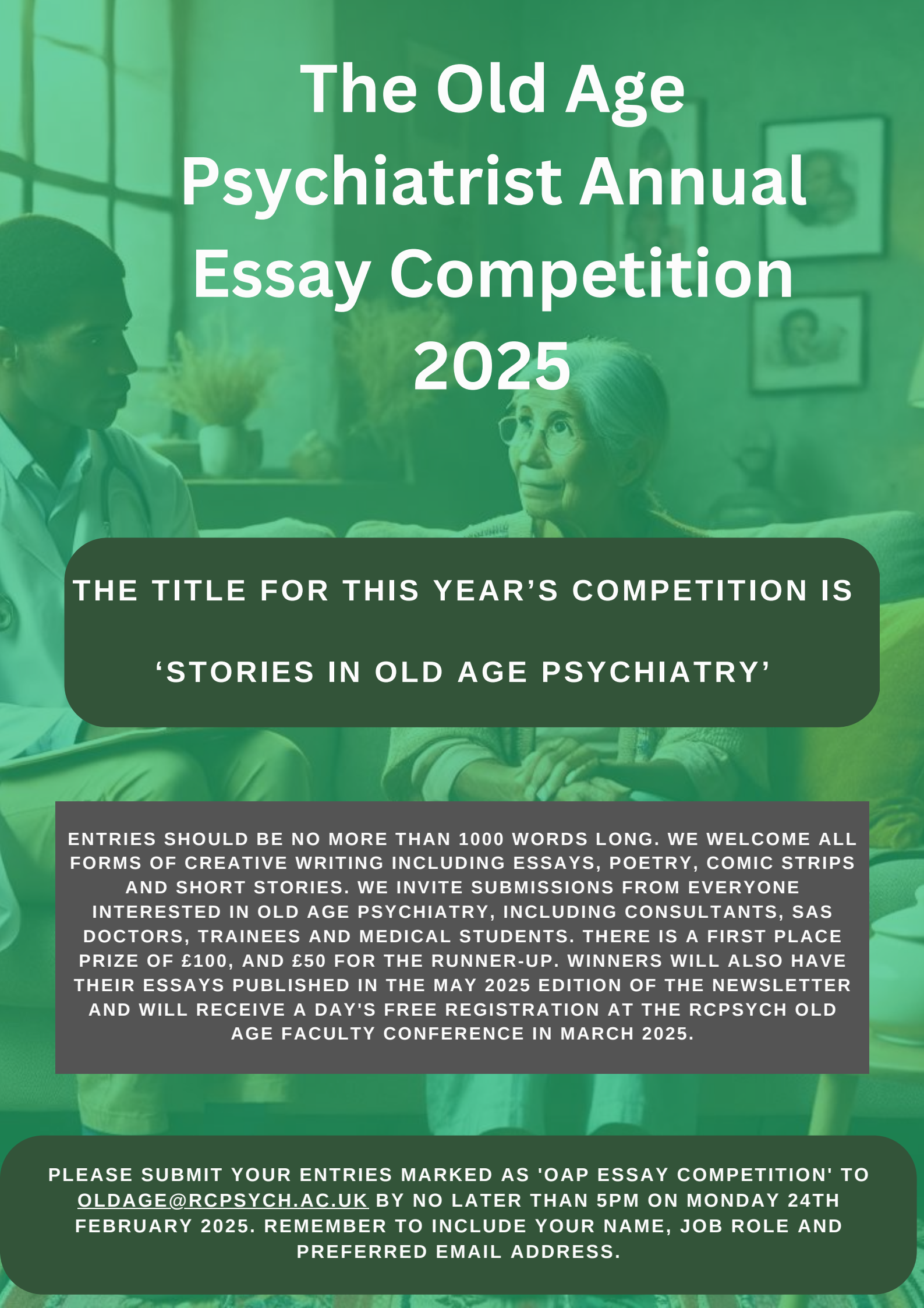
We have identified the CPD modules on the RCPsych CPD section that relates to old age psychiatry and have started the process of updating these modules. We will be also contacting our faculty members seeking volunteers to help us with updating some of the modules relating to our area of practise.

8. Annual Conference

Finally I also want to announce that our next annual faculty conference will be held in Liverpool on 27th and 28th March 2025. This will be an in-person/ Live streaming conference and would welcome you all to attend this event. Dr Chineze Ivenso, Dr Bob Barber and Dr Ben Underwood have already started planning the programme for this event which promises not only to deliver a high-quality educational content but also a place to network and share ideas and develop our speciality.

Once again, I wish you all a wonderful start to the New Year, and I look forward to meeting you in person at our Annual Faculty Conference in March.

Warm wishes.
Mohan



The Old Age Psychiatrist Annual Essay Competition 2025

THE TITLE FOR THIS YEAR'S COMPETITION IS

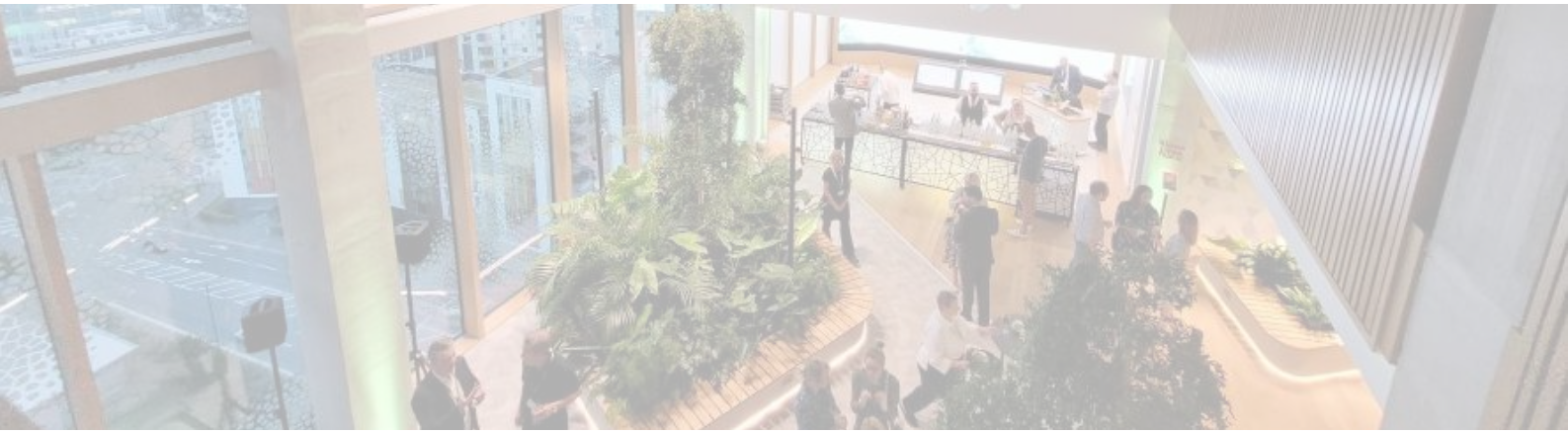
'STORIES IN OLD AGE PSYCHIATRY'

ENTRIES SHOULD BE NO MORE THAN 1000 WORDS LONG. WE WELCOME ALL FORMS OF CREATIVE WRITING INCLUDING ESSAYS, POETRY, COMIC STRIPS AND SHORT STORIES. WE INVITE SUBMISSIONS FROM EVERYONE INTERESTED IN OLD AGE PSYCHIATRY, INCLUDING CONSULTANTS, SAS DOCTORS, TRAINEES AND MEDICAL STUDENTS. THERE IS A FIRST PLACE PRIZE OF £100, AND £50 FOR THE RUNNER-UP. WINNERS WILL ALSO HAVE THEIR ESSAYS PUBLISHED IN THE MAY 2025 EDITION OF THE NEWSLETTER AND WILL RECEIVE A DAY'S FREE REGISTRATION AT THE RCPSYCH OLD AGE FACULTY CONFERENCE IN MARCH 2025.

PLEASE SUBMIT YOUR ENTRIES MARKED AS 'OAP ESSAY COMPETITION' TO OLDAGE@RCPSYCH.AC.UK BY NO LATER THAN 5PM ON MONDAY 24TH FEBRUARY 2025. REMEMBER TO INCLUDE YOUR NAME, JOB ROLE AND PREFERRED EMAIL ADDRESS.

Faculty of Old Age Psychiatry Annual Conference 2025: The future of old age psychiatry

Thursday 27 and Friday 28 March 2025
The Spine, Liverpool



Join us in Liverpool this March!
Sessions will also be available to watch via a livestream, so you can either attend **in-person**, or opt to **watch the livestream**. Both ticket types include on demand access for twelve weeks post event.

Programme highlights:

- **The national picture** - Dr Jeremy Isaacs, National Clinical Director for Dementia & Older People's Mental Health, NHSE
- **Transforming community mental health care** - Dr Amanda Thompsell, National Speciality Advisor for Older people's Mental Health, NHSE
- Kate Lee, Chief Executive, Alzheimer's Society
- Hilary Evans-Newton, Chief Executive Officer, Alzheimer's Research UK
- **The shape of future services and the need for more assertive outreach** - Professor Rob Howard
- **The future of workforce and training** - Dr Wendy Burn, past president
- **Psychological therapies** - Dr Ian James
- Professor Julian Hughes, Professor of Old Age Psychiatry in a collaboration between The Research Institute for the Care of Older People (RICE), the Royal United Hospitals Bath NHS Foundation Trust (RUH) and the University of Bristol.
- Baroness Ilora Finlay, Consultant in Palliative Medicine, Honorary Professor of Palliative Medicine, Cardiff University and current member of the House of Lords
- Professor Suzanne Reeves, Professor of Old Age Psychiatry and Psychopharmacology

New for 2025 - dedicated in-person activities:

- Extra satellite sessions on special interest areas
- Meet the Faculty Executive team - find out more about the work they do
- Trainees breakfast session and Conference Party!

https://www.rcpsych.ac.uk/events/conferences/detail/2025/03/27/default-calendar/faculty-of-old-age-psychiatry-annual-conference-2025

WHY EDI IS NOT THE ICING ON THE CAKE...IT *IS* THE CAKE

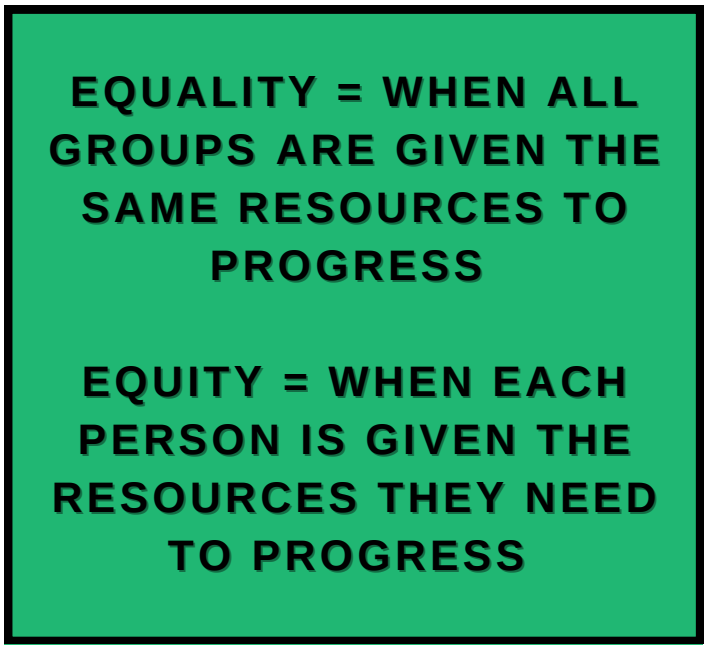
Ruth Adams,
Head of EDI Strategy, Royal College of Psychiatrists
Email: ruth.adams@rcpsych.ac.uk

As a College leading the way amongst other medical royal colleges and charities with our commitment and initiatives on Equity, Diversity, and Inclusion (EDI), we often find ourselves explaining why this is not an optional extra – the icing on the cake – but is central to all we do if we are to truly support enhancing equity for members in psychiatry and recipients of mental health care. So, in this article we want to explore - what is equity? Why is it so important in a mental health context to develop competencies around inclusive mental health care? And to share some of the work underway to embed equity and foster fairness and equity in all we do - a core part of the college strategy.

What is equity?

We live in an unequal world where some people face far more barriers. These are determined by a range of social and structural factors and perpetuated through policies and practices over time.

Equity-led approaches require addressing the social and structural determinants of health, some of which are historic, but continue to exert an influence through our policies and social structures.



Why is it so important in a mental health context?

Not only are there clear and compelling moral, ethical and clinical reasons to address *health disparities* and *workforce inequities*, the financial cost of not doing so is enormous.

Those who access mental health services are often the most vulnerable in our society. I*nequity increases the risk of mental health problems.* There is strong evidence that people from marginalised groups, especially those from minoritised ethnic communities; LGBTQ+ backgrounds; women and those with disabilities, have *poorer access, a poorer experience and/or worse outcomes in mental healthcare.*

We are also in the *midst of a workforce crisis.* There are significant differences in attainment, referrals for disciplinary action, career progression and pay for staff from these minoritised groups. *Negative experiences in the workplace* affect retention at a time when we can ill afford to lose staff and talent unnecessarily.

College action to embed equity and foster fairness and equality

Our Fairness for all strategy is set out within the College Strategic Plan 2024-2026.

Our top three strategic priorities are to:

a) *move from equality towards equity* and to put equity at the heart of all of our college work, in particular around race and ethnicity, sex, sexuality and disability.

b) *get better at understanding and addressing intersectional inequities* – that is, the compounded effect when people have more than one protected characteristic, for example a Black, disabled woman – and

c) *expand and sustain changes* made since our focus on EDI began. Our aim is to ensure that e-ffective policies and procedures around equity and equality are fully embedded into our systems and become part of how things are routinely done.

Joint Presidential leads for Equity and Equality, Dr Rajesh Mohan and Dr Amrit Sachar and Joint Presidential leads for Women and Mental Health, Dr Catherine Durkin and Dr Philippa Greenfield are leading on this work.

Dr Mohan said: "There is a huge amount of work happening to achieve our fairness aims. Engaging across all areas of the College is key and this year we recruited 22 members to our Equity Champions Network - College Ambassadors working with devolved nations, divisions and faculties to support our aim to consider equity in all we do.

We have continued our focus on tackling discrimination in the workplace for members and others through our Act Against Racism campaign and soon to be published recommendations for supporting reasonable adjustments for people with disabilities in the workplace.

"We have a specific extra focus on SAS doctors and International Medical Graduates (IMGs), recognising they are some of our members who are most impacted; continue with programmes to tackle differential attainment and ensure coproduction and co-design are the norm in all areas of practice.

Work is also underway on the College's first women and girls mental health strategy, recognising the intersecting disadvantage they face accessing mental health care and the need for a gender sensitive approach.

Dr Philippa Greenfield said: "One in five women experience a mental disorder, but there are vast numbers of women and girls who face barriers to accessing services and having their mental health needs understood.

Our aim is to raise awareness of women's mental health issues across the lifespan, highlighting puberty, the perinatal period and the menopause as times of increased risk. This lifespan approach will focus on the significant impact of interpersonal violence which disproportionately impacts on women and girls, on mental wellbeing, and the need for a trauma-informed approach.
We will also focus on the impact of hormonal health and its interface with women's experience of mental illness. Our aim is to support all women accessing mental health services including our workforce to ensure all our needs are being met."

Through CCQI and other accreditation systems we look to boost measures of equality/equity and measure the impact of our work through an increased focus on data collection, learning and evolving methodologies.

We also continue to actively influence systemic change through our input on key policy areas, such as the Mental Health Act Review, sharing best practice and supporting mental health organisations and national regulators to improve equity measures.

Other activity progressed through the College's Equality Action Plan (2021-2023) includes:

For patient and carers:

- Established the Advancing Mental Health Equality (AMHE) Collaborative which is helping organisations to tackle health inequalities using a QI approach to co-produce solutions with their local communities
- Introduced EDI measures into CCQI's core standards for mental health services across the UK
- Continue to ensure lived experience informs what we do, working with 150 patients and carers in 250 paid roles.
- Launch of the first curriculum in any medical specialty to stipulate that all junior doctors going into psychiatry must learn about structural discrimination, to better serve patients

For members

- New initiatives to tackle psychiatrists' differential attainment
- Carried out research, developing and promoting recommendations to help stamp out discrimination against LGBTQ+ clinicians
- Launched the Act Against Racism campaign
- Published a gender pay gap action plan for women
- Amended the Consultant and SAS doctors Job Description checklist for College approval to improve equity of opportunity
- Drafting recommendations for supporting reasonable adjustments for people with disabilities in the workplace (due to be published in January).

For staff

- Launched an 18-point action plan to promote gender equality across the staff team

- Achieved Level 3 status in the Disability Confident Employer Scheme, which encourages employers to take action to improve how they recruit, retain and develop disabled people.

- Reduced the college's gender pay gap among its staff to 2.13% by 2023, down from 17% in 2019. This contrasts with a national average median gender pay gap of 14.9%.

- Reduced the college's ethnicity pay gap among its staff reduced further to 2.02% by 2023, far lower than the average ethnicity pay gap among some large charities at 21.9%.

If you'd like to get involved in RCPsych's EDI work, contact Dr Sachar or Dr Mohan via X (formerly Twitter) at @apksachar and @raj_psyc respectively, Dr Greenfield or Dr Durkin or email Ruth Adams, Head of EDI Strategy: ruth.adams@rcpsych.ac.uk.

Conclusion

Equity, Diversity, and Inclusion (EDI) are at the heart of our college's mission, shaping how we support both patients and members. EDI is not an optional extra but a core principle to ensure fairness and equity in mental health care and there is ample evidence that the NHS will need to embrace EDI in order to deliver its goals. Dr Sachar concluded by saying: "Our initiatives focus on tackling workforce inequities, supporting under-represented population groups, and ensuring inclusive mental health services. This includes addressing the challenges faced by women (using a trauma-informed and life course approach), minoritised ethnic communities, LGBTQ+ individuals, and people with disabilities. We aim to get a better understanding of the multiplier effect intersectionality between these and other protected characteristics has. Through our Equity Champions Network, we're building sustainability by engaging members across the College to embed EDI practices into all areas of work. This collaborative approach ensures long-term, meaningful change in mental health care and within our workforce, fostering a more inclusive and fairer environment."

A SOCIETAL LEGACY

THE LGBTQIA+ COMMUNITY AND PSYCHIATRY IN HISTORICAL PERSPECTIVE

Dr Jonathan Olds
Specialty Doctor, Later Life Liaison Psychiatry Team, Bristol Royal Infirmary, Avon & Wiltshire Mental Health Partnership NHS Trust

The world is changing in a way that empowers today's young people to express themselves fully. Who would have thought, even 30 years ago, that drag queens- once seen as the jesters of smoky and dark gay bars- would become powerful and mainstream symbols of empowerment, strength, inclusivity and celebration in mainstream British media? For many people however, being gay or in fact anyone who would now be considered part of the LGBTIA+ community, has resulted in a life punctuated by loss, isolation, fear, abuse, discrimination, ridicule and assault; often since childhood.

As psychiatrists, we know how such adverse early and prolonged experiences, particularly at developmental times of peoples lives, increases the risk of serious mental health problems with numerous concomitant factors such as alcohol dependence, smoking and illicit drug use. As this generation ages, the legacy of the HIV/AIDS crisis and the introjected messages that result in shame and self-loathing may well manifest through mental illnesses that we need to be aware of including dementia, psychotic and affective disorders, as well as suicide. We also need to be aware of our own legacy as a profession that once classified LGBTIA+ people as mentally ill and in need to treatment, however today we are an inclusive profession and it is wonderful to see how our Royal College has its own Rainbow Special Interest Group (SIG) as well as how it has actively worked to support people of the LGCTIA+ population through its consensus statement supporting the banning of conversion therapy in the UK.

Of particular interest to me is the concept of loneliness in the ageing LGBTIA+ population. It is a fact that children can be cruel to each other and whilst there is thankfully so much awareness and understanding now of issues pertaining to diversity and inclusivity; that has not always been the case. Imagine being born male and gay in 1964 and growing-up in a world where without knowing why, you are told that there is something wrong with you – you are not good enough as a person and no one will ever want you. Of course, the self-loathing from these constant messages would become significant.You reach sexual maturity with few friends and no one to turn-to for advice and guidance on navigating relationships. It is now the mid-1980s and intimate connection with another now becomes not only a sinful act perceived by many, but now carries the risk of death through a new and yet unidentified disease that affects people just like you. The heterosexual generation before you have been exposed to messages that link homosexuality with sexual perversions including paedophilia, and for you, having children will never be an option.You are bound to a lifetime of an ever-diminishing social circle as you age.

I've painted a bleak picture and thankfully 2024 and the future looks very different and much more positive for the LGBTIA+ community. However, the gay man born in 1964 turned 60 this year and before long he will be eligible for older adult mental health care. I urge us all as psychiatrists working with older adults to think about this now and think about this carefully, to afford this often abused and neglected community the compassionate and person-centred mental healthcare they so clearly deserve.

CARING FOR OLDER IRISH PEOPLE IN BRITAIN WITH MENTAL ILLNESS AND COGNITIVE IMPAIRMENT

Dr Jennifer Parker
ST6 in Old Age & General Adult Psychiatry, Avon & Wiltshire Mental Health Partnership NHS Trust

During a rare quiet morning allocation meeting with the Later Life Liaison Psychiatry team, my nursing colleague turns pointedly towards me and advises, 'I've got a patient for you to see'. He provides a potted history of their current physical and mental health issues before breaking into a large smile adding, 'he's from County Mayo'.

My colleagues know I have a supremely soft spot for the elderly Irish patients who are referred to our team. I moved from Ireland to the UK over 10 years ago, initially with the intention of spending one year here working in the NHS – but I found plenty of reasons to stay. A colleague of mine once spoke about her frustration at constantly being used as a 'translator', inappropriate to her clinical skills, for Polish patients within her department owing to her ability to speak their language. No such pressure exists in terms of caring for Irish patients, and when the opportunity arises to put my Irishness to some use I'm delighted to do it. During my liaison psychiatry post, I've set up GAA matches on ward iPads, pored over photographs of a quiet Irish beach a patient visited with his parents as a child and reminisced about the joys and challenges of visiting home. When a gentleman in his 80s with advanced Alzheimer's Dementia who was admitted with profound self-neglect could accurately recount the full line-up of the 1996 Wexford All-Ireland hurling team to me it delighted us both, and listening to 'Dancing at the Crossroads' through my phone's tinny speaker on the acute frailty ward proved a moving moment of surreal joy for us both. It is a great professional privilege in old age psychiatry to get to know our patients, and to provide individualised and culturally-sensitive care plans in all of their guises for them.

The ageing Irish population in Britain

The Irish-born population in Britain is shrinking. The 2021 census shows more than half a million people in England and Wales are Irish-born and identify as ethnically Irish, about a third of whom are over 65 years.(1) Irish migration peaked in the 1950s and 1960s, and as such, Irish people who came to the Britain as young people are now in advanced old age, or have died. In 1950s Britain, infamous signs outside establishments reading 'no Blacks, no dogs, no Irish' spoke of a host country in which resentment and discriminatory views abounded towards migrants from its various former colonies. Later, Irish migrants often met hostility in relation to the so-called 'troubles' in Northern Ireland and the IRA bombing campaign in Britain.(2)

Irish people have a record as poor as, or worse than, many of the main minority ethnic groups living in England in terms of both physical and mental health outcomes - and this disadvantage persists into second and third generations.(3) Irish migrants in Britain are over-represented as users of psychiatric services and as users of primary care for mental health needs, with rates of mental distress well above those for many other migrant groups, with the exception of psychosis rates found in the African–Caribbean population.(4,5) Now, the age profile of the Irish population in Britain and a myriad social and health factors increase the risk of dementia and age related mental health problems.(6)

Under-researched: The Irish are 'not quite different enough'

Patrick Bracken writes that Irish in Britain occupy something of a 'problematic and liminal position' in the research literature, whereby they have often been neglected as a distinct ethnic group- despite ample evidence which acknowledges higher rates of deprivation, premature mortality, physical and mental illness in this population.(7) One possible explanation for the Irish population in Britain being overlooked is race relations: the Irish could be subsumed into 'white' categories of research, even as they experienced racial harassment and discrimination on the basis of their ethnicity. Indeed, the Irish category was only added as a separate ethnic census category in 2001. Specifically, from a mental health point of view, Bracken points out that discussion of the Irish has been generally extremely limited or indeed often entirely absent in British transcultural psychiatry, and what little literature there is often arises from second generation Irish or Irish scholars in the UK. There are some exceptions, with work on Irish migrant populations by Gill Livingstone amongst others, but overall the Irish migrant population is often 'invisible' and under-researched in healthcare.(8)

Culturally Sound Care

Mary Tilki (2009) writes about the importance of cultural sensitivity for older Irish people with dementia.(9) Steps as simple as learning how to pronounce Irish names correctly can have a profound benefit for people (although this is hardly uniquely beneficial within this population). Work by Josie Nugent (2019) shows the benefit of engagement in the traditional arts (music, cultural songs, storytelling and dance) in the lives of Irish people living with dementia in Great Britain.(10) Specific Irish Organisations such as Irish in Britain (and their Healthy Ageing project work) exist to support and advocate for the needs of ageing Irish populations. Reminiscence work which takes into account and is sensitive to the Irish migratory experience can be valuable for people. Avoiding 'paddywhackery', such as excess depictions of leprechauns, shamrocks and such like is generally considered best practice- although some older adults, particularly those with dementia, do enjoy overt Irish references.

Conclusion

One of the great privileges of working in old age psychiatry is the opportunity to hear people's stories and learn about their lives. Taking these life stories into account when crafting culturally-sensitive care plans for them is a great opportunity to strengthen the treatment we give our patients. The ageing Irish community in Britain are a vastly heterogonous group, but overall are over-represented in psychiatry and deserve to have their needs as a distinct ethnic minority considered when we care for them.

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BRIDGING THE GAPS IN MENTAL HEALTH SERVICES FOR OLDER ADULTS FROM ETHNIC MINORITY POPULATIONS

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Introduction:

The Royal College of Psychiatrists emphasises the importance of delivering culturally appropriate, supportive, and person-centred care for the ageing population(1). According to the 2021 census for England and Wales, 11 million people, or 18.6% of the population, are age 65 or older. In this older adult population, white ethnic group make up the majority at 93.6%, meaning all other ethnicities account for just 6.4%. The Asian ethnic group represent the largest at 3.8%, followed by the Black ethnic group and other ethnic groups, and those of mixed ethnicities are the smallest group at 0.4% (Figure1). Ethnic diversity decreases with age. White ethnicities between ages 65-74 represent 92.7% of the population, reaching 95.2% at 85 or more(2). The population of older adults in the UK is expected by 2050 to surpass 19 million, making up one-quarter of the population(3). This article will explore cultural diversity and the barriers that ethnic minorities in older adults may encounter in accessing mental health care while shedding some light on how to bridge the gaps in service with some initiatives in the UK.

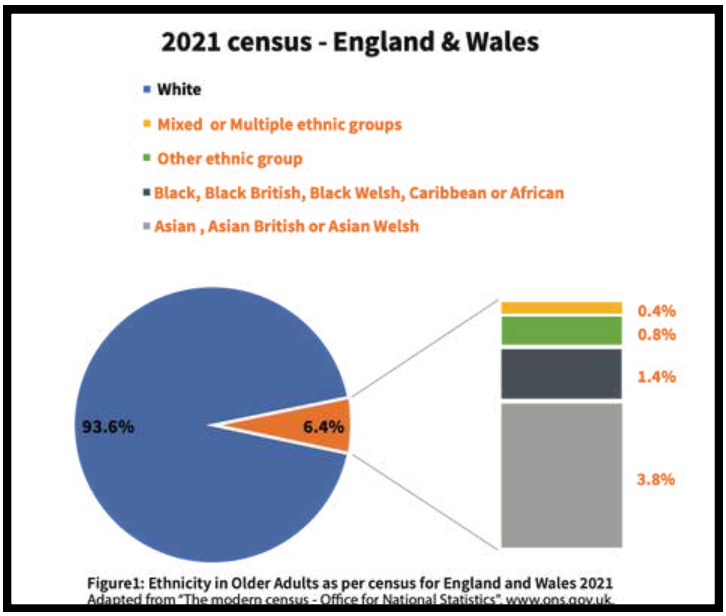

Figure1: Ethnicity in Older Adults as per census for England and Wales 2021
Adapted from "The modern census - Office for National Statistics", www.ons.gov.uk

Ethnic Minorities, with respect to their heterogeneity as a whole group, should not be lumped into one group. They mainly come from Indian subcontinent, Caribbean, China, Somalia, Vietnam, Eastern Europe, Mediterranean, Middle East, and Ireland. The college operates the definition BME, that is "cultural heritage distinct from the majority population"(4)(5). However, it is essential to note that the 2021 census defines it another way "all other ethnic groups except White British group" instead of BME, to avoid the emphasis on certain ethnic minorities groups, specifically Black and Asian communities(6). These ethnicities are facing consistent challenges that need our kind attention and extra care.

Ethnic minority populations are characterised by a higher prevalence of depression and dementia than the dominant ethnic group, counting more frequent visits with primary care and low with specialized Older Adults psychiatric services. High rates of suicide were reported with elderlies from Indian subcontinent origin or born in China or Africa(7). Research shows that various important factors are influential in their mental health care:

1. Accessibilities to the service.
2. Generational Gap.
3. Ethnicity.
4. Socio-economic difficulties.
5. Health literacy.

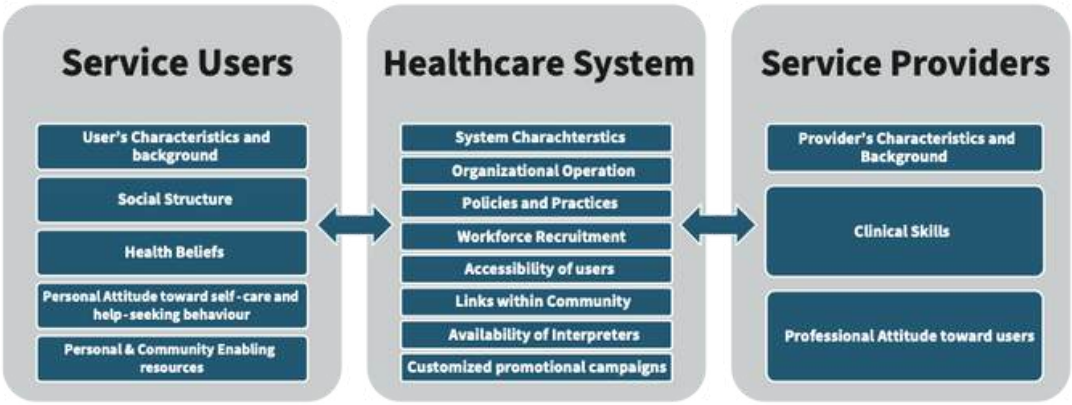

Figure2: The levels of Barriers faced by older adults with ethnic minorities

Underscoring these challenging factors that compromise accessibility to a wide range of care levels is well-established in several reports and conducted research(5). The generational gap could impede seeking help and delivering service. Some of these elderly need more awareness and understanding of how the urbanised healthcare system operates, especially those from rural origin backgrounds, who may navigate unaided through piles of barriers that hinder effective therapeutic relationships and efficient service delivery.

The National Service Framework (NSF) for Mental Health (Department of Health, 1999) and other related reports consistently shed light on the gap between service users and providers in mental healthcare services which is still far from being highly accessible services mainly related to Dementia Care(8) (9).

The Barriers faced by older adults from ethnic minorities:

Bhattacharyya and Benbow (2013) presented a model, which identifies the barriers faced by elderly people from ethnic minority backgrounds in accessing mental health care(5). These barriers can be broadly classified into three levels: service users, healthcare systems, and service providers. (Figure2)

Several key factors must be considered across these three levels to ensure adequate mental healthcare care. They may make them more vulnerable, including their race and personal characteristics of poor awareness of the care that is available, the challenges of inaccessibility, the sensitivity to disclosing their sufferings, and their expectations from the service. Family members may play a crucial role in (under)estimating and delivering supportive care, and difficulties could arise from the compounded stigma they experience. Religious or cultural perspectives can influence their belief systems, particularly health-related ones, shaping their approach to seeking help for care and wellness. It is not uncommon for them to search for alternative routes from the proper channels when in need by contacting their social network, clerks or spiritual healers(10).

Healthcare systems should be flexible enough to be inclusive through improving the characteristics of quality of service delivery, a smooth organizational operation that facilitates their engagement, educating and applying policies and evidence-based practices, recruiting additional workforce, enhancing the accessibility in service, liaising with geriatrician to address their physical health, reaching out within the community and with charitable institutes that empower them with information and support related to several benefits in health, social care, housing, employment, and income security and pension, e.g., Policy Research Institute on Ageing and Ethnicity (PRIAE), National Institute for Mental Health in England (NIMHE).

The presence and availability of interpreters facilitate the healing process and contribute to obtaining a clearer picture of what truly matters. Promotional campaigns that target ethnic minorities will add value to their awareness on how and when to seek help when necessary, for example, the BME Dementia Service – Touchstone Support Centre in Leeds founded in 2013 hosts a weekly South Asian Dementia Café in their native language, creating a supportive space for elderly individuals from Asian ethnic backgrounds. (10)(11)(12)(13).

Service providers can have an impact on minority groups, which may affect the therapeutic relationship. The crucial role of resident doctors cannot be overstated. It is essential for their clinical skills to be well-developed in order to address a variety of cultural differences and to accommodate the diverse population while upholding professionalism in their endeavours.

Conclusions:

While challenges persist across the healthcare system, service users, and providers, more efforts need to be placed into innovative special services for older adults from ethnic minorities that are integrated with existing ethnocentric services using language-compatible validated tools and interpreters(5). The work by The Bristol BME People Dementia Research Group provided useful insights on “the wider picture” on dementia affecting old age communities of minor ethnicities in the UK(14). In 2020, a transformative pilot study for the Patient and Carer Race Equality Framework (PCREF) was launched across four trusts in the UK, aiming to dismantle barriers for our diverse communities. This initiative emphasizes the importance of strong leadership and governance, national organizational competencies, and the invaluable insights of patients and carers. By the end of the financial year 2024/25, NHS mental health trusts and providers will be empowered to embrace the PCREF, setting a new standard in care and inclusion for all(15).

Finally, Developing a treatment model grounded within healthcare organizations should aim to enhance service delivery and foster a culture of research, learning, and knowledge dissemination. This approach ensures broader impacts, fostering a more effective and well-delivered therapeutic process. Engaging with local communities and creating tailored, person-centred services will be crucial to addressing barriers elderly people face, ensuring their dignity in care and wellbeing, and bridging the gaps between "us" and "them."

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RESOURCES TO SUPPORT PRESCRIBING MONOCLONAL ANTIBODY THERAPIES IN ALZHEIMER'S DISEASE

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The last 18 months have been a busy time for regulatory authorities around the world as they grapple with whether to approve lecanemab and donanemab, monoclonal antibodies that target amyloid in Alzheimer's disease. Illustrating this activity, by the end of 2024, lecanemab was approved in the U.S., Japan, China, South Korea, Hong Kong, Israel, UAE and in November the European Medicines Agency's human medicines committee recommended granting it marketing authorisation, reversing a previous negative opinion in July.

Here in the UK, the MHRA also approved lecanemab (Leqembi) in August and donanemab (Kisunla) in October. At the same time, NICE published its draft guidance (covering England and Wales) specifying these medicines were not cost-effective to use in the NHS. Final NICE appraisals are anticipated in February 2025 for lecanemab and March 2025 for donanemab, with the Scottish Consortium of Medicines also expected in 2025. Until then, clinically these medications are only available via private practice.

As with any medication, the prescribing framework for these drugs is guided by the MHRA marketing approval as reflected in the relevant summary of product characteristic (SmPC). Weighing up risks and benefits, the licence issued by the MHRA for both monoclonal antibodies was restricted to adults in the early stages of Alzheimer's disease (MCI or mid dementia) with one or no copies of the apolipoprotein E4 gene (ApoE4). The total duration of treatment with donanemab was set at a maximum of 18 months, whilst treatment with lecanemab, if well tolerated, could continue until a patient progresses to moderate disease.

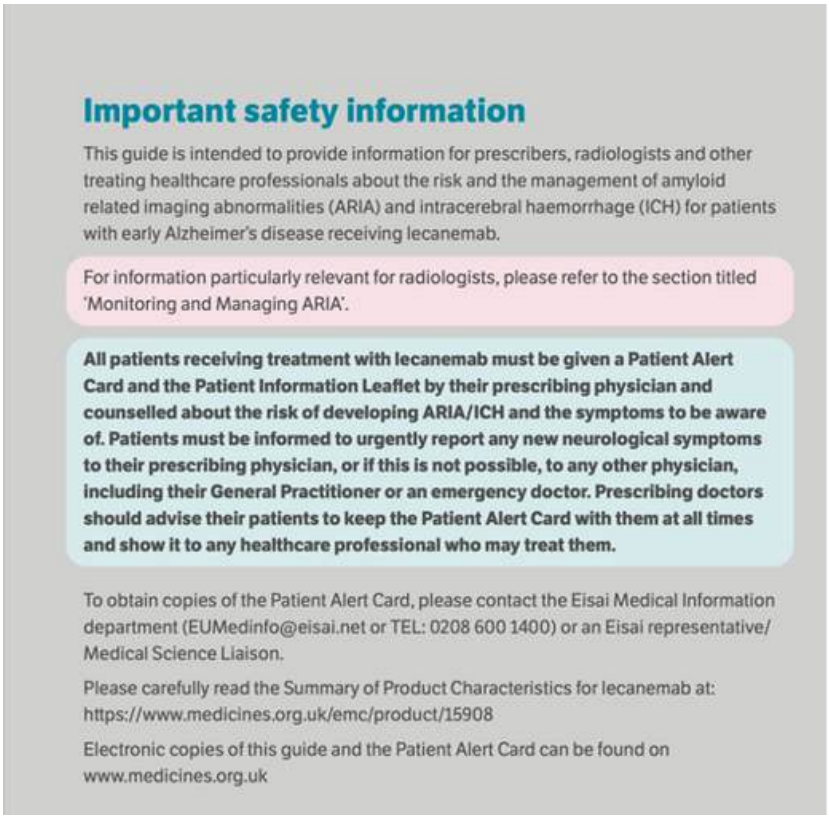
Before initiating either treatment, checking for predetermined exclusionary criteria is mandated and this includes testing for the APOE4 gene alongside determining amyloid positivity (currently via CSF or PET imaging), though deciding whether genetic or molecular testing comes first will be a dilemma. Initiation of treatment will also involve using a central registration system, implemented as part of a controlled access programme (via a third-party organisation, Uniphar). A key aspect of delivering these treatments will be to ensure appropriate risk minimisation measures are in place before and used throughout drug administration.

Naturally there will be many questions about the "who, how, what and when" of safe and effective prescribing. So, this short article focuses on what information resources are currently available in the public domain to help clinicians and patients consider relevant issues. No doubt new materials will emerge, and we are anticipating UK-aligned appropriate use recommendations (akin to those published by Cummings et al in 2023 in US*) will also become available in 2025. This article is not about the merits of each treatment nor what service configuration is required to deliver these medicines, and all prescribing needs to follow due diligence and marketing approvals.

*Reference: Cummings J, Apostolova L, Rabinovici GD, et al. Lecanemab: appropriate use recommendations. J Prev Alzheimers Dis. 2023;10:362–377. doi: 10.14283/jpad.2023.30. [DOI] [PMC free article] [PubMed] [Google Scholar]

Example of Resources for Clinicians / Healthcare Professionals

Resources	Comments
 For lecanemab:  	**Visit:** emc electronic medicines compendium for up to date, approved and regulated prescribing and patient information for licensed medicines. For lecanemab, here you can find three types of resources: • Information for Healthcare professionals with access to SmPC • **Patient leaflets** (PIL) • Risk materials – essential reading for anyone who will prescribe. This includes a guide for healthcare professional as well as access to Patient Alert Card.



Important safety information

This guide is intended to provide information for prescribers, radiologists and other treating healthcare professionals about the risk and the management of amyloid related imaging abnormalities (ARIA) and intracerebral haemorrhage (ICH) for patients with early Alzheimer's disease receiving lecanemab.

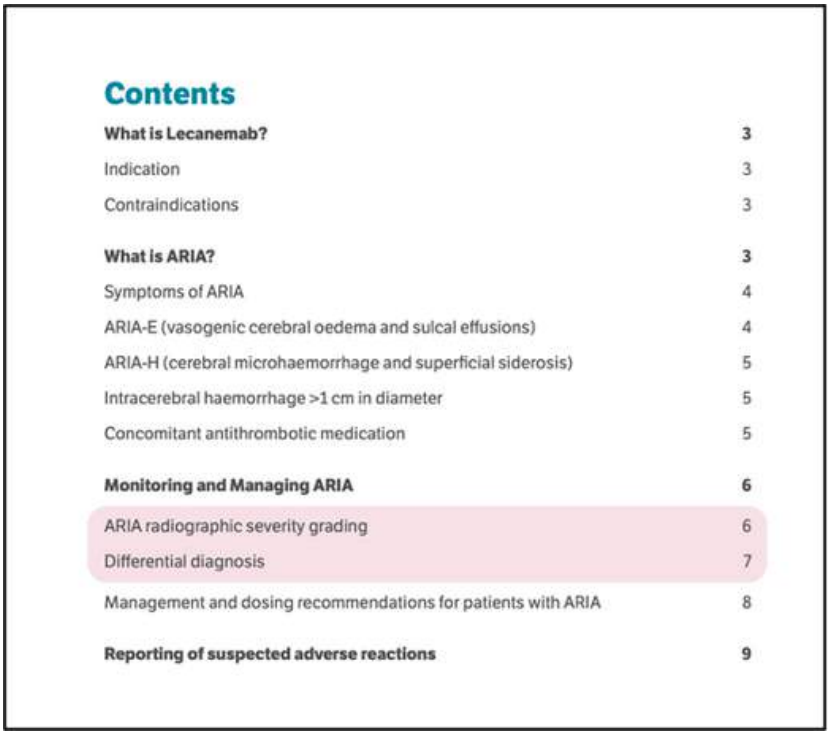
For information particularly relevant for radiologists, please refer to the section titled 'Monitoring and Managing ARIA'.

All patients receiving treatment with lecanemab must be given a Patient Alert Card and the Patient Information Leaflet by their prescribing physician and counselled about the risk of developing ARIA/ICH and the symptoms to be aware of. Patients must be informed to urgently report any new neurological symptoms to their prescribing physician, or if this is not possible, to any other physician, including their General Practitioner or an emergency doctor. Prescribing doctors should advise their patients to keep the Patient Alert Card with them at all times and show it to any healthcare professional who may treat them.

To obtain copies of the Patient Alert Card, please contact the Eisai Medical Information department (EUMedinfo@eisai.net or TEL: 0208 600 1400) or an Eisai representative/ Medical Science Liaison.

Please carefully read the Summary of Product Characteristics for lecanemab at: https://www.medicines.org.uk/emc/product/15908

Electronic copies of this guide and the Patient Alert Card can be found on www.medicines.org.uk



Contents

For donanemab:

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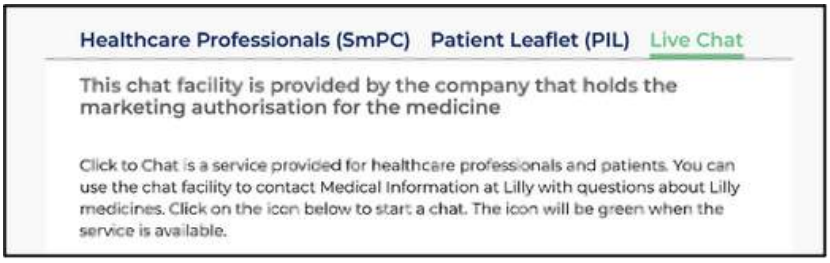


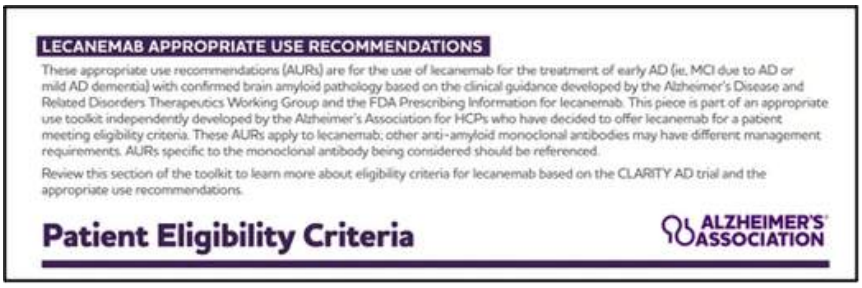
Healthcare Professionals (SmPC) Patient Leaflet (PIL) Live Chat

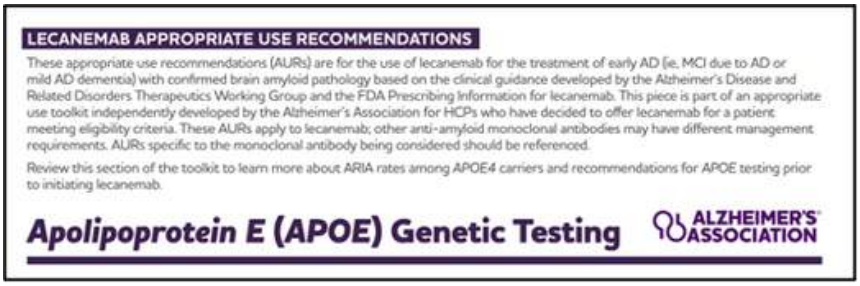
This chat facility is provided by the company that holds the marketing authorisation for the medicine

Click to Chat is a service provided for healthcare professionals and patients. You can use the chat facility to contact Medical Information at Lilly with questions about Lilly medicines. Click on the icon below to start a chat. The icon will be green when the service is available.

For more information, please refer to the Summary of Product Characteristics which is available at https://www.medicines.org.uk/emc/product/15908 or by scanning the QR code below.

Information for donanemab also includes access to SmPC and PIL – with a live chat link to Lilly. To date there is less information about risk mitigation strategies.





Alzheimer's Association lecanemab toolkit

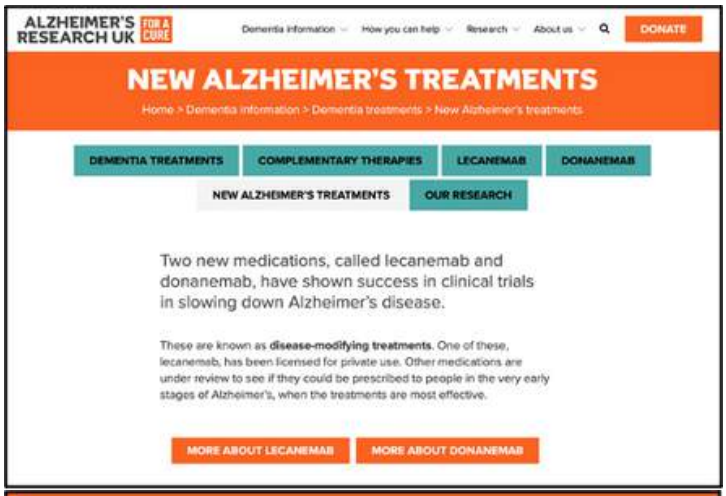
In 2023 the US based appropriate use recommendations (AUR) were published. Naturally these are more closely aligned to FDA approvals, and there are differences between the FDA and MHRA marketing approvals. That said, as this is a form guidance, it contains very useful advice about prescribing.

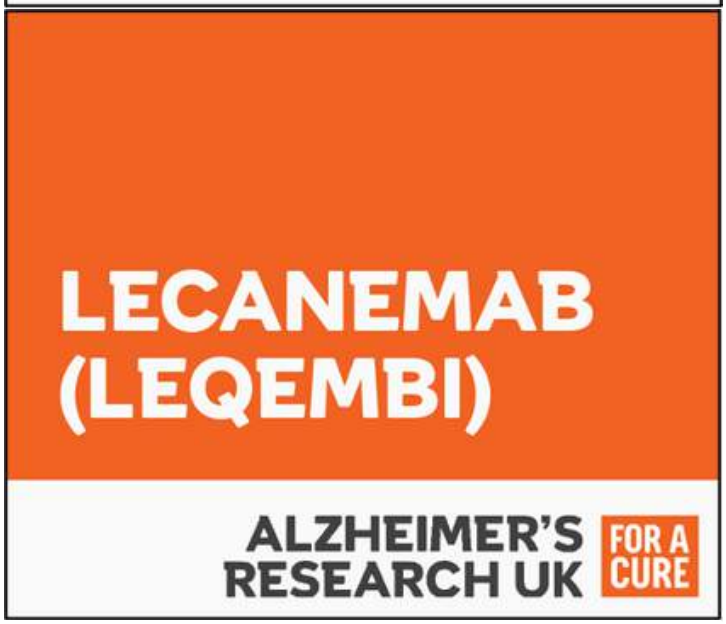
Here you can also find information about ApoE testing.

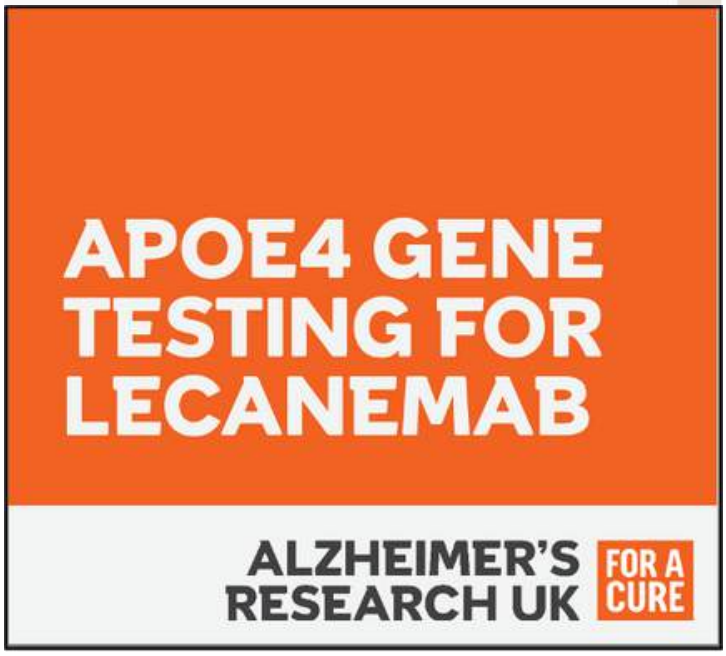
AUR for donanemab (from the US) are due to published soon as well as AUR for lecanemab from UK experts.

Example of Resources for Patients and Families

Resources	Comments
	Information quoted from linked website states: 'All patients receiving treatment with lecanemab must be given a Patient Alert Card and the Patient Information Leaflet by their prescribing physician and counselled about the risk of developing ARIA/ICH and the symptoms to be aware of. This card contains important safety information that patients need to be aware of before starting, during and after stopping treatment with lecanemab. Patients must be informed to urgently report any new neurological symptoms to their prescribing physician, or if this is not possible, to any other physician, including their General Practitioner or an emergency doctor. Prescribing doctors should advise their patients to keep the Patient Alert Card with them at all times and show it to any healthcare professional who may treat them.'



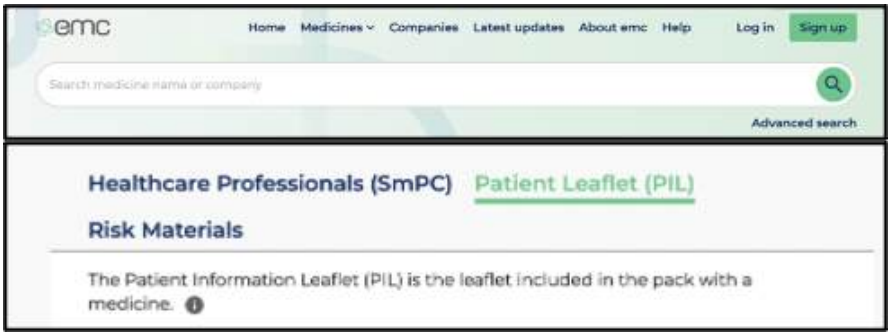


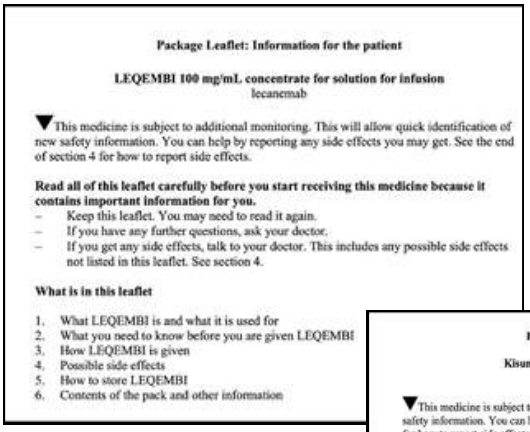


Alzheimer's Research UK (ARUK) have a range of helpful and accessible resources for patients on their website, as illustrated here.

This includes information about ApoE genetic testing.

The Alzheimer's Society has also produced a range of helpful and informative patient facing information about both medications.





Package Leaflet: Information for the patient

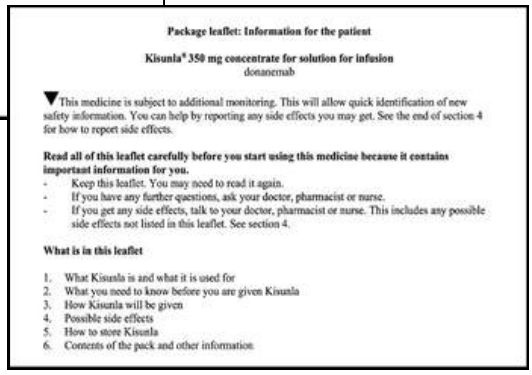
LEQEMBI 100 mg/mL concentrate for solution for infusion
lecanemab

▼This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get. See the end of section 4 for how to report side effects.

Read all of this leaflet carefully before you start receiving this medicine because it contains important information for you.
- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor.
- If you get any side effects, talk to your doctor. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

1. What LEQEMBI is and what it is used for
2. What you need to know before you are given LEQEMBI
3. How LEQEMBI is given
4. Possible side effects
5. How to store LEQEMBI
6. Contents of the pack and other information



Package leaflet: Information for the patient

Kisunla® 350 mg concentrate for solution for infusion
donanemab

▼This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get. See the end of section 4 for how to report side effects.

Read all of this leaflet carefully before you start using this medicine because it contains important information for you.
- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor, pharmacist or nurse.
- If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet

1. What Kisunla is and what it is used for
2. What you need to know before you are given Kisunla
3. How Kisunla will be given
4. Possible side effects
5. How to store Kisunla
6. Contents of the pack and other information

Finally, returning to the EMC website, you can find the relevant patient information leaflets.

SODIUM AMYTAL – NO LONGER PRESCRIBED, BUT STILL RELEVANT (AND DANGEROUS!)

CASE REPORT OF AN ELDERLY PATIENT BEING WEANED OFF BARBITURATES

Dr Conor Brown, Core Psychiatry Trainee (CT2), Northern Ireland Medical and Dental Training Agency (NIMDTA)

Sodium amytal (amobarbital) is a barbiturate medication, first synthesised in Germany in the 1920s to treat anxiety and sleep disorders; as well as being used as an anaesthetic. This case report discusses sodium amytal prescription and subsequent dependence in an 82 year old female with a history of anxiety and agoraphobia. It aims to highlight historical indications, mechanism of action of and potential dangers of cessation. As such, clinical management of withdrawal is discussed including the initial use of a more commonly prescribed barbiturate in place of amobarbital; with the ultimate aim being to cease such dangerous medication and to consider safer alternatives – pharmacologic and psychological.

Introduction:

Barbiturate medications were introduced in clinical practice in at the start of the 20th century, with their primary use being in the treatment of severe neurotic and psychotic disorders. In fact, these drugs were the most commonly used medicines for sedation and hypnosis between the 1920s and 1950s. (1) Barbiturates act as central nervous system depressants. They bind to GABA A (in a similar fashion as the now more commonly prescribed benzodiazepines), potentiating the effect of GABA at this receptor.

In the case of our patient, anonymised to Mrs F, she had been prescribed sodium amytal in the 1970s with the indication of 'severe anxiety and agoraphobia'. Of note, she was taking 180mg three times a day – totalling 540mg daily. Such a dose is much higher than the maximum dose recommended in cases of insomnia (200mg daily), with little evidence circulating for the maximum dose in treatment of other conditions.

Barbiturates are not routinely used in modern clinical practice. As per the BNF, intermediate acting barbiturates such as sodium amytal should be avoided in the elderly, and only have a role in the treatment of severe intractable insomnia(3). Similarly, their 'replacement drug', benzodiazepines are currently recommended for no longer than 2-4 weeks in the management of severe, disabling anxiety states. Further, current guidance suggests avoiding prescribing these drugs in the elderly due to risks of falls and confusion. (3)

As Mrs F had been taking amobarbital for greater than 50 years, she had become both psychologically and physically dependent on the drug. It has been reported in literature that admission is required for patients prescribed >0.4g per day of secobarbital or an equivalent medication for 90 days or longer (4). Barbiturates have long caused addiction issues, with a reported 135,000 patients deemed addicted in England in 1965 (1). Previous literature also reports that barbiturates with short to intermediate half-lives, including amobarbital, are 'almost by definition being abused…as there are almost no therapeutic indications for long-term treatment'(4).

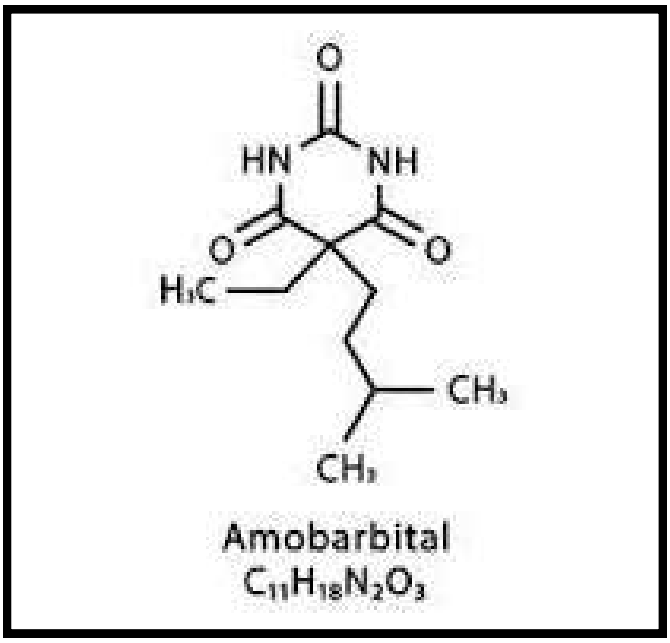
The Case

A combination of Brexit and COVID-19 led to difficulties in supply of sodium amytal, and so Mrs F was referred to the Community Mental Health Team for Older Persons in 2021. At this time, she was reportedly keen to switch to an alternative medication. At the initial psychiatric consultation, Mrs F reported symptoms such as anxiety, catastrophic thinking and sleep disturbance. Mrs F had agreed a reduction in sodium amytal from 180mg TDS to 120mg QDS, with supplemental lorazepam being utilised to ease the process of withdrawal. Unfortunately, she was unable to tolerate such a reduction, and recommenced her initial dose after 2 days. Two further reviews were carried out, and notably Mrs F reported that she was 'no longer anxious about supply issues'. She cancelled her following outpatient appointment and was lost to follow up, continuing on the same dose that she was prescribed at the time of initial referral.

Mrs F was however re-referred to Older Persons Psychiatric Services in 2024. At this time, her GP reported that she was 'one of only 30 patients in the UK' to be prescribed sodium amytal, and that it was 'no longer being produced'. At the time of referral, Mrs F had just a 7 day supply of medication left.

Guidance from the local Medicines Information team had been sought prior to admission. They recommended a phenobarbital taper for seizure prophylaxis when discontinuing other barbiturates, where 100mg amobarbital was roughly equivalent to 30mg phenobarbital. Phenobarbital is a long acting barbiturate which would be more commonly found in practice, given its use in management of epilepsy.

As such, an attempt was made at the safe withdrawal of sodium amytal in the inpatient setting. This was due to the significant risks associated with abrupt withdrawal, including seizure, hallucinations and cardiovascular collapse tending to occur after 16 hours of cessation with such risk remaining up until approximately 5 days.



More commonly, withdrawal symptoms from barbiturates mimic those of alcohol withdrawal; including but not limited to anxiety, dizziness and gastrointestinal disturbance. Orthostatic hypotension can also be a feature, which can be problematic in the older, co-morbid patient often subject to polypharmacy. Minor symptoms often occur within 8-12 hours (the half life of the drug is thought to be 20-25 hours), and withdrawal symptoms tend to reduce in severity approximately 2 weeks after cessation.

Mrs F had run out of medication on the day that she was admitted, and given the aforementioned risks, a thorough plan was developed to ensure close monitoring. She was commenced on 1:1 special observations initially due to the risk of seizures. Her clinical observations were performed on a regular basis and a CIWA (Clinical Institute Withdrawal Assessment for Alcohol) score was also performed hourly to monitor withdrawal severity. To this end, lorazepam was prescribed at a dose of 1mg every 6 hours, as well as an 'as required' dose of 1mg prescribed for when CIWA score was >8.

At consultant review the following day, Mrs F was commenced on phenobarbital at a dose of 30 mg QDS + 30 mg PRN to a maximum of 150 mg/day, continuing on regular lorazepam at 1mg QDS. Of note, this is slightly lower than the aforementioned recommendation which would equate to 162mg/day. Subsequently, owing to increasing agitation and anxiety, Mrs F's dose was increased to 60mg mane, 30mg TDS plus 30mg PRN and her dose of lorazepam was reduced to 1mg TDS. She was discharged on both medications, 9 days after admission.

Discussion and Conclusion:

During her admission to hospital, Mrs F herself reported that, had she known of the addictive nature of the medications, she would never have agreed to commence sodium amytal.

The treating team discussed the preferred option to follow on from the withdrawal of amobarbital with subsequent tapering of phenobarbital, given that it shares many of the same risks as the former. Mrs F however was not keen to change medications again at present, owing to her age and ongoing anxiety. In fact, at a subsequent outpatient review, Mrs F reported that she felt that she would require more lorazepam to cope with ongoing anxiety, however this was not facilitated. In terms of patient safety, it should be highlighted that the patient was discharged on 2 addictive, sedative medications (even if the lorazepam was a short term measure), which could prove challenging to rationalise moving forward and perhaps gives an insight into the ongoing difficulties faced by outpatient teams in terms of cessation of addictive medicines. Importantly, the patient would not however experience the same supply issues currently with phenobarbital. It should also be noted that she had declined psychological therapy with the Community Mental Health Team for Older Persons.

To conclude, the aims of this report were to highlight the use and action of the barbiturate class of medications, whilst also discussing difficulties with supply issues, dependence and the associated potential for withdrawal. Ensuring patient safety is paramount, and in many cases patients who are prescribed this class of medications for a prolonged period of time require inpatient management to allow for a safe transition to an alternative medication.

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IMPACT OF DOSE TITRATION USING THE SEIZURE QUALITY RATING (SQR) SCALE ON ELECTROCONVULSIVE THERAPY OUTCOMES:
A QUALITY IMPROVEMENT PROJECT

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Objective

The aim of this Quality Improvement Project (QIP) was to incorporate the Seizure Quality Rating (SQR) scale into our Electroconvulsive Therapy (ECT) service. This was done to optimise ECT dose titration compared to traditional methods based on seizure duration alone, and improve clinical outcomes, particularly by reducing cognitive side effects that can occur with higher doses of electric current (1), thereby having an impact on overall patient experience.

Introduction

Electroconvulsive Therapy (ECT) remains a critical intervention for severe depression, especially in treatment-resistant cases and those with an imminent risk to life. Recent clinical advancements have emphasised optimising ECT procedures to enhance effectiveness while minimising side effects, particularly in elderly patients with complex depression. (2)

A key tool in optimising this procedure is the Seizure Quality Rating (SQR) scale, which provides a structured, objective method for measuring and optimising seizure quality during ECT. This scale is designed to evaluate several seizure parameters through EEG, helping clinicians titrate the dose based on seizure quality, rather than duration alone.

This QIP evaluates the implementation of the SQR scale into our service, hypothesising that

it leads to more efficient dosing (lower electric current) and improved clinical outcomes, including reduced cognitive side effects, particularly in vulnerable populations. Theoretically, lower doses of ECT should lead to fewer side effects, such as memory impairment, though this remains to be fully validated. A more structured dosing approach, as facilitated by the SQR scale, could potentially minimize the risk of side effects, such as memory impairment, associated with higher doses of electric current.

Although studies on ECT are often limited by challenges in blinding and small sample sizes, findings indicate a promising trend toward more efficient and safer ECT dosing (3). The SQR scale adds value by allowing clinicians to make data-driven decisions regarding dose titration. However, some parameters, such as interhemispheric coherence, are subjective and require further validation for consistency across different practitioners. (4)

Methodology

This QIP was undertaken within the ECT clinic at Surrey & Borders Partnership (SABP) NHS Foundation Trust. The SQR scale was implemented to assess seizure quality by measuring several parameters, including visual and EEG seizure duration, mid-ictal amplitude, interhemispheric coherence, postictal suppression, and peak heart rate along with age, and then scored accordingly. Two groups were compared - before and after the introduction of the scale:

- Pre-SQR group (Standard): Patients who began and completed ECT treatment between 1st May 2023 and 30th October 2023, dose titrated based on duration of therapeutic seizure.
- SQR group (post-intervention group): Patients who began and completed ECT treatment between 1st December 2023 and 31st May 2024, dose titrated based on SQR rating scale.

Inclusion criteria were patients with depression. Exclusion criteria were patients with Schizophrenia or other psychotic conditions as the primary diagnosis. Primary outcome measures were the number and dose of treatments, Clinician's Global Improvement (CGI) score and CGI subjective memory score post-ECT. The groups were also compared for age, gender, and subtype of depression.

	Treatments	Dose (mC)	CGI (S)	Sub Mem (S)	CGI (I)	Sub Mem (End)
Pre SQR (standard)	12	705	6.33	0.91	2.72	1.90
SQR (post-intervention)	12	622	5.29	1	2.71	2

TABLE 4

Results

There were 11 patients in pre-SQR (standard) group and 7 in the post-SQR (post-intervention) group meeting criteria for inclusion in this QIP.

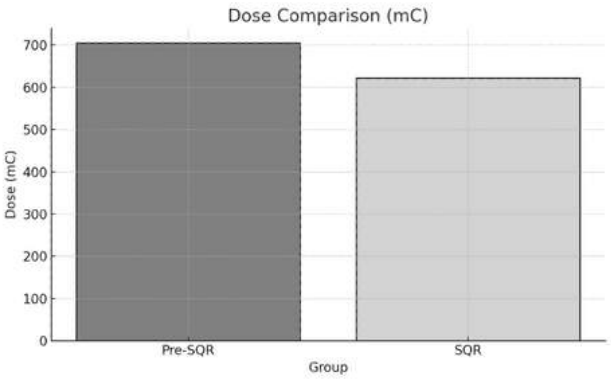
The pre-SQR group comprised 3 male and 8 female patients with a mean age of 68, whilst the post-SQR group comprised one male and six female patients with a mean age of 58. The pre-SQR groups had a variety of diagnoses including bipolar depression(3), Severe depression (1), Schizoaffective disorder – depressive episode(1), Mixed anxiety and depression(1) and Recurrent Depression (5). Meanwhile, the post-SQR group comprised 7 patients with a diagnosis of recurrent depression.

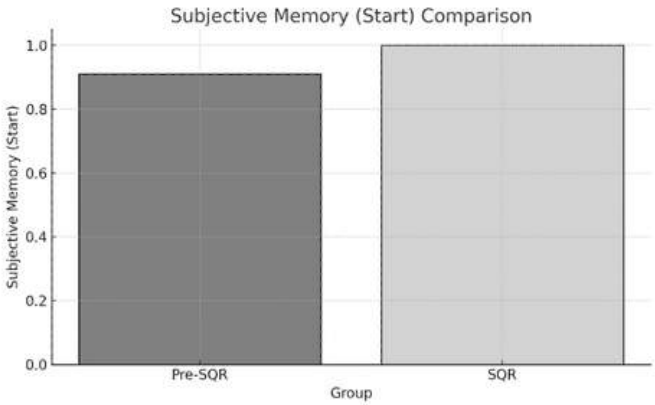
Importantly, although the mean number of treatments between both the groups was the same, there was a trend towards lower dose of electric current in the group titrated using the SQR scale. Table 4 provides information about their outcomes:

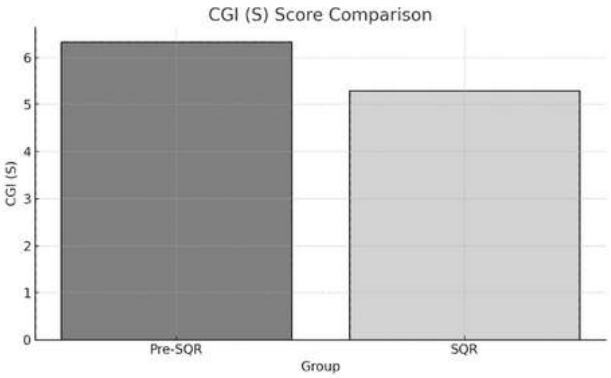
Seizure Quality Rating Scale

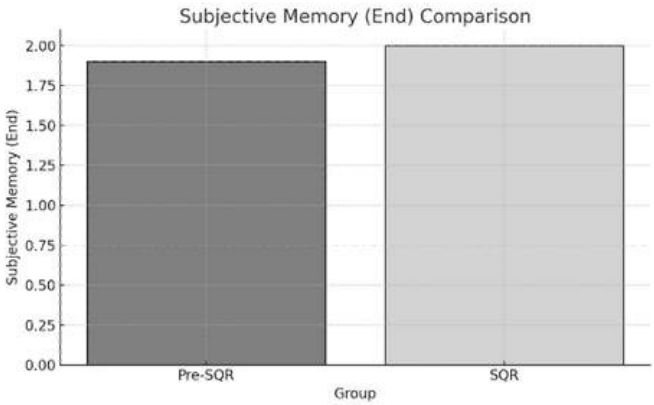
- **Visible seizure duration** (duration of visible muscle contractions)
  - Less than 10s - **0**
  - 10-15s - **1**
  - Over 15s – **2**
- **EEG seizure duration** (duration of seizure activity on the EEG)
  - Less than 20s - **0**
  - Over 20s – **1**
- **Mid-ictal amplitude** (If the overall amplitude of the seizure activity on the EEG is low, medium, or high)
  - Low (<50%) – **0**
  - Medium (50%-99%) - **1**
  - High (100%) – **2**
- **Interhemispheric coherence** (Is there overall coherence between each hemisphere on the EEG)
  - No – **0**
  - Yes – **1**
- **Postictal suppression** (whether there is a clear end point and flat line to mark the end of seizure activity on the EEG)
  - Poor – **0**
  - Fair - **1**
  - Good – **2**
- **Peak heart rate** (maximum heart rate measured during the seizure)
  - Less than 100 – **0**
  - 100-124 - **1**
  - >125 – **2**

Total score - /10
Aim for: ≥ 8 if age <40
≥ 7 if age 40-70
≥ 6 if age >70







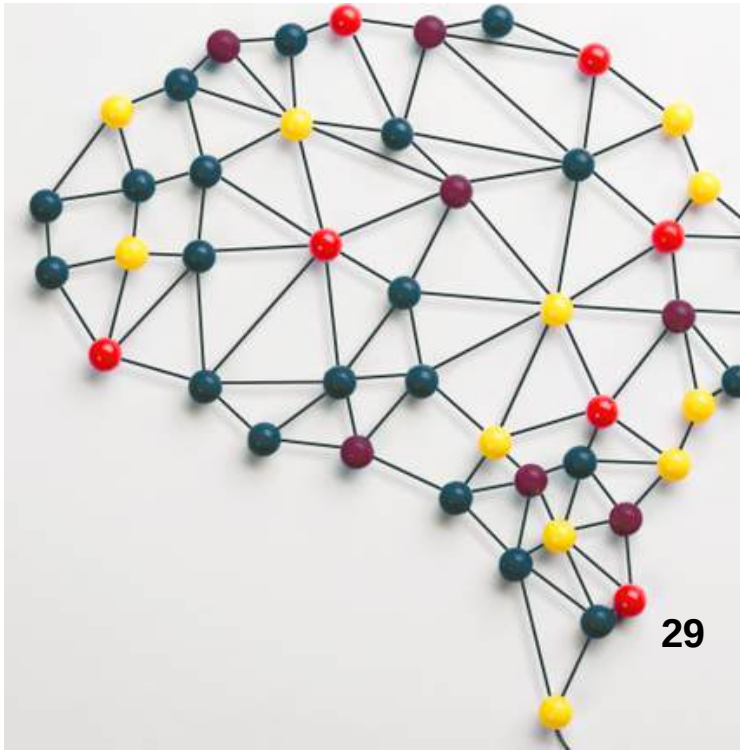


Discussion

The introduction of the SQR scale into our ECT clinic led to a trend towards lower doses of ECT while maintaining similar clinical outcomes in our small sample group. Although clinical outcome measures, including CGI and memory scores, remained largely unchanged, the small size of the group, lack of patient feedback, and the immediate nature of the measurements likely limited our ability to detect more substantial improvements. (3) Thus, no overt benefit or harm was observed, and the findings may need to be interpreted with caution.

IThis QIP introduced the use of the SQR scale, which led to lower doses of ECT, which might suggest the potential for reduced side effects, although this remains speculative. The SQR scale's ability to help clinicians make more informed, data-driven decisions regarding dose titration is a valuable tool, but it requires further validation. (4) Given that some subjective parameters require additional consistency across clinicians, further research with larger sample sizes and standardised training may be necessary to enhance the reliability of the scale.

The next steps for our service include gathering patient feedback to assess whether reduced doses lead to improved cognitive and emotional well-being. We strive to adopt the SQR scale as part of our standard operating procedures within the ECT guidelines of the trust, continuing to collect data, and involving patients in feedback loops to further refine our approach.



Conclusion

The SQR scale represents a promising development as a structured tool that has the potential to reduce electric dose which appears to maintain therapeutic efficacy.

This QIP has demonstrated the potential of the SQR scale in optimising ECT dosing by enabling a more structured and data-driven approach. By using lower doses, we aim to reduce the cognitive side effects typically associated with higher electric currents, especially in elderly populations. Although clinical outcomes have largely remained unchanged, the trend toward using lower doses is promising, though further research and validation are required. Moving forward, the next steps for our service include integrating the SQR scale into our ECT policy, gathering patient feedback to evaluate the cognitive and emotional impact of lower doses, and continuing to collect data. This would help to validate the clinical significance of these changes and contribute to future research on optimising ECT dosing protocols. Future work could also focus on enhancing the scale's consistency across subjective parameters like interhemispheric coherence and expanding its application in larger clinical settings.

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DISSECTING THE DISCHARGE PLANNING PROCESS ON A FUNCTIONAL OLDER ADULTS' PSYCHIATRIC WARD

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Background:
Dovedale 1 is a 15-bedded (7 male and 8 female) older adults' functional inpatient psychiatric ward for people above 65 years of age. It is part of the Sheffield Health and Social Care NHS Foundation Trust.

Prior to embarking on this service evaluation project, existing literature was reviewed to identify any gold standard guidance to length of stay or admission on older adults' inpatient units. In our review, there were similar projects done in East London NHS Foundation Trust in 2017 and 2018 in two separate older adults' inpatient units within their trust. (1,2) These projects did not use a standard to compare their service with but compared wards within their trust to each other. As there were no other functional old age wards within the trust to compare with, we were unable to replicate their proposed study design.

On review of literature, there is no gold standard length of stay recommended. Various resources such as the Adult and Older Peoples' Mental Health Services 2022-2023 National Report by the NHS Benchmarking Network(3) and NHS England's guide to Acute inpatient mental health care for Adults and Older Adults(4) were consulted, which cited an average length of stay of mean 87 and median 89 days and 90 days respectively for older adults nationally during that particular year. On referring to the RCPsych CCQI Standards for Older Adult Mental Health Services, the only guidance available was related to adopting a patient-centred and collaborative approach in the discharge planning process.

This highlights the difficulty in generating a "magic number" as the ideal length of stay due to how the various variables impacting admission and discharge that cannot be all controlled at once. Keeping this in view, we decided to identify the most common factors impacting length of admission on Dovedale 1 and how each of them contributed towards patient care and discharge planning.

Aims:
To identify factors impacting length of stay on Dovedale 1 and how they affect patient care and discharge planning processes.

Service Evaluation Design and Methodology:
This was a retrospective, cross sectional review in which patient records were accessed through Insight- electronic patient information system from January 2022 till December 2022. A total of 59 inpatient admissions took place during this period. Each patient's notes were reviewed including AMHP reports, MDT documentation and discharge summaries to determine demographic data, detention status, length of stay etc. This data was then entered onto an Excel spreadsheet.

Table 1:	Admissions to Dovedale 1 1st January 2022 to 31st December 2022				
Age (yrs)	61-70: 20 (34.4 %)	71-80: 23 (39.6 %)	81- 91:15 (25.8%)		
sGender	Male: 30 (51.7%)	Female: 28 (48.2%)			
First Admission	33 (56.8 %)				
Detention Status	Informal: 19 (32.7%)	Section 2: 25 (43.1%)	Section 3: 13 (22.4%)		
Length of Admission (In days)	1-46: 19 (32.7%)	46-91: 18 (31%)	91-136: 5 (8.6%)	181-226: 0 (0%)	226-271: 1 (1.7%)

Results:

Some patients were re-admitted during the year and each admission was counted as a separate entity. Out of 59 admissions identified from an electronic database, one was excluded as they were not admitted after an initial assessment, therefore only 58 admissions were considered for this study. The average length of stay was calculated to be 72.54 days .

On review of notes, a clear reason for a delay in discharge was documented for 18 admissions (31 %) and not recorded for 31 admissions (53.4%) in their MDT notes. A discrepancy that was noted was that information was not consistently documented in the same format or place, for example this was not always documented in the MDT notes, but in the progress notes section instead, which could have led to missing data when audited.

Some of the common reasons identified for delay are listed in Table 2.

Discharge planning processes and hurdles:

Once a patient is deemed clinically ready for discharge, this is documented in patients' electronic notes including weekly MDT documentation and handovers. A ward-based discharge coordinator will help complete referrals to community teams and social care for any outstanding and ongoing support that is required to ensure a safe discharge.

A ward-based Discharge Coordinator will clarify patient's needs on admission to contribute towards discharge planning. Some key factors that are considered are their social situation (eg: a care package was in place) or involvement of a social worker. They may also require an Occupational Therapist assessment to clarify the home situation to help identify what aids or support may be required, along with functional assessments on the ward to support a social worker referral. Most of this information can be obtained at point of admission to prevent delays when ready for discharge, including obtaining carer's/family's views and ensuring they are attending MDT meetings.

Table 2: Common reasons for delayed discharges

Poor Response to Treatment	12 patients	Severity of acute mental illness Readmission within short time span Non-compliance with treatment as inpatient
Risk- related	2 patients	Related to poor response to treatment High risk to self, making discharge to community teams unsafe Some required transfer to acute adult wards due to high risk/chaotic behaviour inappropriate to be managed on an elderly ward
Social Care Related	5 patients	Awaiting acceptance from housing/placement Awaiting delivery of appropriate equipment at care home Disparity between patient's wishes to live at home, but family wanting 24-hour care
Other:	5 patients	Awaiting transfer to Dementia Ward Transferred to Sheffield Teaching Hospital for physical health concerns Death due to physical health causes

Some additional barriers identified to the discharge planning process include the following:

Transitioning between two Electronic Patient Record Systems:
The use of two patient systems Insight and Rio as information is recorded in various places. As standard practice, an estimated date of discharge is set in MDT, which allows the team to work towards it through allocation of tasks, but this has gone off radar due to the use of two electronic patient records as the Trust transitions from Insight to Rio. The reason the period between January 2022 and December 2022 was chosen was because at the time there was only one electronic system being used by the entire Trust. From January 2023 onwards, it was noted that Older Adults' services were using Rio, and the rest of the Trust was using Insight, which made data collection complex across the two systems. This was a major limitation to the study.

Staff shortages:
Staff shortage, which lead to having to pick up other clinical duties and giving up discharge planning role.

Limited Access to step down provision including mental health residential care beds-
There are limited step-down placements for older adult patients in Sheffield. The only available service known as Beech (Lightwood) is a ten-bedded service, criteria for which cites that a person needs to be fully independent in all ADLs to be considered for a placement. This has been a successful discharge destination for some of our services users however the current situation is that placement at Beech is being prioritised for adult inpatients.
The Sheffield City Council provide limited access to care homes for elderly patients.

These care home placements are prioritized for adult wards, for patients who are deemed to be bed blocking. Prior to and during COVID, there was availability of step-down beds, but these are no longer available due to funding limitations.

Navigating Social Care

The Sheffield Teaching Hospitals (acute physical health hospitals) follow different discharge pathways and have access to Assess to Care beds. As a mental health trust, we have access to Short Term Intervention Team (STIT) which is a 6-week care package via Sheffield City Council, this is for those returning to their home address but require a care package to support with personal care, managing medications, meals etc.

Social worker referrals are made for those who have two or more identified needs within the domains of the Care Act Assessment. Social worker allocation only occurs when someone is deemed ready for discharge planning to commence. Social workers take part in capacity assessments for accommodation and social care needs, identifying placements (with support from the ward discharge coordinator), including decisions regarding patients needing full time care. They can look at longer care packages and arrange funding if the patient is Section 117 eligible. If a best interest meeting is required, this can be arranged with the ward team. There is a lack of specialist mental health residential and nursing homes in Sheffield, which causes additional delays in accessing placements for patients.

Community Mental Health Team input

The usual pathway is for patients to be discharged with Older Adult Home Treatment (OA HTT) Support. Weekly meetings are held with the OAHTT Link workers to discuss potential referrals. Once a referral is made, these are screened on the ward by the team. Those discharged to 24-hour care who won't need the intensive input from OAHTT other than 72 hour follow up are referred back to Community Mental Health Teams.

Escalation of Delayed Discharges

Weekly Clinically Ready for Discharge Meetings are held on Wednesday afternoons. Attended by Discharge Coordinator and those patients who are ready for discharge are highlighted and reasons for delay are escalated. The Meetings are attended by Social Care Managers, SHSC Senior leads, ward representation from all SHSC inpatient services.

In more 'complex' cases when patients are becoming blocked in their admission due to varying issues e.g social care issues, risk issues, a professionals' meeting can be arranged between ward, community services and external services.

Complex cases are rarer and are arranged when there are ongoing risk issues, not progressing with treatment options, disagreements between teams and are chaired by lead psychologists to understand and navigate the dynamics leading to these complexities.

Lessons and Limitations:

As demonstrated in our service evaluation, the length of admission and discharge planning are important indicators of quality of patient care.. Some of the challenges highlighted in this work are compounded by the presence of physical comorbidities and frailty leading to specialist care needs in our older adults' patient group. Factors such as the staggered transition between electronic patient record systems from Insight to Rio could be mitigated soon and would warrant a repeat audit to see if that leads to a significant improvement in the admission and discharge planning process.

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CROSSING BORDERS: TRANSITIONS BETWEEN SCOTLAND AND ENGLAND IN TRAINING

Dr Indrajit Chatterjee - ST4 dual training (General Adult and Old Age psychiatry), Kent and Medway NHS and Social Care Partnership Trust

It seems only yesterday that I was a bright eyed junior doctor in London, equally nervous and excited, at the prospect of moving to Scotland to train in psychiatry. Fast forward four years and I took the long road back to the south of England, to do my higher training in dual specialties- General Adult and Old age, but this time in Kent. Having heard the saying, "Psychiatry is the same wherever you go", I had built up the courage to face what might come my way. The first month went by in the blink of an eye and I find myself reflecting on what is different.

From living underneath perpetually cloudy skies with a chronic leak, it only took three sunny days at a stretch, for my faith in summer to be restored. The narrow roads and a more congested town centre is something that takes a while to adjust to. It is, hard to beat the serene views of Scotland, especially when one is on the road but again, it is one of the rare places whose geography is both mirthful and bleak.

I have commenced my training in a community Old age rotation and it feels nice to say that the team has taken a lot of steps to create a soft landing for trainees moving from other deaneries. My last rotation in an old age post in psychiatry was in 2021 in Airbles Road Centre, Lanarkshire and although I am inclined to compare my experiences of the first month, I am aware of being a core trainee back then when the world was still reeling from the effects of the pandemic and lockdown.

My previous experience was with a compact team looking after patients from a smaller geographical area. This time around, while attending the MDT team meeting, I was met with a larger network of colleagues, some joining in person and others online.

My previous experience was with a compact team looking after patients from a smaller geographical area. This time around, while attending the MDT team meeting, I was met with a larger network of colleagues, some joining in person and others online. My current community clinic site is located in a larger and a more modern building named Elizabeth Raybould Centre, which also has offices for the General Adult CMHT and all the consultants, although the latter arrangement is not too dissimilar to what my community site is in Lanarkshire.

One of the major changes I noticed is how outpatient and inpatient care responsibilities are shared. The same consultant does not hold community and inpatient caseload unlike how things worked in Scotland. One of the positives from the former way of working is potentially better medical continuity of care although it would involve more travel for the doctor in question, splitting his work time between inpatient and community sites. Daily triage and RAG board meetings are also a novel addition in my work timetable as the team discusses GP referrals daily and the service users they are particularly worried about and their clinical progress.

I was also told how that the Scottish and the English Mental Health Act differed in certain respects. The tribunal system in Scotland is geared towards reviewing the necessity of long term orders while, in the English system, they usually respond to applications of challenging detentions under different sections. Scotland also has a concept of a "named person" to represent the person, enhancing patient advocacy.

I have not yet obtained Section 12 approval but plan to apply for it in due course and gain a better understanding of utilising the English legislation as part of my work as a higher trainee.

RESEARCH UPDATE

Dr Curtis Osborne, Trainee Editor of The Old Age Psychiatrist

Understanding diversity in later life through images of old age
Friederike Enßle and Ilse Helbrecht

Introduction:
This study examined how societal perceptions of old age can obscure the diverse experiences of older adults.
The authors argue that public discourse often relies on two dominant stereotypes: the "active ager" and the "frail, dependent elder." These limited images fail to capture the complexity and variety of aging experiences, particularly in increasingly diverse societies.

Drawing on qualitative research conducted in Berlin, the study introduces alternative images of old age that reflect the nuanced realities of older individuals. For instance, the "Caring Elders" image highlights older adults who, influenced by transnational ties, engage in caregiving roles within their communities. The "Shared Memories" image emphasizes the importance of linguistic and biographical commonalities, showing how older adults seek connections based on shared life experiences and native languages. Additionally, the "Collected Memories" image underscores the significance of individual life paths and personal histories in shaping one's experience of aging.

The study identifies three reasons why these alternative images remain underrepresented in public discourse:

1. **Actors Transmitting Images**: Media and policymakers often perpetuate simplistic stereotypes due to a lack of exposure to the diverse realities of aging.

2. **Institutionalization of Images**: Established institutions may resist incorporating more complex images of old age, favoring familiar narratives that align with existing policies and societal structures.

3. **Challenge of Communicating Complexity**: Conveying the multifaceted nature of aging experiences is inherently challenging, leading to the persistence of reductive stereotypes.

The authors advocate for empirical and conceptual research to bring these alternative images to light, thereby enriching public understanding of aging. By acknowledging and representing the diverse experiences of older adults, society can move beyond monolithic stereotypes, fostering a more inclusive and accurate portrayal of later life.

Full article available:
https://www.cambridge.org/core/journals/ageing-and-society/article/understanding-diversity-in-later-life-through-images-of-old-age/1FF3897BB3C15A1B0C2031CC1EFC6D73

COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health

L. Kola and B.Kohrt et al.

The COVID-19 pandemic has profoundly impacted global mental health, with low- and middle-income countries (LMICs) facing distinct challenges. Fragile healthcare systems, limited resources, and the socio-economic toll of containment measures have deepened mental health disparities, leading to increased psychological distress and rising rates of disorders. For instance, a study in Bangladesh found 33% of respondents experienced depression and 5% reported suicidal ideation during the pandemic.

Despite these challenges, some LMICs have adopted proactive strategies to address mental health needs. These include integrating mental health into national COVID-19 response plans, adhering to WHO guidelines, and using digital platforms to provide support. Such efforts signal growing recognition of the importance of mental health in public health systems.

The pandemic also presents an opportunity to reimagine mental health systems in LMICs. Key strategies include:

- Integrating mental health services into universal health coverage
- Expanding access through task-sharing with non-specialist health workers
- Leveraging digital technologies for care and training

Promoting voluntary, rights-based treatment approaches and focusing on neglected populations, such as children and those with substance use disorders, are also crucial. These reforms can strengthen mental health systems and resilience in LMICs while offering insights applicable to high-income settings globally.

Full article available:
https://pmc.ncbi.nlm.nih.gov/articles/PMC9764935/

Same Old, Same Old? Age Differences in the Diversity of Daily Life

C.Weber, M Quintus et al.

This study investigated how daily experiences vary with age, focusing on the diversity of social interactions, activities, and locations. The research comprised two complementary studies:

*__Study 1:__This study utilized daily diaries from two groups—246 younger adults (average age 21.8 years) and 119 older adults (average age 67.7 years). Participants recorded their daily activities, social partners, and locations over a specified period. Findings indicated that older adults exhibited less diversity across days in their social interactions and activities compared to younger adults. This suggests that as people age, their daily routines may become more stable and less varied.

Study 2: Employing experience sampling methods, this study assessed 365 individuals aged between 14 and 88 years over three weeks. Participants provided real-time reports of their current activities, social partners, and locations at random times throughout the day. Consistent with Study 1, results demonstrated that older adults experienced less within-day diversity in their activities and social interactions. Notably, health limitations partially explained these age-related differences, indicating that health status plays a role in the variety of daily experiences.

Overall, the research highlights a trend toward reduced diversity in daily life as individuals age, influenced in part by health constraints. These findings underscore the importance of considering age-related changes in daily experiences and the potential impact of health on maintaining a varied and engaging daily life.

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

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THE DEPICTION OF BEREAVED OLDER ADULTS IN THE FILM 'UP'

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IMAGE: DISNEY/ PIXAR

Introduction:

Working as a resident doctor in old age psychiatry, I have come across many patients who are navigating various stages of the complex journey that bereavement is. Through observing this, I have noted the vastness and complexity of the feelings associated with losing a loved one. Some of the most poignant cases come from the loss of a spouse, particularly when two people have been intertwined for decades of their lives. I remember watching the film 'Up' for the first time years ago, and being intrigued by the way the journey of bereavement is portrayed throughout. I was inspired to rewatch the film during my F2 job in old age psychiatry, and reflected on how this was an insightful depiction of bereavement in older adults, and considered also how the film could be a useful tool to introduce children to the concept too.

Film: Up (2009) – A Disney Pixar film

'Up' is an animated film aimed at a young audience; it follows journey of Carl, an elderly gentleman, as he comes to terms with his wife Ellie's death. The film starts with a montage of Carl and Ellie's lives together. It begins full of colour, energy, and the spirit of adventure, showing Carl enjoying even the more mundane aspects of his life. It closes with Ellie's death – immediately the music slows, the colours drain to grey, and energy diminishes with Carl's movements becoming slower. Death and its impact on loved ones left behind are difficult concepts to introduce to young children, but I feel the shift in the colours, the music, and the overall mood of the film helps simplify this in a considered and sensitive way.

We follow Carl as he tries, and ultimately succeeds, to reach Paradise Falls, a place he had promised to take Ellie one day, in the hope that this will bring comfort and peace to him. As the film progresses, I find it fascinating how Carl is shown to be travelling through the stages of grief. Denial is expressed through him continuing to talk to Ellie as though she is still beside him. This is entwined with moments of anger, in particular when someone accidentally damages his and Ellie's hand-painted mailbox. Carl starts bargaining to cope with his loss, feeling that if he can only get to Paradise Falls, everything will be okay again.

There are features of depression more prominent in the start of the film, as touched on already with Carl's lack of energy and slowing of his movements, but also I think in Carl's retreat to a routine where he does very little meaningful activity. He is depicted as a grumpy old man initially, softening as time goes on and with the help of his companion Russel, a young 'wilderness explorer'. It is clear the thought of allowing Russel into his life is a challenge to begin with, perhaps because the idea of forming a new relationship will push Ellie aside.

As the story evolves, we see Carl's energy return, as does his spirit for adventure, and colour floods back onto our screens. Towards the end, Carl is able to move on with his life – while part of this may be linked to finally reaching Paradise Falls, I feel there is also reflection of his life with Ellie and an acceptance that she has died, finally enabling Carl to develop a relationship with Russel.

Overall this film has a wonderful way of delving into bereavement and grief, using music and cinematography to help portray complex concepts to wide audiences of children and adults alike.

TRAINEE FOCUS: PRACTICAL CONSIDERATIONS FOR INTERNATIONAL MEDICAL GRADUATES (IMGS) STARTING THEIR FIRST PSYCHIATRY JOB IN THE UK

Dr Harleen Birgi
RCPsych Old Age Faculty Trainee Representative and Specialty Trainee in Old Age Psychiatry, NELFT

Welcome to the UK! Starting a new job can be equal parts exciting and daunting. Listed below are few tips to help you on this journey from a fellow IMG.

Prior to coming to UK-

1. **Visa requirements-** Ensure that you have applied for the correct visa as per your job requirements and certificate of sponsorship. If in doubt, do not hesitate to contact the human resource (HR) department of your hospital and look on the gov.uk official website.

2. **Accommodation-** When you first move to the UK, one of the major issues can be finding the right place to stay. If you are visiting the country for the first time, it might be helpful to initially book a temporary short-term and then once here you can explore around your work area for long-term accommodation. There are various websites available to browse houses for rent such as Zoopla, Rightmove and SpareRoom. It might also be helpful to look around the area for local property advisors.

3. **Pre-employment checks**- Prior to starting your job, your employing Trust HR department will contact you for pre-employment checks which can include checks for your identity, visa, criminal record or restrictions via the Disclosure and Barring service (DBS) check. Most Trusts will also request an occupational health check which depending on the job role can include past immunisation history, current vaccination status, any medical issues that might impact your job role. These are important, as you'll likely be unable to work prior to completing them.

4. **Shadowing opportunities-** If you have never worked in the NHS before or are very new to the job role, it is advisable that you ask your Trust for a shadowing period where you observe other clinicians for few days/weeks prior to starting the job on your own.

On arrival to the UK-

1. **Induction-** Induction is an important part of the on-boarding experience for the new job, providing the necessary insight and knowledge to commence your job in a safe and timely manner. Induction sessions usually involve presentations, lectures from various clinicians and/or departments and can also sometimes include tours of the hospital site. The General Medical Council (GMC) also does 'Welcome to UK practice' workshops for new IMGs which can be helpful.

2. **Indemnity-** It is necessary to hold personal indemnity for your clinical practice whilst working in the UK. Medical defense organisations offer doctors access to medico-legal advice as well as legal representative if needed. The three main Medical Defence Organisation in the UK are (1)The Medical Protection Society (MPS), (2) The Medical Defence Union (MDU) AND (3) the Medical and Dental Defence Union of Scotland (MDDUS).

3. **Bank account-** Opening a bank account within the first couple of weeks is essential, as HR/payroll will require these details to process your salary. Some banks may ask for a letter from your HR or employer to facilitate the account opening, so be sure to reach out to HR and request it.

Tips to excel:

1. **Build your cultural competence**- Gaining experience of British culture, language and customs is essential for working in psychiatry. Many Trusts offer training and peer support via IMG champions within or associated with their organisations.

2. **Engage with the RCPsych:** The Royal College of Psychiatrists are keen to support IMGs who choose to follow a career in psychiatry in the UK. The IMG page of their website has an array of practical insights into the IMG role and can be found here: https://www.rcpsych.ac.uk/training/international-medical-graduates. The RCPsych runs training events specifically aimed at IMGs which are well received.

3. **Join the RCPsych Old Age Faculty:** The Old Age Faculty supports trainees through offering education events, running competitions and more. Keep an eye out for our updates here in the newsletter, and get in touch with your trainee representatives as needed via oldage@rcpsych.ac.uk

TRAINEE FOCUS: CPD CORNER

Dr Jennifer Parker
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We're always on the look out for great courses and events aimed at old age psychiatry trainees - Please send us any recommendations and reviews of courses or conferences that we can feature in the next edition - email oldage@rcpsych.ac.uk with any suggestions.

Upcoming conferences and courses:

1. Engaging Minds: Webinars for Old Age Psychiatry Higher Trainees

A new free webinars series designed by the Old Age Faculty specifically for trainees, to give you access to clinical updates, networking opportunities and engagement with experts. Sessions are designed and hosted by the Trainee Representatives from the Old Age Faculty, and are only open to Higher Trainees to attend, thanks to the generous funding support of the Faculty.

2. Faculty of Old Age Psychiatry Annual Conference 2025: Future Challenges

This conference takes place in Liverpool/online (hybrid) on 27-28 March 2025. The programme is bursting with interesting topics and speakers, and there will be some trainee-specific events taking place. Poster submissions are open until 27 January.

3. British Neuropsychiatry Association (BNPA) Annual Conference 2025

This conference takes place in London on 13-14 March 2025 with various sessions which will appeal to old age psychiatrists including impulsivity and apathy in Parkinson's Disease

Trainee review of previous courses:

Dr Amr Romeh, an ST6 Specialty Trainee in Old Age Psychiatry, Aneurin Bevan University Health Board, attended one of our previously recommended courses - The Cambridge Dementia Course, and sent us this review:

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‘The course was quite comprehensive and as far as I am concerned as a trainee in old age psychiatry, it covered every relevant aspect of learning I needed in a balanced informative and interactive style. To me, the course felt like an enticing journey that starts from the basics of history taking, cognitive testing and patient interview/examination skills to a more complex level of understanding neuroimaging and getting a grasp of neuropsychological testing. The course also explored the different types of dementia including common and rare types. There was also a session about post-diagnostic support and end of life care. Furthermore, there were some breakout rooms for discussions among the delegates. It was also very interesting to witness some panel discussion/debates around some controversial issues. I believe that the course has added a lot of relevant information to my knowledge.

I without hesitation recommend this course to anyone heading into the specialty of old age psychiatry. I think it would be most useful if they are able to attend it in the beginning of their training (ST4) but also at any time during training. I am sure that I will be applying for it again at some point after I finish my training to have a refresher around the topics.’

Book your place for 2025 at https://cambridgedementiacourse.org

WINNERS OF THE NATIONAL OLD AGE PSYCHIATRY TRAINEE ESSAY PRIZE 2024

This prize is awarded annually by the Old Age Faculty for an original and inspiring essay of between 4,000 and 6,000 words on a broadly based clinical topic directly relating to the care of mentally ill older adults.
There are two prizes; one for a Foundation Doctor/ Core Trainee (£150) and one for a Specialty Trainee (£150).
The closing date is 1st November each year.

Information about the various available prizes can be found on the Faculty's prize page.

This year's winners are...

Nimra Waheed (CT category) - for an essay entitled' *Utility costs and seasonal depression: The mental health effects of fuel poverty in older adults*'

and

Tharunkrishnan Radhakrishnan (ST category) for an essay entitled *'Digital Inclusion – Empowering the Elderly in a Digital World*'

Read their winning essays below!

UTILITY COSTS AND SEASONAL DEPRESSION: THE MENTAL HEALTH EFFECTS OF FUEL POVERTY IN OLDER ADULTS

Nimra Waheed
Core Psychiatry Trainee (CT1) Old Age Psychiatry at Tameside Hospital, Tameside and Glossop Integrated Care NHS Foundation Trust

Introduction

Fuel poverty arises when a household cannot afford to heat its home to a comfortable temperature, typically due to a combination of low-income, high-energy costs, and poorly insulated or energy-inefficient housing. This condition has significant impacts on both physical and mental health, especially during colder seasons when adequate warmth is essential for well-being. In the UK, fuel poverty is particularly prevalent among the elderly. Older adults are often more vulnerable due to limited income from pensions, increased susceptibility to cold-related health issues, and a higher likelihood of living in older, less energy-efficient homes. According to the UK government, in 2021, over 10% of households with at least one-person aged 60+ were in fuel poverty, a number that has risen with increasing energy costs. [1]

Globally, the prevalence varies significantly based on energy costs, income levels, and the efficiency of housing infrastructure. Cold-climate regions and countries with high energy costs, such as Northern Europe and parts of North America, report higher rates of fuel poverty among the elderly. In contrast, in warmer regions, fuel poverty can still affect older populations but may relate more to cooling costs in hot climates.

Seasonal Depression and Anxiety

Seasonal Affective Disorder (SAD) is a form of depression that typically recurs during specific seasons, most commonly in autumn and winter, and is linked to reduced sunlight exposure. SAD's primary symptoms include feelings of hopelessness, fatigue, and decreased motivation, which can impair daily functioning and well-being. [2] The disorder is believed to be connected to the reduction of natural light in colder months, affecting serotonin levels and disrupting the body's circadian rhythm, which regulates sleep and mood. [3] Additionally, melatonin production can increase during these darker months, contributing to lethargy and mood changes.

Colder months can intensify symptoms of SAD and may also aggravate other mental health conditions, such as generalized anxiety and major depressive disorder (MDD). For individuals with existing anxiety disorders, reduced daylight and colder weather can lead to decreased outdoor activity and social interaction, further impacting mental well-being. [4] Studies have shown that individuals with a predisposition to mood disorders may experience heightened symptoms during winter, with the lack of light leading to increased feelings of isolation and anxiety. [5]

This essay explores the intricate relationship between fuel poverty and mental health challenges among the elderly, focusing on how colder months intensify these issues. Elderly individuals facing fuel poverty are disproportionately affected by mental health decline due to the stress of inadequate heating, the physical discomfort of cold living conditions, and the financial strain of high energy costs. [1]

The essay aims to examine this connection by analysing the psychological toll of living without sufficient warmth and security.

Additionally, it will propose actionable solutions, such as targeted social policies, enhanced energy efficiency measures, and community-based support, to mitigate the impact of fuel poverty on mental health outcomes among older adults. Through this investigation, the discussion aims to underscore the importance of comprehensive strategies to improve the quality of life for vulnerable elderly populations.

The Link Between Physical Comfort and Mental Well-being in Older Adults

Colder temperatures place a unique physiological strain on older adults, who are more vulnerable to the effects of cold due to age-related changes in thermoregulation, reduced metabolic rate, and often, the presence of chronic health conditions. These factors increase the body's effort to maintain core temperature, which can heighten physical stress and discomfort. Studies show that exposure to low temperatures can exacerbate cardiovascular and respiratory issues and lead to muscle stiffness and joint pain, making daily movement more challenging and painful for the elderly. [6] This physical stress has psychological implications, as prolonged discomfort contributes to heightened anxiety and increased levels of cortisol, the stress hormone, which can affect mental resilience and mood stability in older adults.

Physical discomfort from insufficient heating is directly linked to worsened mental health outcomes in older adults, as the stress of living in a cold environment can contribute to feelings of anxiety, sadness, and even isolation. The inability to maintain a comfortable home environment can make socialization challenging, furthering loneliness and leading to a cycle of mental distress.

[7] For those prone to Seasonal Affective Disorder (SAD), inadequate warmth compounds the effects of reduced sunlight exposure, leading to a heightened risk of depressive episodes during the colder months. The lack of adequate heating has been shown to increase feelings of powerlessness and low morale, as well as intensify pre-existing conditions like generalized anxiety and depressive disorders. [4]

Recent research underscores the link between inadequate heating and negative mental health outcomes in older adults. A study by the UK's Office for National Statistics (2022) reports that older adults living in fuel poverty are at an increased risk of depression and anxiety, with data showing that they are over 40% more likely to report feelings of hopelessness and loneliness during winter months compared to their adequately heated counterparts.[7] Another significant study by Healy and Clinch (2022) highlighted that elderly individuals in inadequately heated homes had a 50% higher rate of hospital admissions for mental health concerns during winter. These findings stress the critical connection between physical comfort and mental resilience, underscoring the importance of addressing fuel poverty to support overall well-being in older populations.

Fuel Poverty as a Catalyst for Seasonal Depression and Anxiety

Fuel poverty places a significant financial strain on many elderly individuals, who are often reliant on fixed or limited incomes. With rising energy prices and inadequate housing insulation, many older adults face difficult choices between heating their homes and meeting other basic needs, a situation often referred to as "heat or eat." This financial burden contributes to a profound sense of helplessness, as many feel unable to escape the cyclical nature of fuel poverty, leading to heightened anxiety and mental fatigue. [6] For those in cold homes, the daily experience of financial stress is magnified during winter, as the inability to maintain a warm, comfortable environment exacerbates feelings of vulnerability and lowers resilience to seasonal mental health challenges. Studies show that financial strain related to energy costs significantly correlates with poorer mental health, reinforcing how the economic aspects of fuel poverty deeply impact emotional well-being. [7]

The inability to heat one's home adequately during colder months not only affects physical comfort but also limits mobility and social engagement, leading to an increased risk of isolation.

For many elderly individuals, cold weather can make going outside challenging, and a poorly heated home further reduces the likelihood of visitors, especially in rural or underserved communities where transportation options are limited. Consequently, older adults may become more homebound during winter, facing prolonged periods of loneliness that heighten the risk of seasonal depression. [9] Physical activity is often limited under these conditions, as colder indoor temperatures discourage movement, while a lack of social interaction compounds feelings of sadness and isolation, creating a compounding effect on seasonal affective disorder (SAD) and other depressive symptoms.[8]

Various case studies illuminate the tangible effects of fuel poverty on mental health among elderly populations. For example, a case study conducted by Age UK (2022) highlighted the story of an 81-year-old woman who, due to rising fuel costs, reduced her heating use to save money, leading to heightened anxiety and social withdrawal. This individual reported feeling "trapped by the cold" and "forgotten" during the winter months, revealing the psychological toll of enduring cold conditions. Another example from a community support program in Scotland showcased how elderly residents in fuel-poor areas had higher rates of emergency room visits for anxiety and depressive symptoms during winter, illustrating the serious impact of inadequate heating on mental health outcomes.[10] These cases serve as poignant reminders of how fuel poverty can act as a catalyst for mental distress in older adults, especially as they navigate the psychological and physical challenges of colder months.

Added Health Risks of Fuel Poverty

Fuel poverty not only impacts the mental health of older adults but also poses serious physical health risks, exacerbating existing health conditions and increasing vulnerability to new ailments.

Exposure to cold temperatures in inadequately heated homes can worsen respiratory issues such as chronic obstructive pulmonary disease (COPD) and asthma and aggravate cardiovascular conditions by increasing blood pressure and the risk of heart attacks and strokes.[13]

These physical health challenges place an additional burden on mental well-being, as the compounded stress of illness, discomfort, and a lack of warmth leads to a further decline in resilience and mental health stability. Older adults already face a higher risk of physical health deterioration due to age-related factors, and the strain of fuel poverty amplifies these risks, creating a cycle in which both physical and mental health suffer due to inadequate home heating.

The untreated mental health conditions that arise from fuel poverty in elderly populations contribute to escalating healthcare and social care costs. When older adults experience prolonged periods of anxiety, depression, and seasonal affective disorder (SAD) due to cold living conditions, these untreated issues often lead to greater reliance on healthcare services, from primary care consultations to emergency hospital admissions.

Studies indicate that individuals experiencing fuel poverty are significantly more likely to require hospital treatment for both physical and mental health issues during colder months, highlighting the strain this places on already stretched healthcare resources.[7] Furthermore, social care services may also bear an increased burden, as elderly individuals in fuel-poor homes may require additional support due to decreased mobility, isolation, and a diminished ability to perform daily activities in cold conditions. Addressing fuel poverty could, therefore, alleviate not only individual distress but also reduce the systemic costs associated with the healthcare and social support needs of older adults.

Policy Recommendations and Community Programs to Address Fuel Poverty and Seasonal Mental Health Needs

Government-led programs such as the UK's Winter Fuel Payment and the Warm Home Discount Scheme provide crucial support to elderly individuals, helping them afford basic heating during colder months. However, the increasing costs of energy and the inadequacies of these programs in reaching all those in need necessitate broader, more comprehensive approaches. Several strategies can be adopted to alleviate fuel poverty and its detrimental effects on mental health among the elderly.

1. Enhanced Financial Assistance and Subsidies

While existing programs offer valuable assistance, they often fall short in addressing the full extent of fuel poverty among vulnerable populations. Expanding eligibility for financial aid and increasing the amounts disbursed can significantly help those struggling to afford heating costs. Programs could include direct cash transfers to those living in poverty, specifically earmarked for energy costs, ensuring that vulnerable individuals can prioritize their health and warmth without the constant stress of financial burden. Moreover, adjusting these programs to account for rising energy costs annually would ensure that the support remains relevant and effective.

2. Home Energy Efficiency Initiatives

Investing in home energy efficiency improvements for low-income households, particularly among the elderly, is a crucial long-term solution to fuel poverty. Initiatives such as retrofitting homes with better insulation, energy-efficient heating systems, and double-glazing windows can drastically reduce energy consumption and bills. Programs like the Energy Company Obligation (ECO) in the UK aim to tackle fuel poverty by helping homeowners make energy efficiency improvements. Expanding such initiatives to provide low-interest loans or grants for necessary upgrades can have profound benefits, as warmer homes lead to reduced heating costs, improved mental health outcomes, and better overall health for older adults.

3. Targeted Mental Health Support Services

In addition to financial assistance and energy efficiency programs, targeted mental health support services are essential to help elderly individuals cope with the psychological stresses related to fuel poverty. Community-based mental health programs could offer counselling and therapy specifically focused on the mental health impacts of living in fuel poverty. Outreach services can help identify individuals in need, ensuring that they receive timely and appropriate support. Programs integrating mental health services with existing fuel poverty interventions can create a more holistic approach, addressing the intertwined challenges of mental and physical health.

4. Community Engagement and Support Networks

Building community support networks can be instrumental in mitigating the effects of fuel poverty on mental health. Local organizations, such as charities and community centres, can offer warm spaces where elderly individuals can gather during the winter months, providing social interaction and reducing feelings of isolation. Initiatives like community meals or activity groups can encourage engagement, fostering social connections that combat loneliness and its associated mental health risks. Moreover, volunteer programs can be established to check in on vulnerable elderly residents, ensuring they have the support needed to maintain their mental and physical well-being during colder months.

5. Public Awareness Campaigns
Raising public awareness about the realities of fuel poverty and its impacts on mental health is essential for fostering community understanding and support. Campaigns that educate the public on recognizing signs of distress in elderly neighbours and encourage proactive outreach can create a more compassionate and supportive environment. These campaigns can also emphasize the importance of energy efficiency and the availability of support programs, helping individuals access the resources they need.

6. Policy Revisions and Regulatory Measures
Addressing fuel poverty requires systemic changes at the policy level. Policymakers should prioritize housing policies that ensure all elderly individuals have access to safe, warm, and energy-efficient homes. Regulations can be put in place to hold energy companies accountable for price hikes, ensuring that those in vulnerable situations are protected from excessive costs. Moreover, establishing a universal standard for minimum energy efficiency in rental properties can help prevent landlords from neglecting necessary upgrades that keep homes warm and healthy.

Case Studies: Successful Interventions
1. The Green Homes Grant
The Green Homes Grant, launched in England, provided vouchers for homeowners to implement energy-efficient improvements, particularly benefiting low-income households. This initiative has shown promise in reducing energy costs and improving the comfort of homes for elderly individuals. Case studies highlight instances where recipients reported significant decreases in energy bills and increased warmth in their homes. Anecdotal evidence suggests that many elderly recipients of the grant experienced improved mental well-being because of their newly insulated and efficient homes, enabling them to maintain a healthier lifestyle and greater social engagement. [7]

2. Age-Friendly Communities Initiative
The Age-Friendly Communities initiative, established in several regions, aims to create environments that support the well-being of older adults, including addressing issues of fuel poverty. In these communities, local governments and organizations work together to enhance social services, transportation, and housing stability for older adults. One notable success story from a community in Scotland demonstrated a significant reduction in hospital admissions related to mental health issues among elderly residents. By creating warm, welcoming spaces and facilitating connections with local resources, the initiative not only improved physical comfort but also fostered a sense of belonging and community, addressing both the physical and mental health needs of participants.

Long-Term Strategies for Combating Fuel Poverty
In addition to immediate interventions, long-term strategies must be developed to tackle the systemic issues contributing to fuel poverty. These strategies require collaboration between government entities, non-profit organizations, and the private sector.

1. Comprehensive Housing Policies
A multifaceted approach to housing policy that prioritizes affordable and energy-efficient housing options for the elderly is crucial. This includes not only supporting new housing developments but also investing in retrofitting existing homes to meet modern energy standards. Public-private partnerships could play a key role in funding and facilitating these initiatives, ensuring that vulnerable populations are prioritized.

2. Sustainable Energy Solutions
Promoting sustainable energy sources can significantly reduce long-term energy costs for households.

Investment in renewable energy projects, such as solar panels, can provide older adults with the means to generate their energy, ultimately reducing reliance on conventional energy sources. Programs that subsidize the installation of renewable energy systems in low-income homes can have a lasting impact, reducing fuel poverty while promoting environmental sustainability.

3. Integrating Health and Energy Policies

Collaboration between health services and energy policy can enhance outcomes for older adults facing fuel poverty. By integrating health assessments into energy assistance programs, healthcare providers can identify individuals at risk of mental health decline due to fuel poverty, allowing for timely intervention and support. This approach fosters a comprehensive understanding of how physical and mental health intersect with energy access, ensuring that vulnerable populations receive holistic care.

Conclusion

Fuel poverty is not just a financial crisis; it is a significant public health issue that has far-reaching implications for the mental and physical well-being of vulnerable populations, particularly the elderly. The effects of inadequate heating during colder months can trigger a cascade of negative outcomes, from exacerbated physical health conditions to increased rates of anxiety and depression. Addressing fuel poverty requires a multi-faceted approach that incorporates financial support, energy efficiency improvements, community engagement, and integrated health services.

As the UK and other nations face the growing challenge of energy costs and climate change, it is imperative that policymakers prioritize the needs of the elderly. This demographic not only contributes significantly to the social fabric but also deserves the dignity of living in warm, safe, and comfortable environments. To achieve these goals, collaborative efforts among governments, non-profit organizations, and community stakeholders are essential.

The recommendations outlined in this essay offer a pathway to not only alleviate fuel poverty but also to enhance the overall quality of life for older adults. By implementing effective strategies—ranging from enhanced financial aid and energy efficiency initiatives to mental health support and public awareness campaigns—we can combat the detrimental effects of fuel poverty and foster resilience among elderly populations.

Moreover, the case studies discussed illustrate the power of targeted interventions in breaking the cycle of fuel poverty and improving mental health outcomes. As we move forward, it is crucial to remain vigilant about the intersecting issues of energy, health, and social equity, ensuring that every elderly individual has access to the resources they need to thrive, particularly during the harsh winter months.

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DIGITAL INCLUSION – EMPOWERING THE ELDERLY IN A DIGITAL WORLD

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"Please help me!" These words came from an 87-year-old lady in my follow-up clinic on a bright Monday morning. She lives alone, with no family nearby, and most of her friends have passed away. For over four years, she's been receiving treatment for depression. Now, she faced a new hurdle: her GP surgery no longer accepted written or telephone requests for repeat prescriptions. Struggling to reach the receptionist, she found herself in a bind. In the past, her neighbour had kindly placed her online prescription orders, but he was now unwell and couldn't assist.

Seeing her distress, I asked if she had a smartphone and offered to help. Unfortunately, she hadn't brought it to her appointment, and I also had some concerns about her memory and cognitive function. Together, we managed to complete her request using a computer, but her situation lingered in my thoughts. It made me wonder how many other elderly individuals in our community were facing similar struggles, silently battling to adapt to technology that seems second nature to younger generations.

In the months that followed, I encountered more patients with varying levels of cognitive impairment, each one facing challenges with essential tasks like banking, managing healthcare needs, and even staying connected with family—all made harder by technology they found confusing or inaccessible. These encounters raised pressing questions for me: Should society be more considerate and inclusive for those with digital challenges? Who will stand as an advocate for the elderly—especially those with emerging cognitive issues and no support network?

With these questions in mind, I turned to the literature to explore this pressing issue. Below is a summary of my findings.

What is digital exclusion?

Digital Exclusion refers to the disparity in access and ability to use Information and Communication Technologies including the Internet(1). It is associated with poor physical and psychological outcomes in the elderly.

A "digital disability" refers to a confluence of cultural, psychological, and technical challenges that arise when a person lacks the ability to navigate and participate effectively in a digital society(2). While some individuals struggle with technology, some older adults thrive without the use of digital technology and may not feel disabled. Therefore, functional assessments in digital settings should consider it in the context of the individual's characteristics.

Why is it important?

The UN categorises population ageing as a defining global trend of our time. The advancements in healthcare along with falling fertility rates have led to longer lifespans. It is a successful result of the concerted efforts of different sections of society to improve living conditions. The number of people over the age of 65 years is expected to double reaching a humongous 1.6 billion by the year 2050(3). The Madrid International Plan of Action on Ageing in 2002 identified technological handicaps and inequity in the elderly and recommended addressing them to promote cohesion among different sections of society (4). Two decades later, the quest for technological advancements that are inclusive and accommodating for the elderly has not yet been fully realised.

It is crucial to adapt the technological innovations for the elderly to prevent them from being isolated digitally. Almost every aspect of our daily lives relies directly or indirectly on digital technology. Accessible technology is a fundamental necessity for promoting an active lifestyle and fostering independence.
Digital exclusion leads to a subjective sense of social isolation(5). There appears to be a direct link between the two.

Unmasking with COVID-19
The COVID-19 pandemic had a profound and multifaceted impact on elderly populations, particularly in terms of their access to and interaction with digital technologies. As the world moved rapidly toward digital solutions for everyday activities, such as healthcare, shopping, and socializing, older adults often found themselves left behind. This situation brought out the latent digital inequalities and intensified the urgency of addressing the digital divide for seniors.

The use of digital technologies has always been an area of contention for the elderly population. Some data published before the onset of the pandemic show a large proportion of the old-age population either did not use the Internet or used it in very limited ways (6). This was more pronounced in those with multiple health co-morbidities due to their limitations in using the technology. One of the most significant impacts of COVID-19 was the accelerated shift to telemedicine and virtual healthcare services. For many seniors, in-person appointments became either impossible or highly risky, making remote consultations a safer alternative. However, without prior digital literacy or access to necessary devices, many older adults struggled to utilize telehealth platforms effectively. This situation revealed the critical need for digital literacy and accessible technologies within healthcare services for the elderly population.

Social isolation was another critical issue exacerbated by COVID-19. Physical distancing and lockdown measures were necessary to protect the health of older adults, who were among the most vulnerable to the virus. However, these measures also led to an increase in loneliness and mental health issues within this demographic. Many elderly individuals, who were already socially isolated, became almost entirely dependent on digital communication tools to stay connected with family and friends. But without digital skills or access to technology, this isolation became more pronounced. Video calls, social media, and messaging apps could have offered significant social support, but only for those who had the means and ability to use them.

Recently, there has been a drive to push for complete digitalisation of health services and going paper-free. This may be good for the environment but this marginalises a subgroup of the elderly who are digitally handicapped. An easy example is the GP surgeries doing away with written requests for repeat prescriptions. Now, to request a repeat prescription, one has to navigate through a complex series of steps on a computer or a smartphone. This may be challenging even for a healthy person in the younger age group, and the difficulty faced by an unwell/frail elderly individual is far greater.

What is happening in the UK?
The UK also follows the world trends in ageing with a relatively shrinking working-age population and increasing elderly population. By 2043 roughly 1 in 4 in the UK would be over 65 years. The number of people over 85 years of age is expected to double by 2050 reaching 3 billion(7). The dependency ratio will increase which will have wider implications for health and social well-being. The well-intentioned eco-friendly goal of going paperless, replacement of postal services by email/text communications and closure of physical branches in favour of online banking have inadvertently marginalised individuals with difficulties in using technology.

The report from the UK House of Lords(8) regarding digital exclusion highlights the distinct challenges encountered by the elderly population, emphasizing obstacles such as digital literacy, accessibility, and cost. Many older individuals experience difficulties with online connectivity due to insufficient skills, physical limitations, and the absence of resources specifically designed for their needs. An estimated 3.9 million people over 65 do not use the Internet. This situation hampers their ability to access vital services, including healthcare, banking, and social interactions. The report advocates for focused assistance, including digital skills training, affordable internet options, and user-friendly digital interfaces tailored for older adults to promote enhanced inclusivity.

Factors Affecting Internet Use:

Internet use among the elderly is moderated by various factors like age, gender, income levels and education. Digital exclusion appears to be present in all the countries irrespective of their economic development. However, the Low and Middle Income Countries (LMIC) due to the limitations in infrastructure and Internet coverage have a higher risk of digital exclusion compared to the Higher Income Countries (HIC) (1). The level of it in England has been estimated to be around 30.4% whilst that in a middle-income country like China was 96.9% (1). Conversely, it is also observed that the rate of functional dependency was lower in countries that had adopted inclusive measures. There is some empirical evidence that suggests that there is a difference in the rate of internet use within the older adult age group with the rates in young old (between 65-69 years) closer to the general adult population and the oldest old (80 years and above) least likely to be online(9). If people are familiar with the use of computers prior to their retirement they are 8.76 times more likely to use the Internet in old age which may play a role in social connections in later life(10). Some of the factors that prevent 'offliners' to start using the Internet are the complexity of the process, steep learning curve, safety concerns and technical problems.

Problems with eye-sight and cognition appear to be affecting the oldest-old among the elderly (10).

Mental Health service users represent one of the most vulnerable sections of the old age population. On top of the physical ailments and ageing, they tend to endure their psychiatric conditions. Major Neurocognitive Disorders like dementias pose a progressively worsening challenge in accessing the Internet to complete tasks. It increases the burden on the caregivers and may lead to carer fatigue and burnout. Physical health co-morbidities like arthritis, pain conditions, vision or hearing impairments, and neurological conditions can interfere with their ability to use tech devices.

How is the UK addressing this?

Age UK runs a 'Digital Champion Program 2022-2026' across the UK. They train volunteers who will support older people with digital skills and also loan devices to those with limited access to technology.

'Widening Digital Participation' was a two-phased program run by the NHS England and NHS Digital between 2013 and 2020 which assessed challenges for digital inclusion and ways to facilitate it. The NHS advocates for digital inclusion among the elderly through various significant initiatives:

Digital Skills Training: Community centres offer support in digital skills, aiding older individuals in performing essential online activities.

Digital Champions: Trained volunteers help senior citizens in utilizing digital health resources and online services.

Intergenerational Mentoring: Programs are established to link younger individuals with older adults, offering practical digital assistance.

Assistive Technology: Devices such as voice-activated tools are available to support elderly users, especially those with disabilities.

Highlights of measures taken across the world:

Japan Society 5.0:

Japan has a rapidly ageing population and has implemented a number of measures for the digital inclusion of the elderly. They aim to use technological advances to overcome various problems in their ageing society under the "super-smart" society initiatives.

As a part of the national digitalisation strategy, the Japanese government has collaborated with mobile phone companies to provide 'digital literacy' to seniors(11). They want to close the digital divide between the young and the old and have set targets for the next ten years. In efforts to promote digitalisation, various local governments in small towns have been handing out free smartphones and tablets to the elderly. They also organise Q&A sessions for the elderly in public places like shopping malls and cultural centres (12). They have developed apps which are specially designed for the elderly to promote smartphone use (13). The Open University of Japan offers 'digital training courses' for the elderly (14). ACCESS is a multinational project aimed at providing various models of digital literacy that are specific to the local population which includes assistive technologies and peer-to-peer learning (15).

Insights from European countries:

The EU has funded various projects to promote digital inclusion for older adults across member states.

'The Grandparents and Grandchildren Project' is an intergenerational learning program run in Germany where young people teach older adults digital skills, fostering social bonds along with knowledge (16). Austria has a similar program called 'Technology in Brief' where young people support old people in their local community with smartphone use.

Slovenia and Serbia provide face-to-face assistance for older people to use their smartphones for digital banking(17).

Slovakia is set to implement a project from 2023 to 2026, aimed at offering complimentary basic digital skills training to nine thousand senior citizens. This initiative involves the recruitment of more digitally proficient older individuals, referred to as "digital champions," who will be tasked with educating residents in various settings.

'The Silver Surfer initiative' in Luxembourg has implemented the "seniors for seniors" approach, which involves recruiting older volunteers who have received specialized training in Internet security. These volunteers are tasked with educating their peers on the safe and secure use of digital technology.

U.S. and Canada:

The U.S. has its own digital skills training and digital literacy programs similar to the ones mentioned above. They have also developed peer support systems and created platforms for the 'digital socialisation' of the elderly. They have also developed online content accessible for the elderly.

The Canadian government has prepared a Code of conduct for their banks to meet the banking requirements of the elderly to promote digital inclusion.

Strategies to address the gaps:

In 2020, the World Health Organization and the United Nations designated 2021- 2030 as the Decade of Healthy Ageing. This initiative underscores the critical necessity for implementing effective measures. The UK has made significant attempts to tackle the digital disparity but there is still room for improvement.

1. Building the fundamentals:

Structured training programs tailored for different levels of skills will impart basic knowledge and build confidence. They may include simple but practical step-by-step instructions to use health portals, using smartphone for their healthcare needs and access health information online.

It is probably better to offer these programs face-to-face with hands-on support for gradual learning. This would offer them a chance to practice their skills and reinforce them in a safe and supportive environment. Trained volunteers or digital "buddies" strategically placed in community centres, libraries or shopping areas will be more effective.

2. Simplifying Technology Interfaces
The newer smartphones are enriched with so many features which may not have much use for older people. Devices developed with the challenges faced by the elderly like limitations in memory, multitasking, dexterity, precision use and sensory limitations would be better suited for their use. Simple layouts, large fonts, larger touch targets and voice control can help seniors navigate their gadgets without the need for precise motor control. Involving elderly users in the product design and testing phases will promote inclusive innovations.

3. Flexibility:
Hybrid models of service delivery: Combining digital and traditional healthcare services allows older adults to gradually transition to digital platforms if they choose to do it. This dual approach ensures that older adults can still engage with healthcare services in a way that is comfortable and accessible for them and can allay fears of alienation from the system.
The geriatric population is incredibly diverse, comprising individuals with a wide range of cognitive, physical, and digital capabilities. Digital skills among older adults typically span a broad spectrum, with the "young-old" (usually defined as those aged 65-74) often more familiar and comfortable with technology compared to the "oldest-old" (85 and above), who may face greater physical and cognitive barriers. Given these differences, a one-size-fits-all approach to digital inclusion is inadequate. Effective digital literacy programs must be tailored to accommodate this range, offering varying levels of support and flexibility.

Strategies should include introductory sessions for those completely new to technology, alongside more advanced training for seniors with foundational skills but who need further guidance. Providing opportunities for seniors to learn, practice, and repeat new digital skills in safe, supportive environments allows them to build confidence at their own pace. It also respects their individual capacities and fosters a sense of achievement, which is crucial for long-term engagement.

By addressing each senior's unique needs and skill level, digital literacy initiatives can promote inclusivity and empowerment, helping older adults navigate an increasingly digital world without feeling marginalized. This thoughtful, layered approach ensures that seniors, regardless of tech proficiency, are given the tools to participate fully and meaningfully in modern society.

4. Reducing Financial Barriers:
Affordable Internet access: Financial constraints remain a significant barrier to digital inclusion in many older adults, particularly those on fixed incomes. Subsidised Internet access for low-income elderly individuals can enable more seniors to access the Internet.
Low-cost / loaned devices: The cost of devices can be detrimental. Allowing seniors to borrow smartphones or tablets from community centres or health facilities can be transformative. Devices with pre-installed healthcare applications and utility applications may be particularly effective.

5. Awareness and engagement:
Raising awareness of the benefits: Many elderly individuals are not fully aware of the ways to utilise digital tools to enhance their well-being. Information campaigns by relevant stakeholders(healthcare providers, staff from public offices) can promote the benefits of digital tools.

Accessing medical records, booking appointments, requesting repeat prescriptions and scheduling tele-consultations can improve the lives of older people considerably.
Engaging the wider family and caregivers: Family members and caregivers often play an important role in supporting older adults' digital health journeys. The successful implementation of intergenerational educational programs for digital literacy in other countries is a good example. Training for the family members or the caregivers on guiding their elderly relatives will help in easing the process of digitalisation.

6. Policy support for digital inclusion:
Government-led measures to protect and safeguard individuals from the risks associated with digitalisation would offer reassurance for the elderly. By investing in digital literacy programs, subsidising access costs and encouraging various stakeholders to adopt inclusive practices, policymakers can address digital exclusion more effectively. Legislative measures promoting accessible design standards could help in tackling digital exclusion.

Combat ageism: The WHO defines ageism as "the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age." Policy and legislation targeting ageism and protecting human rights coupled with educational activities can help in combating ageism.

Cross-sector collaboration: Collaborations between government, technological companies, non-profit organisations and healthcare providers will help in developing comprehensive digital inclusion solutions. Encouraging tech companies to develop and create accessible devices for older adults could advance inclusivity goals.

Should we aim for complete digitalisation?
Despite the arguments for and against the use of digital technologies, the choice to opt out of digital technologies must remain. Sometimes it may be impossible to use devices due to their health conditions(Eg: Cognitive/ sensory impairments etc). So, access to 'offline' but high-quality services to those who choose to opt-out or are unable to use digital devices must be ensured.

Potential benefits of digital literacy for the elderly:
The brain's responsiveness in neural pathways associated with executive functions may be positively influenced by an elderly individual's previous ability to use the Internet(18). Routine use of digital devices and platforms can stimulate mental processes, improving memory, attention, and problem-solving skills. For instance, even simple interactions with digital games or puzzles can enhance cognitive function, as they often require players to engage in problem-solving, critical thinking, and decision-making. These activities are linked to maintaining and even improving cognitive performance, especially in older adults who might otherwise lack these forms of mental exercise.

Beyond cognitive stimulation, digital engagement can also promote emotional well-being, which is indirectly beneficial for cognitive health. During COVID-19, elderly individuals with access to video calls and social media reported feeling less lonely and more socially connected, which are crucial factors for mental health. Studies consistently show that social interaction helps prevent cognitive decline, while isolation and loneliness are strongly linked to an increased risk of dementia and cognitive impairment.
Furthermore, digital technologies that encourage seniors to explore new hobbies or stay physically active can have a holistic impact on cognitive health.

For example, using online classes or video tutorials to learn hobbies like cooking, gardening, or crafting can enhance memory and learning capacity.

Similarly, interactive exercise apps designed for seniors encourage not only physical but also mental engagement, as they require coordination, focus, and commitment.

Digitalisation holds a lot of promise for the elderly despite having elements of risks. It offers some leverage in vital aspects of their life like healthcare and banking. The reach of the Internet goes beyond borders and the possibilities are almost unlimited. This opens up a new world, especially for frail individuals and residents of long-term care settings. Artificial Intelligence (AI), Virtual Reality (VR), and Augmented Reality(AR) are some of the exciting, rapidly-evolving technological advancements that are likely to influence their daily lives in the near future. Smart Homes with sensors and devices connected to the Internet (Internet of Things) can help in preventing and detecting falls, alerting services when urgent/emergency care is needed. Wearable devices like smart watches and health rings can collect health data and facilitate remote consultation with healthcare providers.

Looking to the future, the concept of digital inclusion should encompass the potential for assistive technologies, such as voice-activated devices and telehealth applications, which can vastly improve the quality of life for older adults. These technologies offer immense promise but must be carefully adapted and introduced to avoid overwhelming users with complexity. With thoughtful development, these tools can foster independence, offer new avenues for social connection, and provide essential access to healthcare from the comfort of home.

Conclusion

"Technology has the power to transform lives at every age. When we ensure that seniors are digitally included, we're not only enriching their lives but also enhancing the diversity and wisdom within the digital space."

— **Amy Webb, Futurist and Author**

The digital divide, if unaddressed, threatens to leave elderly individuals isolated, disadvantaged, and unable to access essential services that are progressively moving online. As demonstrated throughout this essay, digital inclusion is about more than just teaching seniors to use devices—it's about empowering them with the skills, confidence, and accessibility they need to engage with the modern world. Achieving true digital inclusion for the elderly requires a multifaceted, collaborative effort from all the stakeholders which would treat them with the dignity they deserve at the same time protect their rights to access services, contribute, live and thrive in modern society.

References available on request