

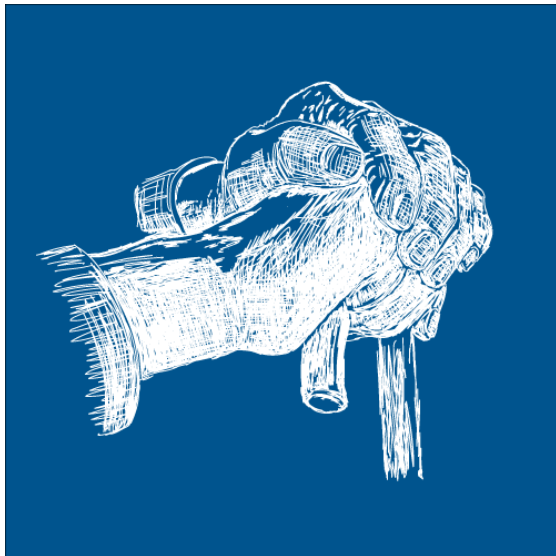


# The Old Age Psychiatrist

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Issue 79, January 2021

Old Age Psychiatry Faculty  
Newsletter



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# Update from the Editorial Team

by

Sharmi Bhattacharyya

Editor, The Old Age Psychiatrist, Royal College of Psychiatrists

[drsharmib@gmail.com](mailto:drsharmib@gmail.com)

Happy New Year from the Editorial team and we hope that the New Year brings you peace, success and prosperity.

The pandemic continues and we continue to adapt and as always I am amazed at the resilience and hard work our colleagues have shown in the last few months to keep our patients safe and well both physically and mentally. In these continuing challenging times with COVID19 we hope the articles in the newsletter will provide some food for thought and highlight the great work Old Age Psychiatrists do.

This newsletter has a section on **COVID – Opportunities and challenges** - we were fortunate to receive a varied number of articles ranging from audits, service developments, virtual assessments and reflection of trainees' experience – all very interesting and exciting to read.

The Chair's report makes an interesting read and update. The faculty conference is scheduled for 25-26 March 2021 so watch the space.

Dr Amanda Thompsell, our outgoing Chair is now the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement. Congratulations Amanda, we are very proud. Her update with Prof Alistair Burns encourages colleagues working in OPMH to join the collaboration platform to share good practice.

For the more research orientated readers, there are the usual updates such as Cochrane corner and research updates. This edition does have other articles including an interesting one on presumption of mental capacity.

This edition also contains information on various other conferences and competitions you maybe interested in, so please register early. Our annual essay competition this year is **Old Age Psychiatry in the Time of Corona... And Beyond?** – all are invited to submit - the last date for submission being Friday 26<sup>th</sup> February 2021. We look forward to your submissions. We have an exciting panel of judges - more to be revealed.

As usual we round off with a book review by Dr Howard, which highlights the description of the long-term positive outcomes that took place after the Spanish

Flu Pandemic in 1918. Hopefully we can come out of this pandemic with positive long-term outcomes too.

The next newsletter will be published in May 2021 so the last date for submission of articles is 16 March 2021.

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

## View from the Chair

by

Dr Mani Santhana Krishnan (Krish)

Chair of the Faculty of Old Age Psychiatry, Royal College  
of Psychiatrists

@deliriumkrish



Dear colleague

Time flies. It was only in July I wrote and we are into the New Year. This pandemic has been testing our resilience. I am thankful for all our members who are continuing to provide clinical leadership in supporting our vulnerable older adults who are suffering with lockdown and isolation.

We had produced some useful [resources](#) at the beginning of the pandemic on the faculty web page and we are adding more resources for our members. I am sure you are also accessing the main [College COVID resources](#) section.

We have had an overwhelming response for the joint winter meeting with BGS. We have over 700 delegates registered. The programme looks excellent. I thank Jo Rodda, Mohan Bhat from our exec and Emma Vardy from the BGS for putting together an excellent event.

The College has decided not to host any Face to face conferences until next summer. Our Annual Faculty conference will be online on 25-26 March 2021. Mohan is busy putting together a program with a group of exec members. Call for posters has already gone out.

We are also supporting a joint event with EAGP in January 2021.

We had our recent faculty executive committee meeting in November remotely.

The key discussions were around the impact of COVID 19 in delivering our services including memory clinics. We also discussed the variability in engagement of our colleagues in community mental health transformation funding applications. You may recall we did a webinar earlier this year. The first round of deadline was in November and the next will be in January 2021. Please support your trusts with the application mainly highlighting the needs of our older adults.

I thank Bob Barber for his work on ARUK Commissioned Survey of Old Age Psychiatrists in UK exploring approaches to the diagnosis of dementia He presented the summary of the findings at the Exec meeting.

The Key points addressed in the survey and focus group is:

- Views on diagnosing symptomatic AD before clinical dementia
- Role of biomarkers in diagnosis
- Disease modifying treatment

We will share the report once ready and this will be published soon.

We welcomed our trainee reps Manni and Orima to the executive. They are hoping to organise a trainee conference in the summer of 2021.

I attended the All Party Parliamentary Group meeting discussion on age inequality and discrimination. I summarised the findings of our college report 'Suffering in silence' and also discussed the impact of COVID 19 on our vulnerable older adults. I was also invited to comment on a [paper from Independent Age](#).

### **Faculty Social Media presence**

The faculty twitter page @RcpsychOldAge is 5 followers short of 2000. Until recently we were the second largest followed faculty on Twitter. Hope you will continue to support and grow our social media presence.

Hope you are able to share information among members quickly with Jiscmail. To join, members can contact Kitty Kottasz on [oldage@rcpsych.ac.uk](mailto:oldage@rcpsych.ac.uk)

I would like to thank Sharmi and the Editorial team for putting together this edition during a testing time. This edition focuses on impact of COVID and how services have responded with compassion and innovation.

Staff well-being has never been given priority until this pandemic. Please look after yourself and support colleagues around you.

Wish you and your families a very Merry Christmas and happy, healthy and peaceful new year.

# Update for Old Age Psychiatry Newsletter

Professor Alistair Burns, National Clinical Director for Dementia

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

Comment from Alistair Burns – It was to my great delight that Amanda has been installed as the National Specialty Advisor (NSA) for Older People's Mental Health (OPMH) at NHS England/NHS Improvement. In a few short weeks, Amanda has made an enormous impact in furthering the issues of OPMH with her characteristic charm and tenacity. We have agreed that we should jointly write the regular newsletter so we can adequately capture both OPMH and dementia.

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In recent months, the COVID pandemic has focused attention on the unequal way that COVID has impacted particularly on older people and has brought huge changes in the ways that we meet older people's mental health needs. It is not surprising that these immediate needs have taken away some of the attention from the structural changes involved in implementing the NHS Long Term Plan (LTP), but COVID makes these changes even more important.

By the time you read this your local STP or ICS will have put in their plans on how they will transform the community health provision for older people and working age adults. These plans are currently being reviewed and the final decisions will be made in early February 2021. Each STP should now have appointed an older persons' mental health lead. I do hope that some of you have this role.

Within these plans your local area will have also decided which two out of the following three areas of patient need they are also going to initially focus on:

- those with a diagnosis of personality disorder/complex emotional needs;
- those in need of mental health rehabilitation and
- those with eating disorders.

In each case the plans should be to improve access and treatment for adults and **older adults**. Your input into what these pathways will look like for older people locally will be essential.

As well as this transformation in community provision, there is also the ambition to transform crisis provision once again ensuring that older people have access to crisis services wherever they are in England. I think what is a good

community crisis alternative for older people still has to be worked out and I would value any thoughts on this.

In my role as NSA for OPMH, I am focusing on how this transformation can be best implemented. This is about increasing awareness of OPMH linking with primary care and the ageing well initiatives; sharing best practice and ensuring the workforce is trained to recognise and deal with older people's mental health. I am pleased to say that at all times there has been a real passion to meet the needs of older people with mental health needs so it really does feel that I am pushing at an open door.

I am acutely aware from your feedback that these changes involve a huge culture change especially when working in a complex system where roles and money grab the headlines. I can however see from the examples that I come across great innovation and amazing ingenuity and that within our speciality we have the leadership skills to help the local system deliver these tremendous changes.

So that we can learn from each other's good practice we have now got an area on the Futures NHS Collaboration Platform where we can share examples. All colleagues working in OPMH are welcome to join the collaboration platform – please register with your organisation e-mail address. If you have any good practice examples or any other resources relevant to innovation in OPMH services, that you are willing to share then we would be very interested to hear them so please send them to [vicky.cartwright2@nhs.net](mailto:vicky.cartwright2@nhs.net)

The Futures Platform also hosts a discussion forum for questions, learnings, tips and guidance relevant to OPMH. I would encourage you to contribute and I look forward to the discussions.

In terms of dementia, it was with great pleasure to see that our [Dementia Wellbeing pathway](#) for the COVID era was published on the NHS England website. As you can imagine, NHS England has a great deal of information that it could publish across the whole of the health service and to have the moniker of the NHS on the pathway was really important.

As for the previous pathway, it does not present new guidance or new policy but merely brings together, hopefully in one digestible and accessible form, all the information that is available in other areas. We added the issue of treating well to reflect the importance of the management of Covid in older people and people with dementia. Any thoughts and comments you had on this would be appreciated.

We continue to extend our tendrils into various areas of work in the NHS and in social care and they are always grateful for the support that colleagues in other areas lend to our voice. One recent example was in terms of the issue of care



home visiting; we drafted some points that we thought were relevant to older people's mental health (for residents, their relatives, families and staff), and were immediately struck that so much of the issue of visiting was around mental health (not entirely, and there are practical aspects as well, but perhaps more than was apparent initially).

We are also linking into the work on Long COVID and the importance of difficulties of memory and concentration which are often seen as a result of the condition. We are able to underscore the importance of these aspects by being in the appropriate meetings.

The issue of Aducanumab has been to the fore and we are leading some thinking on behalf of NHS England about how we can best implement any decision NICE makes in due course about Aducanumab. It is likely that other disease modifying therapies will come along but as a "first in class" it is very important.

Finally, we have had an event looking at what we can learn from research in dementia in the COVID era and, again, that is being taken on by the NHS.

I am afraid that the pervasive use of video conferencing means that the ability to take snapshots of interesting places and interesting people and post them as quizzes is sorely limited. So, there will not be a picture quiz this time but hopefully, as with other things, we expect normal service to be resumed in due course.



# Save the date!

## Clinical practice in Old Age Psychiatry – an update

Friday 22nd January 2021, 10.00 – 14.40 (UK time)

Online: Virtual Venue

Cost: £60.00 - EAGP and Royal College of Psychiatrist members only

£75 - all non-members

We are delighted to announce that the Institute of Mental Health will host this strategic conference which is in partnership with the EAGP (European Association of Geriatric Psychiatry) and The Faculty of Old Age Psychiatry, The Royal College of Psychiatrists.

Building on the successes of the first and second refresher courses held in Leuven, Belgium, in 2016, and Nottingham UK, in 2019 this online virtual learning and networking event for old age psychiatrists will include invited speakers from across the UK and Europe. The clinically focussed event will provide an engaging and stimulating programme for old age psychiatrists and trainees and improve their knowledge and practice.

### **Confirmed speakers:**

- ✚ *Professor Rob Howard, University College London (UCL) – Late life psychosis*
- ✚ *Professor Marie Åsberg, Karolinska Institutet (Stockholm) – Preventing depression in elderly*
- ✚ *Professor David Taylor, Maudsley Hospital & King's College (London) – Optimising drug treatment in elderly*
- ✚ *Dr Didi Rhebergen, GZZ inGeest (Amsterdam) – Late life depression*
- ✚ *Dr Annemieke Dols GGZ InGeest (Amsterdam) - Older Age Bipolar Disorder*
- ✚ *Dr Kumar K Rudra, Consultant Geriatrician & Senior Lecturer (Hon), King's College (London) – Medicine for Old Age psychiatrists*
- ✚ *Dr Volen Ivanov, Ph.D. Psychologist, Karolinska Institute (Stockholm) – Hoarding and squalor syndrome*

**Further details regarding opening of registration and full programme will follow shortly**

**If you have any queries please email [karen.sugars@nottshc.nhs.uk](mailto:karen.sugars@nottshc.nhs.uk)**

Best wishes

Dr Karin Sparring Björkstén

Ass. Prof. Karolinska Institutet (Sweden)

Board Member EAGP

Dr Mohan Bhat

Consultant Psychiatrist & Associate Medical Director

Academic Secretary (Faculty of Old Age Psychiatry, RCPsych, UK)

Dr Sujoy Mukherjee

Consultant Psychiatrist (UK)

Executive Member -Faculty of Old Age Psychiatry

Board Member and Secretary EAGP

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Twitter: @InstituteMH

Blog: [www.imhblog.wordpress.com](http://www.imhblog.wordpress.com)

*(The Institute is a partnership between Nottinghamshire Healthcare NHS Foundation Trust and the University of Nottingham)*

## 180th Anniversary future archive competition

In our Future Archives competition, we want YOU to write history.

As we leave an eventful 2020 behind, the RCPsych prepares to celebrate its 180<sup>th</sup> anniversary in 2021. Anniversaries are not just for celebration, but also for reflection and contemplating our past, present and future.

We want everyone, yes, everyone (patients, carers, junior doctors, consultants, psychologists, nurses and anyone else interested in mental health), to send us their perceptions and experiences of psychiatry and mental health services at the present time. All entries will be preserved in the RCPsych archives, creating a holistic mosaic of psychiatry in 2020/21 for future generations. You'll also be competing for iPad prizes and a chance to speak at the College's next international congress!

Competition now open

Find out more: <https://www.rcpsych.ac.uk/about-us/library-and-archives/archives/future-archive>

# The Surveillance Study of COVID19-associated Neurological and Psychiatric Conditions

Dr Adrian James (President)

Dr Mike Dilley (Neuropsychiatry Faculty Chair).

Benedict Michael (NIHR Health Protection Research Unit for Emerging and Zoonotic Infection)

Dear Colleagues

Please support The Surveillance Study of COVID19-associated Neurological and Psychiatric Conditions. The RCPsych is one of several organisations supporting a programme run by Benedict Michael (NIHR Health Protection Research Unit for Emerging and Zoonotic Infection, University of Liverpool). The programme seeks cases of neurological and psychiatric syndromes associated with suspected or confirmed COVID-19 infection.

Please report cases via this: [Coronerve surveillance survey | Royal College of Psychiatrists \(rcpsych.ac.uk\)](https://coronerve.surveillanceresearch.ac.uk/)

– it is very brief and will take < 5 minutes.

No patient identifiable details will be needed. The Health Research Authority have reviewed and approved the collection of these data for health surveillance.

The data being collected is a very brief survey with four questions: the patient's SARS-CoV2 status (COVID 19 virus), their psychiatric status and their neurological status if known to you.

Please keep your own record. Before you click 'Submit', please print the completed page and keep it alongside a note of the patient's medical record number, so that you can provide more details when Dr Michael's team contacts you, as we will seek more details on these cases in the fullness of time. We will remind members about this form via our weekly COVID-19 email, until there's no need for continued surveillance.

Thank you for your support.

Dr Adrian James (President)

Dr Mike Dilley (Neuropsychiatry Faculty Chair).

Benedict Michael (NIHR Health Protection Research Unit for Emerging and Zoonotic Infection)

On behalf of: NIHR Health Protection Research Unit for Emerging and Zoonotic Infection Programme Study Management Group: Rhys Thomas, Rachael Kneen, Ian Galea, and Sarah Pett.

RCPsych Group: Alan Carson, Tony David, Mike Dilley, Tim Nicholson, Tom Pollak, Valerie Voon

# Neurodegeneration of the Brain

## A Rosetrees interdisciplinary workshop

RCPsych's Neuroscience Project is partnering with the Physics of Medicine/PoLNET network to host a free-to-attend, one-day workshop on *Neurodegeneration of the Brain*

Outstanding speakers from around the UK and beyond will cover topics including:

- *Key questions in understanding neurodegeneration* Giles Hardingham (Edinburgh)
- *Clinical challenges for dementia research* James Rowe (Cambridge)
- *Biomarkers* Henrik Zetterberg (Gothenberg)
- *Imaging* Heidi Johansen-Berg (Oxford)
- *Scalable technologies for pre-clinical detection* Ivan Koychev (Oxford and UKDP)

There will be time to put questions to the speakers and share ideas, and a presentation on funding opportunities for research in this area

Sponsored by the **Rosetrees Trust**, this online, interdisciplinary event will bring together academic researchers working across the biomedical sciences and healthcare professionals.

**Wednesday 10 February 2021**

Virtual meeting via Zoom

**Register free** and get more information, visit [the PoLNET page](#)

**A not-to be-missed event!**

In association with:



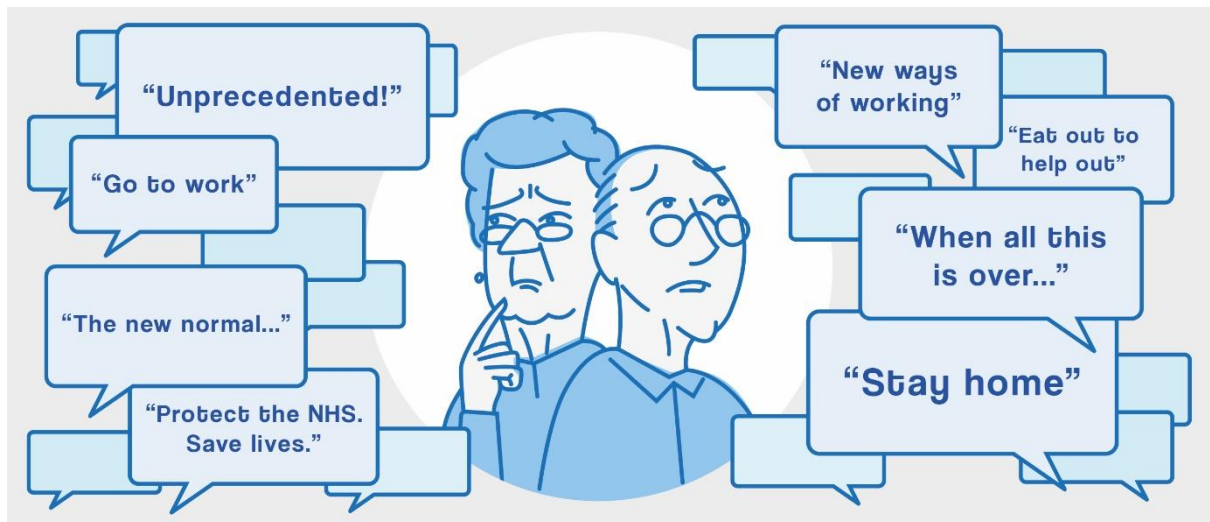
Sponsored by:



# The Old Age Psychiatrist: Annual Essay Competition

The title for this year's essay competition is:

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



One of the many challenges of 2020 has been making sense of our lives, our work, and the experiences of our patients, amidst a cacophony of pandemic-related rhetoric. We hope that this year's essay will provide a space for interesting and creative interpretations on what it has meant for Old Age Psychiatry specifically, and what the future might hold.

How will the COVID-19 pandemic influence how we practise in Old Age Psychiatry? What are the challenges our patients and colleagues are facing as a result of the seismic shifts in how we live, and what will be the longer term impacts?

**Entries should be no more than 1000 words long. Please submit your entries to [essaycompetition2021@gmail.com](mailto:essaycompetition2021@gmail.com) by no later than 5pm on Friday 26<sup>th</sup> February 2021.**

*Remember to include your name, address and preferred e-mail address when you send the essay. There is a first place prize of £100, and £50 for the runner up! Winners will also have their essays published in the next published edition of the Newsletter and will receive a day's free registration at the Old Age Faculty Conference running online in March 2021.*

*We will be organising a fantastic line up of expert judges, and are very excited to see your entries!*



# The Impact of COVID-19 on the presentation and management of delirium in an acute hospital setting

Dr Nicole Edwards CT2 in psychiatry, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

Dr Simon Davidson ST4 in psychiatry, CNTW

Dr Rachel Gore Consultant Psychiatrist, CNTW

Dr Frauke Boddy Consultant Psychiatrist, CNTW

Nicola Hamilton, Northumberland and North Tyneside Psychiatric Liaison Team Manager, CNTW

## Introduction

The Coronavirus pandemic has impacted almost all aspects of life across most of the world, and the full degree and nature of these effects are yet to be understood. Broadly, they can be understood as consequences of actual infection with the virus and diagnosis of COVID-19, and the consequences of the pandemic itself through the significant changes and restrictions to everyday life, social contact, and the functioning of the health service etc. For older people specifically, there are likely to have been particular additional challenges.

Delirium is a very common presentation in older people in acute hospitals as well as a complication of admission. Within the Northumberland Older Persons' Psychiatric Liaison Team (OP PLT), we were interested in examining the impact of COVID-19 in the presentation of delirium, and our subsequent management of this, compared to delirium presenting in individuals without a diagnosis of COVID-19. The overall aim of this service evaluation was to identify any themes or trends which might help inform future practice in a world where COVID-19 is likely to remain prevalent.

## Methods

This service evaluation used a retrospective design wherein records of patients referred to the OP PLT between 1<sup>st</sup> March 2020 and 30<sup>th</sup> June 2020 were examined. The inclusion criteria for the first data set were individuals referred to the Northumberland OP PLT over the age of 16, any sex, diagnosed with delirium, and have evidence of a positive COVID-19 infection. The second data

set had the same inclusion criteria as the first, with the exception that these individuals were negative on all tests for COVID-19 infection. Referrals were screened for inclusion and then the relevant data extracted. Caldicott approval and ethical approval were not deemed necessary due to the study design and recognition that the results and conclusions would not be generalisable.

The data collected included age, gender, 'type' of delirium (hyperactive/hypoactive/mixed/resolving), reason for admission to acute hospital, date tested positive for COVID-19 and presence of symptoms, underlying psychiatric illnesses and prescribed psychotropics, any changes to psychotropic medications, length of time on the OP PLT caseload and the outcome following discharge (e.g. discharge home, into 24 hour, deceased etc.)

## Results

A total of 77 patients were identified as having been referred to the OP PLT with delirium between the dates of the evaluation. Of these 77, fifteen were diagnosed as COVID-19 positive and the remaining 62 were COVID-19 negative. The prevalence of pre-existing psychiatric disorders amongst the groups was relatively similar; 60% in the COVID cohort and 50% in the non-COVID cohort. These pre-existing disorders included MCI, dementia (including Alzheimer's, Lewy Body and vascular), delusional disorder, depression, schizophrenia and other psychotic disorders, and Bipolar Affective Disorder.

Of the COVID cohort, the majority presented with a hyperactive delirium (64%) compared to 14% hypoactive and 22% mixed. Similarly the majority of the non-COVID cohort were hyperactive (66%) compared to 16% hypoactive and 5% mixed. A proportion of the non-COVID cohort (13%) were deemed as having a "resolving delirium" at the point of involvement with OP PLT. The range of number of days on caseload for the COVID cohort was between 1 and 66 with an average length of time on caseload of 21 days. The non-COVID cohort had a smaller range between 1 and 40 days, and a lower average length on caseload of 13 days.

With regards to pharmacological management of delirium, we found the rate of prescribing of psychotropics (including antipsychotics, antidepressants, benzodiazepines, melatonin and other drugs) was higher in the COVID cohort (46.7%) compared to the non-COVID cohort (21.0%). Each of these medication subgroups individually were also prescribed in a higher percentage in the COVID cohort. Of particular note, 33.1% of patients in the COVID cohort were prescribed antipsychotics compared to 8.1% of the non-COVID cohort.

As expected, there was a higher incidence of death in the COVID cohort (33.3%) compared to non-COVID (9.7%). One patient from the non-COVID cohort was admitted to a psychiatric unit, however none of the COVID cohort were. The

results show that a lower percentage of patients in the COVID cohort were discharged to their usual place of residence, either being discharged to new 24 hour care or sadly dying. In the non-COVID cohort 40.3% returned to their usual place of residence compared to 26.7% of the COVID cohort. This can be partly attributed to the higher numbers of death in the latter, however when the patients who were deceased or still inpatients are removed, 55.6% of the COVID cohort (5/9 in absolute numbers) were discharged to 24 hour care compared to 41.3% of the non-COVID cohort (19/46).

## Conclusions

Firstly, we recognise that the small sample size makes it difficult to draw any firm conclusions or suggestions of causality, however, we believe the data does highlight some significant findings.

It is interesting to note that the subtypes of delirium are similarly proportioned in both cohorts and broadly match the prevalence found in larger data sets; generally a higher proportion of hyperactive delirium. This makes the disparity between cohorts with regards pharmacological management all the more striking. The higher percentage of psychotropic medication use of all types stands out to us as a significant finding, in particular the increased use of antipsychotics. This could signify that the delirium associated with COVID infection is more severe, leading to greater disturbance of sensorium, which in turn requires the increased use of psychotropic medication.

Other factors to consider, however, include the fact that COVID positive patients are frequently isolated to ward side-rooms, and concerns regarding the spread of the infection may make behavioural approaches more challenging. Furthermore, it may not be the delirium per se, which is more severe, but the symptoms of delirium combined with the symptoms of COVID causing patients to feel increasingly anxious and distressed. Family members are likely to feel scared and concerned for their loved ones, whilst clinicians may feel a sense of helplessness. It is possible that these emotions are at play when considering the increased use of antipsychotics, conveying our desire to "do something" to help. Whatever the underlying factors may be, these results have highlighted a need to further audit our prescribing practices in delirium.

These results also suggest an overall poorer outcome for the COVID cohort. As previously noted, this may simply convey the increased mortality of patients infected with COVID, although we may consider what role the increased prescription of psychotropic medication plays. A greater proportion of the COVID cohort were also discharged into 24 hour care rather than returning to their usual POR and this may represent the potential longer term effects of recovering from COVID infection, such as reduced nutritional intake, lethargy and increased anxiety or a reduced confidence. It is important for us to reflect on these results

and consider how we may prepare families and relatives for various outcomes of recovery.

Finally, we also noted that patients in the COVID cohort spent on average, a longer time on the PLT caseload. We have reflected on the impact this could have on the service should there be a second wave of COVID in the winter, at a time when caseload numbers are already likely to be higher. This information could help us to be better prepared for the impact of a potential second wave, for example by moving swiftly to increasing staffing numbers or shifting staff to the busiest areas.

# COVID 19 -? The Bright Side

Dr Sudip Sikdar Consultant in Old Age Psychiatry, Mersey Care NHSFT,  
Honorary Research Fellow, University of Liverpool.

Finance Officer, Old Age Faculty, Royal College of Psychiatrists

There have been endless reports of the negative effects of the ongoing pandemic that engulfed United Kingdom since March 2020.

Physicians and general public have learnt a lot about this disease since the first wave hit us. Terms like the R rate, cytokine storm, prone ventilation; websites like worldometer, ourworldindata etc. has become common parlance in our everyday life.

While acute admissions and death rates started rising in the country, many routine NHS services were put on hold at the start of pandemic. Staff was redeployed from community to inpatient areas, doctors were deployed to areas that were not their specialties.

Like most other mental health trusts in UK, we wrote to GPs only to refer urgent cases; especially those related to dementia assessment.

However, by the end of April, it became apparent to me that we could not put everything in the back burner. During this period, NHS has been looking at digital assessment platforms, Attend Anywhere was starting to be rolled out, and old age psychiatrists were trying digital platforms like Zoom, WhatsApp video, Facetime to start assessments of new patients and following up existing patients. As part of my trust's clinical digital leadership group, I pushed and succeeded to get full read only access of EMIS (our GP records). Skype for business was rolled out in the trust; Zoom was starting to be used to deliver weekly academic teaching. iPads and laptops were given to each inpatient unit.

Digital revolution was well on its way in NHS at a scale previously unseen in its history.

## **So what are the bright sides of Covid 19?**

1. Video assessments – More than 90% of my community assessments of new and follow up patients are being done via Attend Anywhere platform. Facetime video is used if relatives have an Apple device, especially when Attend Anywhere platform develops glitches in the middle of an assessment. Inpatient ward round are being done either via Skype for Business video through ward laptops or IPADS when patients are isolating.

2. All care home assessments and general hospital liaison assessments in hospitals not recovered by liaison services are being done remotely via mobile phones and tablets of carers or junior doctors in hospital wards.
3. WPBAs for trainees are being conducted by simply joining the video call on the Attend Anywhere platform when a trainee is assessing a patient, either from a different clinic room or even from their homes.
4. MHA assessments have been done via video, digital MHA forms are being used in our trust via the Thalamos platform.
5. Community Multidisciplinary Team meetings are being held via Skype for Business as many nurses are working from home to reduce the footfall in our community estates.
6. My additional carbon footprint is zero as all I do is to drive from home to my room in my community base and do all my clinical work from there.
7. Travel cost to the trust is zero as I am not going out to do routine community visits.
8. Travel cost to patients and families is zero as all assessments are done while patients and relatives are at home rather than having to come to clinics. As many relatives have been furloughed or are working from home, they do not have to take time off from work to accompany patients to clinics or to be present for home visits to provide collateral history.
9. Patient and carer satisfaction are high as I or my team members have often been the only health care professional that an elderly patient or their relatives have seen since end of March as GPs are primarily doing telephone triage and consultations.
10. Always on VPN network has allowed me to respond to emergencies in my dementia inpatient unit from home, especially when Covid hit our dementia ward during the first wave.

I expect to continue with many of these practices even when Covid 19 becomes a history, however long it might take.

# How times have changed: Our local response to the COVID-19 pandemic.

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

The World Health Organisation declared COVID-19 a global pandemic on the 11<sup>th</sup> of March 2020<sup>1</sup>. Since then we've all become experts at donning and doffing personal protective equipment (PPE) and I've certainly become used to the comfortable life of wearing scrubs. There have undoubtedly been numerous challenges for everyone over the last 8 months and mental health services across North Wales, like so many other regions, have had to make considerable changes to service provision.

Betsi Cadwaladr University Health Board (BCUHB) is the largest health board in Wales serving a population of around 699,500 across the six counties of North Wales<sup>2</sup>. The health board encompasses three district general hospitals (DGH); Gwynedd (West), Glan Clwyd (Central) and Wrexham Maelor (East).

## **Inpatient services**

Prior to the COVID-19 pandemic, old age psychiatric services across BCUHB were using the sectoral model of care. In total, there were three organic and two functional old age wards, of which two organic wards were not located on a DGH site.

In early April, BCUHB went into phase one of their COVID-19 response plan which included an aim to cohort all old age psychiatric inpatients. Cohorting is the idea of grouping patients based on their vulnerability and whether or not they are infected with COVID-19. Cohorting aims to isolate infected patients and prevent the spread of infection between different clinical areas<sup>3</sup>.

The inpatient psychiatric unit in the East became the regional centre for all new admissions under old age psychiatric services across BCUHB. It comprised of two organic and two functional wards. Initially the new unit in the East was separated into red, amber and green wards. The aim of this was to further cohort new admissions for a 14 day quarantine period and to isolate suspected and positive COVID-19 cases. However, it soon became apparent that this model was linked with further spread of the virus as patients with suspected COVID-19 infection were being moved between wards. The Infection Prevention and Control (IPC) team were involved throughout and their advice changed over time

as our knowledge of the virus grew. In early June, the IPC team advised to change the model to every ward having their own isolation corridor. Under this new model, anyone showing signs and symptoms of potential COVID-19 infection were moved into their own room on the isolation corridor of their ward and a COVID-19 test undertaken. All new admissions would remain in isolation for 14 days and have a COVID-19 test on days 1, 5, 10 and 15.

The wards were closed to all unessential visitors. Telecommunication applications were used to enable patients to speak to loved ones on portable devices. Doctors continued to undertake face-to-face reviews for inpatients, wearing the appropriate PPE. In order to ensure a supportive environment and timely specialist review for patients, a rota for a senior old age psychiatry consultant cover from 9am to 5pm over the weekend was arranged. This was on top of the usual on call consultant rota.

One of the biggest emotional and practical challenges for the psychiatric inpatient teams was providing End of Life (EoL) care to patients. Pre-COVID-19, all patients requiring EoL care in psychiatric inpatient services across BCUHB were transferred to other divisions. It was inspiring to see the staff's response to this new role, their commitment to learning new skills, their ability to adapt, their resilience, and the overwhelming empathy and care shown towards patients at the end of their lives. The inpatient teams are grateful to our palliative care and medical colleagues who provided invaluable support and education to medical and nursing staff on providing EoL care in a great example of effective team working between specialties. In my opinion, psychiatric wards across BCUHB should continue to be able to provide EoL care for inpatients post-COVID-19 pandemic, where appropriate.

## **Outpatient Services**

There have also been major changes to service provisions within older persons community mental health teams (OPCMHT). A number of both medical and nursing staff from the community teams were re-deployed to inpatient services and had to adapt quickly to their new roles. The day hospitals and health respite beds were closed. Memory services ceased all new patient assessments. They continued to offer remote telephone consultations for patients already open to the service but face-to-face contacts were initially stopped. The OPCMHT continued to assess new referrals, mostly via remote telephone consultations. Urgent face-to-face community visits were carried out with full PPE.

Medical clinics as we knew them stopped. Most medical reviews were undertaken via telephone consultations. Urgent community visits were carried out when necessary.



## **Impact**

The total number of positive cases of COVID-19 infection in old age psychiatric inpatient services across BCUHB since March and up to the end of September was 60 patients, out of a total of around 165 inpatient admissions. The true number of positive cases is likely to be higher as there was no routine testing of contacts undertaken until July. Sadly, 10 old age psychiatric inpatients died from COVID-19 related illness across BCUHB.

Overall, the number of acute hospital admissions under old age psychiatric services in BCUHB has reduced slightly over the months of March to September compared to the same time period last year. What is more interesting is that the number of admissions has not reduced equally across all of BCUHB. The number of admissions from the West has decreased 56% from the same period last year. In the Central region there was a 6% decrease but the East region saw a 17% increase in the number of admissions. The patient population hasn't changed during this short period therefore the number of admissions should be comparative to last year. The reason for this difference is likely to be multifactorial and will require further analysis over the next few months. One could speculate that the distance required to travel for inpatient admissions could mean that patients from the West, and their families, were less agreeable to informal hospital admission. If this is the case, were we admitting people unnecessarily in the past or has the threshold for admission been raised? Somehow these patients are now being managed in the community, but where is the increased support coming from? Has the pressure simply moved from inpatient services to community services and how are they managing to sustain the increased level of support?

A major negative impact is the reduced face-to-face patient contact which is essential for psychiatric services. No matter how advanced new technologies become, it will never live up to face-to-face interactions in our ability to build a rapport with others. Visits from family and friends are very important to recovery for the majority of patients.

There has also been a big impact on the OPCMHT services as well. The memory services waiting list has now grown to around 6 months wait for new assessments, compared to around 3 weeks previously, and many patients are being re-referred by their GPs requesting an urgent review.

## **Future plans**

As the second wave approaches, many old age psychiatry services in BCUHB are still not back to functioning at their baseline levels. Social distancing measures are now in place which allows us to continue functioning at a higher level than during the first wave. The OPCMHTs are expecting the imminent arrival of

portable tablet devices to enable more remote consultations to take place. As we've heard on so many occasions, these are unprecedented times and only time will tell what the longer term implications of this pandemic will be.

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# A Global Pandemic in an Old Age Inpatient Hospital: A Core Trainees Experience of Patient Care and Training.

By Dr Zoe Goff, CT3 at Leeds and York Partnership Foundation Trust and Academic Clinical Fellow at the University of Leeds.

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The COVID-19 global pandemic has forced us to rapidly change and adapt our ways in both a professional and social context. Psychiatric services have been no different to any other medical or surgical specialty during this challenging time and have had to swiftly modify service delivery and methods of training in order to maintain a safe environment that enables effective patient care, but still continues to value the need for teaching and trainee development.

Working as a Core Trainee in the Trust's Old Age Inpatient Hospital during the first wave of the COVID-19 pandemic meant that you were at the forefront of managing COVID-19 in a psychiatric setting. This vulnerable and often frail cohort of patients was hit first, and often hit the hardest. Despite our best efforts to tackle the spread of the virus with measures such as personal protective equipment, social distancing and reviewing the newest available evidence for guidance, it seemed that new cases were cropping up all around us. This issue was likely multifaceted, with challenges posed from the virus itself, including the seemingly silent cases that surprisingly still affected the elderly, as well as obstacles specific to a mental health setting, such as attempting to isolate a patient that was distressed and could not understand the rationale for this. Although this posed a challenging time for the inpatient service, many effective adaptations were implemented in order to support the teams working on the frontline.

What felt the most important of these changes were those to the ways of leadership and multi-disciplinary team working. This was because, as a junior psychiatry trainee working on the old age ward, you would often find yourself in a situation where difficult physical health management and escalation decisions needed to be made. These decisions were becoming ever more prevalent and at times it seemed that you would be assessing whole wards of patients for their

degree of frailty and if escalation plans were already in place, in advance of anything catastrophic occurring. During the normal working day, these decisions and plans could be discussed with the multi-disciplinary team, however out of hours seemed a more frightening prospect when you were the only doctor resident in the whole hospital.

As the severity of the pandemic increased, the Old Age Inpatient Consultants began working in a shift-based pattern to ensure senior support was more readily available out of hours. Having someone on site who you could discuss plans and trouble-shoot problems with face to face was invaluable to trainees who were ever more frequently being posed with challenging situations. Designated times for senior support via telephone also became available. This meant that some issues could be resolved swiftly at the start of a shift, or if this was not possible then a trainee would at least know that a senior colleague was aware of the difficulties and if advice was needed during the course of the day or night, there was increased confidence in making a call to a familiar person who was already likely to be expecting that contact.

Another issue which we have had to face is that of teaching and training. At the start of the pandemic, it felt as if everything was being cancelled. Teaching ceased, examinations were cancelled and for some even rotations were suspended. There was a feeling of loss in terms of training opportunities and career progression. There was the added difficulty of re-deployment, with the sense of being uprooted from a placement and then trying to establish yourself in another posting. Although this was difficult, it could be argued that our nursing colleagues had a much harder time, given that many of them had not worked in an inpatient environment for many years and as trainee psychiatrists we did have the benefit of having visited the wards out of hours, so had some familiarity with the environment we had been placed in.

Although it was a particularly challenging and uncertain time, training opportunities gradually began to be re-introduced via online platforms such as Microsoft Teams and Zoom. Despite clear benefits to online platforms, such as their flexibility and accessibility, it wasn't long until the term 'Zoom fatigue' crept into our everyday language. The concept of Zoom fatigue is quite difficult to wrap your head around: why is it that you feel so exhausted in this format rather compared to a face to face meeting? It's been argued that Zoom meetings require you to 'hyper-focus' with intense periods of concentration in order to absorb the same level of information compared to meetings in person.

<sup>[1]</sup> The loss of whole-body interaction due to seeing only a face on the screen, and also aspects of precisely timed speech and gestures lost through the slight

delay of online platforms means our brains have to work much harder to pick up on these social cues <sup>[2]</sup> and as a result we are likely to feel much more fatigued when engaging in this type of interaction. Utilising shorter presentations for teaching has helped to boost concentration and engagement with the teaching session and reduced the issue of associated fatigue that may be experienced when having to concentrate intensely for much longer periods of time.

Overall, working in old age psychiatry during the COVID-19 pandemic has proved to be challenging and it is likely that these challenges will continue with further peaks in the number of cases. Lessons can be learnt from trial, evaluation and the subsequent improvement in the changes that we make to our methods of leadership, management and teaching and also by adapting our use of technology in order to continue delivering the best possible care during these uncertain times.

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# The Impact of the COVID-19 pandemic on clinical and research activities related to old age psychiatry.

Perspective and conversation within the North East England South Asia Mental Health Alliance (NEESAMA) older persons division.

Stella-M Paddick (ST6 and Clinical Lecturer in Old Age Psychiatry), Gateshead Health NHS Foundation Trust

In conversation with

Prekshya Thapa, MSc Registered Psychiatric Nurse and Lecturer, Department of Psychiatric Nursing, B.P. Koirala Institute of Health Sciences, Dharan, Nepal &

Professor Nidesh Sapkota, Geriatric Psychiatrist, B.P. Koirala Institute Nepal

## **Background**

The North East England South Asia Mental Health Alliance (NEESAMA) aims to collaborate in addressing training and research gaps in psychiatry. I co-lead the older person's mental health strand on behalf of the North East England team.

This is a summary of face to face and email discussions with Prof Sapkota (the only geriatric psychiatrist in Nepal and president of the Alzheimer's and Related Dementia Society Nepal) and Preksha Thapa, one of the only MSc qualified psychiatric nurses in Nepal who also lectures in psychiatric nursing. Together we were recently awarded a British Council grant to conduct a capacity-building project and epidemiological survey of older peoples mental health needs in Dharan, Eastern Nepal, and have been working to get this project ready to start when the risk of COVID-19 has reduced.

## **How have your clinical and research responsibilities been affected by the pandemic?**

### **Ms Thapa**

COVID-19 has heavily impacted countries like ours with limited resources. Initially with the strict lockdown, the nursing college remained closed for 3 months from April. Although few cases were reported at this period there was quite lot of distress regarding COVID 19. The institute resumed theoretical teaching via online platforms like ZOOM, GOOGLEMEET but clinical postings were hampered. The college decided to call undergraduate students to resume clinical postings after 7 days of quarantine and PCR reporting from September.

With the increasing number of COVID-19 positive health workers, I have been given the additional responsibility of Clinical Nursing Supervisor. I manage several wards( Psychiatry, Paediatrics and Gynae) , resources ( nurses) and workout issues with the management. Our institute has been running a 100 bedded Covid-19 hospital since May but no additional manpower could be recruited. Existing manpower from the current hospital had to be mobilized to the Covid-19 hospital and a lot of task shifting and sharing had to be done. This led to a lot of distress and burnout among frontline HCWs, especially nurses. The regular services of the hospital (including psychiatry, OPD, OT) had to be curtailed significantly and have not returned to pre-COVID status.

### **Prof Sapkota**

Because of this pandemic, the healthcare system of this country has faced tremendous challenges. We don't have a referral system like GPs in the UK or adequate and equipped infrastructure. Corona positive and other patients are currently treated in the same hospital with much of the resources consumed by the positive patients. There is fear and stigma of the virus in the community and unless it is an emergency, people refrain from hospital visits. This has created problems in regular follow up. The focus of policy makers is on the virus and other issues are secondary. We are trying our best to address this. At an institutional level we are providing a telemedicine/helpline service. At a private level I am giving two hours per day for WhatsApp video calls for older persons issues. Just today I evaluated a female patient in Kathmandu, 86 with possible dementia.

### **Stella**

My clinical work was affected immediately as we had to switch to telemedicine and only see patients face to face in an emergency. Older patients were reluctant to be seen as they were understandably frightened of the virus. We were concerned that we would be redeployed to non-psychiatry roles but this did not happen. My global health research had to stop immediately, and our 10 Masters students in Tanzania returned home to the UK. We had to find

alternative masters projects for them at short notice, which was distressing and anxiety provoking for them. I am now trying to see which projects are feasible to continue.

### **How has healthcare been affected as a result of COVID-19?**

#### **Ms Thapa**

With the increasing number of cases, there was shortage of essential PPE and human resources. Many health workers tested positive and were in isolation additionally burdening remaining workers. The fear of getting COVID 19 , the lack of PPE, and of clear planning and policies nationally and locally deteriorated the health care delivery system and heavily impacted patient care.

#### **Prof Sapkota**

Stakeholders should realize that COVID-19 is going to stay with us for long period of time. We need to think of our older patients who are in dire need of health care for non-COVID reasons . If this continues long term, quality of life and longevity could be compromised. Nepal may face other challenges like increase in maternal and infant mortality rate, lack of immunization and loss of community activities.

#### **Stella**

Initially, I was very worried for our older patients in Gateshead. All their existing community activities were stopped (day services, luncheon clubs etc) and it was clear the pandemic was resulting in distress, anxiety and social isolation. We continued conducting reviews by telephone, but it was often challenging to properly understand patients needs especially as few had access to video calling. Later my hospital decided we could resume face to face assessments with strict safeguards and use of PPE which I think was very beneficial, both for clinicians and patients but I think there will be a long term impact on our patients. In particular I have seen a lot of patients with cognitive impairment and dementia deteriorate rapidly from the start of the lockdown.

### **Have any new ways of working or potentially positive changes resulted from the pandemic where you are working?**

#### **Ms Thapa**

The use of virtual platforms like ZOOM , GOOGLEMEET in our teaching methodology was new and can be taken as a positive change. The concept of working from home was also a change As the mother of five year old child, I got



the opportunity to spend time with my children. Earlier, there was much negligence regarding IPC (infection prevention and control) activities in the hospital which has drastically changed with Covid-19 and these measures are strictly implemented everywhere. Unnecessary spending has been drastically cut down and people are much conscious on utilization of resources. There is very poor online shopping and delivery mechanism here in Nepal. However, those in home isolation were supported a lot by their neighbours and the culture of mutual support has been re-ignited, which definitely is another positive point.

### **Prof Sapkota**

I do not see any positives, but we have become more aware of the contagious nature of this virus.

### **Stella**

I have been amazed by how we have managed to continue work and communications remotely with your team and with other collaborators in India and Tanzania during the pandemic. I do not think this will ever replace face-to-face working completely, but I think there is a possibility to drastically reduce the amount of travel required. I am also mum to a 5 year old and I think my being away from home less is beneficial for her. I have been able to deliver lectures and seminars for postgraduate students from my clinical workplace which is more efficient in combining academic and clinical work. Also I was impressed by the clear communication system put in place at my hospital trust to inform staff and reduce anxiety in response to the pandemic.

### **BP Koirala Institute and College of Nursing, Dharan, Nepal**



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**Older Persons section of NEESAMA discussing research priorities in Kathmandu, 2018.**



Left to right - Prof Mathew Varghese (Professor of old age psychiatry, NIMHANS Bangalore), Stella-M Paddick Newcastle University/Gateshead NHS Foundation Trust, Prof Nidesh Sapkota, B.P. Koirala Institute Nepal, Prof Richard Walker (Professor of Ageing and International health and Consultant Geriatrician, Northumbria Healthcare NHS Foundation trust).

### **Acknowledgements**

NEESAMA is supported by the British Council, Newcastle University and Cumbria Northumberland Tyne and Wear NHS Trust. The capacity building collaboration with the Alzheimer's Association of Nepal and planned epidemiological survey are funded through the British Council Science South Asia small grants programme and we thank all these institutions for giving us the opportunity to collaborate in this way.

# Our Covid 19 experience: the good, bad and ugly

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## Introduction

The Covid19 pandemic has involved 3 components, a highly contagious virus - SARSCov2 - mainly affecting people aged over 80, a culture of fear leading to increasing risk aversion, and an escalating sovereign debt overhang, risking a return to public sector austerity. Currently a 'second wave' involving all three components is underway.

Over the last 9 months, care of older adults, especially those with mental health difficulties, has been restricted due to various 'lockdown' measures with enforced shielding of older adults at home with minimal visits from carers in order to reduce the risk Covid19 delirium, and to reduce subsequent mortality.

## The good, bad and ugly of lockdowns

**On good experiences**, old age psychiatry services (including most memory clinics) have been resilient to lockdown pressures, by moving to telephone consultations similar to General practitioners (GP's). This has included virtual consultations using Skype and WhatsApp, despite previous concerns on data protection.

Care Home Liaison has involved allocating a psychiatric nurse for each home to support staff and to respond to emerging mental health issues such as delirium, challenging behaviour and depression. This innovation has been welcomed by care home managers, social services and GPs.

Consultant staff have altered their work practices with most working from home via electronic notes, virtual team consultations and, a lucky few, having access to electronic prescribing. Overall, there has been a willingness to 'go the extra mile' in supporting patients, carers and GP's.

**On bad experiences**, the main complaint from older adults has been on loneliness caused by shielding, coupled with hopelessness of ever returning to

normal social activities; probably affecting those with depression and cognitive impairment the most. Discontinuation of day services, coffee mornings and church attendance has compounded social isolation, with older adults struggling with virtual communication. Some have questioned the need to shield themselves, preferring the risk contacting Covid in order to hug their grandchildren after many months; an infringement of the right to family life under the European Convention of Human Rights (ECHR). Furthermore, shielding has probably led to increased frailty through reduced muscle bulk, with consequent risk of falls and fractures.

Due to restrictions on face to face consultations in primary care, referrals to memory services have reduced, as screening requirements including cognitive assessments and blood testing have been impractical. It is not uncommon for episodes of disorientation and / or challenging behaviour in care home settings to be responded to with a prescription for antibiotics and / or anxiolytics without a formal examination or investigation.

**On ugly**, the main issue was the decision by the NHS to discharge around 25,000 older adult hospitalised patients to care home beds in April, before routine testing for SARS-Cov2 was available. This directive probably resulted in 50% of care homes contracting Covid19, with over 18,500 deaths, most being patients with frailty and dementia; a breach of the ECHR right to life. This directive is awaiting a legal review as there was no attempt to separate the potentially infective from the other residents, for example by arranging separate care home floors with dedicated staffing. The rationale for bed clearance was to 'protect the NHS' although in reality acute hospitals did not come close to becoming overwhelmed.

There is emerging evidence of some primary care services placing all care home residents arbitrarily on 'Do Not Attempt Resuscitation' orders with minimal consultation with care staff, families and the elders concerned, resulting in reduced interventions for cardiac infarcts, strokes and cancer. It is estimated that non Covid 'lockdown deaths' amount to at least 25,000 in Britain, again mainly involving older adults.

### **Lessons for the speciality.**

Overall, old age psychiatry has acquitted itself well during the first wave of this pandemic; due to efforts in collaborating with primary care and with care homes. This will be a positive when commissioners decide on priorities in allocating funding for 'care closer to home', for example on delivering integrated input to care homes. Furthermore, when Nightingale units are opened to cope with the second wave of Covid19, old age psychiatry input will be needed to manage older patients with delirium, challenging behaviour and mood disorders on site.

On improving GP access to old age psychiatry expertise, communication platforms such as Microsoft Teams and Consultant Connect are being utilised in most areas, backed up by access to patient databases such as the Great North East Care Record. Furthermore, communication with Consultant Geriatricians and Emergency Care Consultants via Whats App is being used to complement emails, in order to reduce prescribing errors and to facilitate discharges from acute hospitals.

On future competencies for old age psychiatry, neuroscience research in old age depression, psychoses, delirium and dementia using immune modulators has been accelerated through better understanding immune dysregulation secondary to Covid19, alongside repurposing recent vaccine technologies used against SARSCov2 for moderating dementia progression. This suggests the need to upgrade the speciality curriculum involving knowledge of immunology and cell biology.

The other emerging issue for psychiatry as a whole is the need to comprehend the pervasive effect of early life trauma, and to mitigate its effects by preventing 're-traumatisation' during clinical contacts. Furthermore, old age psychiatrists need to be more skilled in co-producing Suicide Safety Plans developing Advance Care Plans.

## **Conclusions**

The SARSCov2 pandemic and the associated lockdown has provided the opportunity for old age psychiatry to show its strengths, especially the ability to collaborate with other specialities. This provides a useful base to develop integrated services, for example in care home liaison. Evaluation of innovations in consultation need to be published, alongside upgrading the curriculum to take in to account developments in trauma informed consultation skills and neuroimmunology.

## **References available on request**



# Silver linings: an unexpected opportunity for quality improvement during the COVID-19 pandemic.

Ravinder Kaur Hayer (ST6 in OA Psychiatry),

Ella Tumelty (5th Year Medical Student, University of Birmingham),

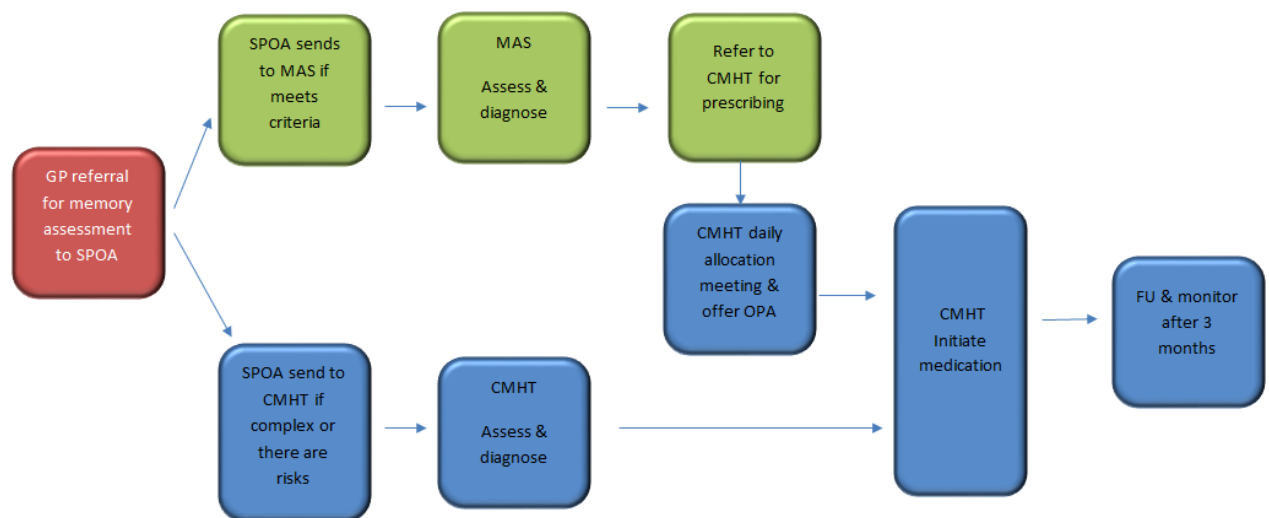
Nibha Hegde (Consultant in OA Psychiatry),

Farooq Khan (Consultant in OA Psychiatry) and Tom Cleverley (Information Manager).

The timely diagnosis of dementia has been increasingly recognised as a priority in health policy agenda. Despite evidence favouring an early diagnosis, the proportion of individuals formally diagnosed with dementia and thus able to begin treatment, remains low. This can often mean that opportunities for individuals and their carers to make informed decisions about the future, and for professionals to optimise quality of life, are missed. Furthermore, the NHS Constitution document states that service users should be able to start their consultant led treatment within a maximum of 18 weeks from referral for non-urgent conditions. For dementia, where medication aims to slow down progression of the syndrome, early treatment is a priority.

This article reports a quality improvement project conducted within a Community Mental Health Team (CMHT) in the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT), aimed at reducing the waiting time from diagnosis to the initiation of dementia medication. Currently, the CMHT receives a minority of direct referrals for memory assessments which are triaged by the Single Point of Access (SPOA). These referrals usually involve individuals with suspected psychiatric co-morbidities or where there are considerable risks. The majority of referrals are deemed by SPOA to be low risk and do not involve any other potentially treatable mental disorders, and these are thus triaged to the Memory Assessment Service (MAS) which is commissioned purely as a diagnostic service. Once diagnosed, the MAS team refer the service user to the CMHT for consideration of medication if appropriate and an appointment with a CMHT medic is then offered to determine the service user's suitability for these (*Figure 1*).

Figure 1:



The aim of this project was to reduce the waiting time from the point of referral from MAS following diagnosis, to initiation of medication by an older adult CMHT, to a median of 50 days. This was considered to be an achievable target given that at baseline, the median of the mean weekly wait time was 81 days. A multitude of factors contributed towards this delay (*Figure 2*). Although there were some factors due to resourcing within the team, others were attributable to patient factors or circumstances beyond both the MAS and CMHT's control, such as delays in the reporting of scans. Arguably, the most significant contributing factor were the *two* sets of waiting times; one for a memory assessment and another to be seen by a medic for consideration of treatment.

Involvement of service users and carers in this project was key and their input was sought from the outset. The authors (RKH and ET) attended a Dementia Council meeting and met with service users and their carers to explore their views on our proposed change ideas. For example, a suggestion of creating a specialist-led medication information group was met with feedback that, *"It feels like an obvious filler, and that it is trying to compensate for the long wait, but not actually useful."* They agreed that written information about dementia medication, in the form of a leaflet, would have been useful *prior* to their appointment with a psychiatrist.

Figure 2:

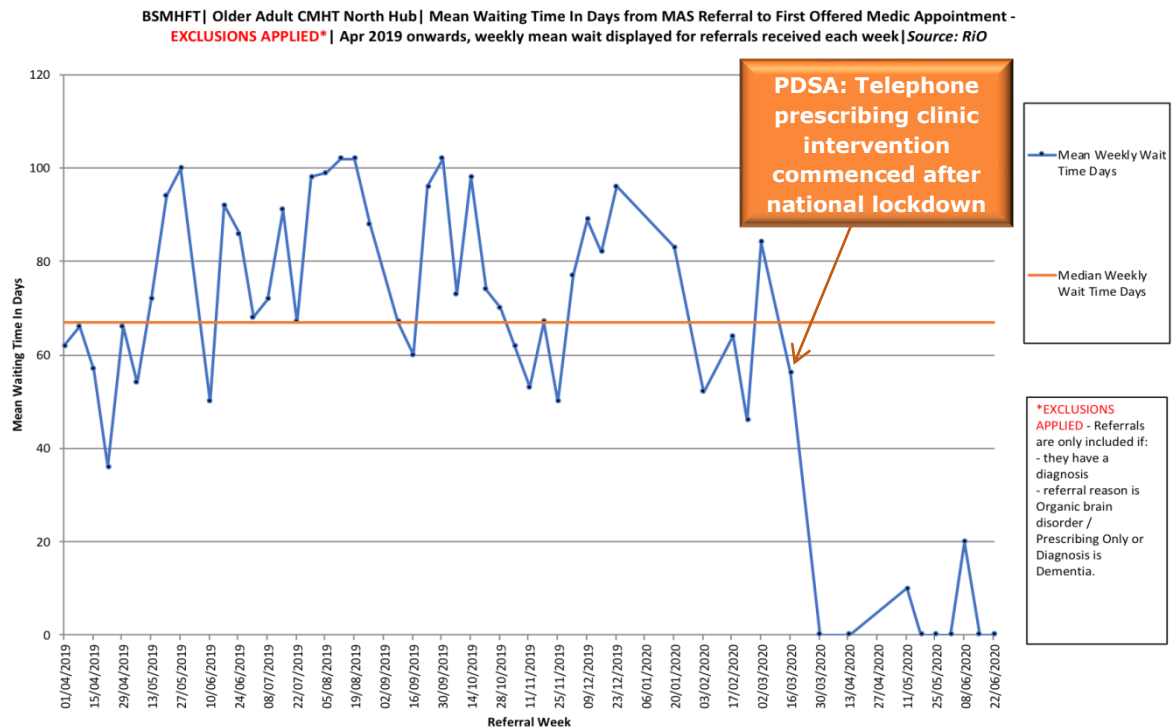
Patient Factors	Primary Care Factors	MAS Factors	CMHT Factors	Other
<ul style="list-style-type: none"> <li>DNA of appointments.</li> <li>Service users requesting more time to consider their options.</li> </ul>	<ul style="list-style-type: none"> <li>Up to date bloods required at the time of prescribing and/or ECG.</li> </ul>	<ul style="list-style-type: none"> <li>Lack of resources resulting in longer waiting times for assessments.</li> <li>Clinicians encountering unexpected medical complexity.</li> </ul>	<ul style="list-style-type: none"> <li>Lack of resources resulting in longer waiting times for assessment.</li> </ul>	<ul style="list-style-type: none"> <li>Waiting time for imaging appointments.</li> <li>Waiting time for images to be reported.</li> </ul>

Various Plan-Do-Study-Act (PDSA) cycles were carried out between August 2019 and January 2020 with limited success. Then struck the Covid-19 pandemic. The next PDSA involving junior doctor led clinics was halted due to redeployment and it appeared the project had seemingly been stopped in its tracks. However, quite unexpectedly, another PDSA emerged, one which previously had not been deemed possible due to MAS being commissioned as a diagnostic service.

The pandemic resulted in a pause in one of the MAS Consultant's research work. He kindly offered to ease pressure on the Trust by using this time to organise telephone reviews to initiate medication after service users were diagnosed by MAS. The Consultant assessed the service user's suitability for medication, before referring to the CMHT and requesting they generate the initial prescription and arrange follow-up. This novel telephone clinic became an unexpected PDSA cycle, and began in March 2020 after the national lockdown was announced. As a result of the introduction of the telephone prescribing clinic, the mean weekly waiting time went from a median of 81 days (between 01/04/19 and 09/03/2020) to 0 days (between 16/03/2020 and 22/06/2020) (Figure 3). The overall median of the mean weekly wait across the entire project was 67 days (shown by the red horizontal line in the run chart below). This PDSA had made a significant impact on the time from diagnosis to initiation of medication.



Figure 3:



As a result of the success of this PDSA, the Clinical Director for the services is now proposing this model of working to commissioners within the Trust. Whilst it is acknowledged that a telephone clinic may not be appropriate for all service users, we have demonstrated that it could be utilised by many. Furthermore, a medication information leaflet, to be sent out with the letter for the prescribing outpatient appointment, is in the later stages of development as a result of feedback from service users and carers. This highlights that despite the undeniable devastation caused by Covid-19, it has resulted in the opportunity, and indeed necessity, to work differently. In this instance, the pandemic resulted in a PDSA which would otherwise not have come to fruition. In doing so, we have been able to evidence an undeniably more efficient way to run services for memory assessment and treatment within the Trust, which, in turn, will also undoubtedly improve our service users experience and outcomes - a silver lining amidst the darkest of clouds.

References available upon request.

# The Mental Capacity Act 2005 and the rebuttable presumption of capacity

Dr David Harmer – CT3 Psychiatry Trainee

Dr Martin Curtice – Consultant Old Age Psychiatrist,

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Issues of capacity in people with dementia are commonplace, and on occasion may make their way to the Court of Protection before being settled. An illuminating 'extremely difficult' legal case of this nature was published in January 2020<sup>1</sup> – providing interesting points of reflection for old age psychiatrists, and indeed all healthcare professionals, in relation to the correct application of the Mental Capacity Act 2005 (MCA). This judgment focussed on s1(2) whereby a person must be presumed to have capacity unless it is established that they lack capacity (the burden of proving incapacity being 'squarely on the shoulders' of the applicants<sup>2</sup>). The judgment noted the importance of this presumption of capacity being a 'fundamental safeguard of human autonomy' which necessitated 'cogent, clear and carefully analysed information before it can be rebutted'.

## The case

The person in this case was QJ, an 87 year-old man, with an established diagnosis of vascular dementia. The judge noted the severity of this to be under some debate, but for some context it was described as being of 'moderate' severity in 2018, with evidence of multiple previous infarcts on brain imaging at the time.

In addition to this, QJ was described as being 'highly frail' and was unable to mobilise without assistance being essentially bed-bound. He had been a resident in a care home for some time. The focus of this case was to determine whether QJ had the capacity to make decisions around the nature and extent of medical treatment that he should receive – from treatment of acute illness, to supplementary diet and nutrition, to being admitted to hospital or not.

At the time of the case, QJ had been admitted to an elderly care ward at a general hospital with a chest infection. Prior to this there were already concerns regarding on-going poor oral intake, which were raised at his care home (for many weeks he had not eaten and was only taking 'miniscule' amounts of food,

Fortisip and water in hospital). It was these issues that sparked the chain of events leading to this judgment. He was under the care of an experienced geriatrician (Dr B) – who contributed a report to the court. There was also testimony from a consultant in old age psychiatry (Dr A) which we will consider first.

### **The first expert opinion**

The opinion from Dr A was given via an initial report to the court, with a further addendum added a day later. This acknowledged the non-contentious proposition that QJ lacked the capacity to decide about welfare decisions regarding residence and his general level of care. It was felt that QJ significantly minimised the impact his frailty had on his own ability to self-care – thus he failed a test of capacity on being unable to weigh up the relevant information.

However, Dr A concluded QJ *did* have capacity to entrust lawyers to act on his behalf in court, and importantly to make decisions around his nutritional and fluid intake and to decide about his medical treatment. It was noted however, that significant steps had to be taken to adapt to QJ's communication needs – as he spoke little (often with a dry and croaky voice due to his poor fluid intake) and would 'tend to shrug, nod or shake his head' to achieve communication. Nonetheless, Dr A felt QJ's non-verbal interaction was still an important affirmative aspect of the assessment, and concluded QJ was capacitous and able to understand and engage with decisions around his diet and medical care.

### **The second expert opinion**

The second expert report was given by Dr B – QJ's consultant geriatrician at the time – whose expertise was noted in acting as the dementia lead for the trust he was working in for nearly 20 years. This second report was requested with an emphasis on three specific areas of capacity:

- a) Decisions around nutrition – both orally and through artificial means such as a nasogastric tube.
- b) Decisions around medical treatment.
- c) Decisions around admitted QJ to hospital.

Dr B acknowledged that QJ had been assessed previously as being capacitous to take the above decisions by Dr A (and also in a previous court case by his GP). The judge noted that Dr A had assessed QJ at his care home in surroundings familiar to him which may have 'created propitious circumstances' for supporting decision-making and promoting QJ's capacity (as opposed to Dr B being disadvantaged in this respect by having to undertake his assessment in the hospital environment).

Dr B reported having lengthy discussions with QJ about oral nutrition and the risks of his continued refusal, as well as the risks and benefits of nasogastric feeding – again noting the difficulty in communicating directly with QJ. He felt that whilst QJ appeared to understand the information related to these discussions at the time, this did not persist and QJ was unable to recall this information after only several minutes. Dr B discussed with QJ the potential life-threatening effects of his refusal to eat.

Dr B also commented on previous opinions related to QJ offering a 'silent protest' at times, where he would refuse to interact at all – thus potentially hampering communication. Dr B noted that such a loss of language skills or lack of cooperation with an interview, or a combination of both was a typical process seen in many dementia patients, which contributed in part to Dr B's conclusion that QJ lacked capacity related to these treatment decisions. The judge cautioned against relying on general claims of behavioural trends across groups of similar patients and that each case required evaluation on their own unique and specific issues.

### **The decision**

The judgment acknowledged this was a finely balanced case. Ultimately the court concluded, on the balance of probabilities (on which all MCA decisions are decided), that QJ *did* have the capacity to make the above treatment decisions – primarily because the presumption of capacity was not satisfactorily rebutted or disproved in this case. Due to the conclusion of QJ being capacitous, best interests (MCA s4) did not need to be evaluated.

Notably the judge stated that:

*'It is important to emphasise that lack of capacity cannot be established merely by reference to a person's condition or an aspect of his behaviour which might lead others to make unjustified assumptions about capacity (s.2(3) MCA). An aspect of QJ's behaviour included his reluctance to answer certain questions. It should not be construed from this that he is unable to. There is a good deal of evidence which suggests that this is a choice.'*

### **Avoiding assumptions**

It is this point which the judge in this case emphasised, and it is worth re-emphasising here. We all know that capacity is decision-specific, yet undoubtedly we are capable of making potentially irresponsible assumptions about such decisions based on broader themes or aspects of a patient, or even groups of patients – on the initial reading of this case the authors could see how such presumptions could easily arise in this case.

Perhaps the real learning point from this case is to remember the principles of the MCA contained within s1. Not only in the presumption of capacity (s1(2)), but also in the principle of taking all practicable steps to help the person in question understand and make that decision (s1(3)). It would have been only too easy to assume QJ lacked the capacity to make these decisions based on a superficial assessment of his lack of verbal input or engagement with the assessment as a whole. Yet the burden remains on us as professionals to make that assessment and offer a specific rebuttal – remembering that the default position in all our patients is that they retain capacity, regardless of the nature or severity of their impairment, until proven otherwise.

This case ended harmoniously with all parties ultimately agreeing to a plan going forward of limited monitoring and oral supplements, with no further acute hospital admissions due to dietary refusal which both respected QJ's autonomy and had regards for his dignity.

## References

- 1) *QJ v A Local Authority & Anor* [2020] EWCOP 7 (29 January 2020)  
accessed via: <http://www.bailii.org/ew/cases/EWCOP/2020/7.html>
  
- 2) *Avon and Wiltshire Mental Health Partnership v WA & Anor* (Rev 1) [2020] EWCOP 37 (16 July 2020) accessed via:  
<http://www.bailii.org/ew/cases/EWCOP/2020/37.html>

## Cochrane Corner

by

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Non-pharmacological interventions for dementia need rigorous evaluation if patients, clinicians and health systems are to invest time and money in them. The number of high quality trials in this area is increasing, but systematic reviewers of specific non-pharmacological interventions still often find themselves unable to confirm or exclude effects for various reasons, including small trials, high risks of bias in many older and some newer trials, and a diversity of outcome measures, which militates against meaningful data synthesis.

These were some of the problems encountered in our recently updated review of *Aromatherapy for dementia* (Ball 2020). A good number of years ago, after positive results from one well-conducted RCT (Ballard 2002), there was some enthusiasm for aromatherapy as a possible treatment for agitation in dementia. This updated systematic review identified 13 eligible studies (RCTs comparing aromatherapy with placebo aromatherapy or with usual treatment) with a total of 708 participants (range 18 to 130), all conducted between 2001 and 2020. The 12 trials which described their setting had all been conducted in care homes or hospital wards. The most commonly assessed outcomes were agitation and overall behavioural and psychological symptoms (BPSD), but reporting was exceptionally poor overall and several studies either provided no usable data or the review authors' confidence in the data was very low. Because data were unsuitable for meta-analysis, the authors had to fall back on narrative reporting of the results of those studies for which they had low or moderate confidence in the results, making valid and informative synthesis challenging. As an aside for interested readers: to address this challenge, earlier this year some Cochrane methodologists and others published guidance on how data in systematic reviews can be summarised when they are not amenable to quantitative synthesis (Campbell 2020). The authors of the aromatherapy review found inconsistent results with the balance of evidence against an effect of treatment on agitation, but in favour of a detectable (not necessarily clinically important) effect on overall BPSD. Results were more finely balanced when only the higher quality trials – those for which they could be moderately confident in the effect estimates – were considered. The implications of the review are perhaps more for research than for practice at this stage. Efficacy cannot be excluded, but further trials are only worth conducting if they are relatively large and rigorously

designed, and if they use validated measures of patient-important outcomes - including harms, which were barely investigated in the existing trials.

Sticking with non-pharmacological interventions, we also recently published a new review on *Personally tailored activities for improving psychosocial outcomes for people with dementia in community settings* (Möhler 2020). There were five studies and 262 participants in this review. As you might expect, the interventions were led by occupational therapists, although in four studies, after assessing the patients, they trained family caregivers to deliver the activities. Here the authors found low-certainty evidence that interventions built around personally tailored activities may reduce challenging behaviour (standardised mean difference (SMD)  $-0.44$ , 95% CI  $-0.77$  to  $-0.10$ ; 4 studies; 305 participants) and may slightly improve the patient's quality of life and caregivers' distress. Other outcomes, for all of which there may be little or no effect of the interventions, were patients' depression, affect, passivity and engagement, and caregivers' burden, quality of life and depression, although the results for most of these outcomes were based on few studies and participants. The review therefore finds some evidence to support the common-sense proposition that it is helpful for patients to have time set aside to support them with activities connected to their own interests and preferences. Is this a valuable result? If we want to argue for investment in occupational therapy services for people with dementia, then it probably is.

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# Research update

by

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## **Living with dementia: increased level of caregiver stress in times of COVID-19. Cohen et al. International Psychogeriatrics<sup>1</sup>.**

This brief report from Cohen *et al* looks at the care of older people with dementia in Argentina, and how the pandemic has impacted this. The rationale for the study came from concerns that there is a significant conflict between what would normally be encouraged as the mainstay of therapies for people living with dementia (including various social and physical activities) and the guidance of reducing in person social interaction to reduce the risk of transmission of the virus.

The study involved a questionnaire given to the family caregivers of 80 people with either Alzheimer's Disease or related dementias who were known to the Aging and Memory Center in Buenos Aires. The questionnaire was delivered online during April 2020. The focus of the questions within the survey looked at anxiety experienced by the individuals with dementia, and this was reported in a subjective manner from the caregiver respondents and not with the use of any specific diagnostic criteria or screening tools. The questionnaire also asked about stress levels experienced by the caregivers. The study used a retrospective "pretest-posttest" design in order to reduce potential responder bias.

The results showed that there was a relatively even distribution of the stages of dementia of the individuals included – approximately two thirds with moderate to severe dementia. The study reports that 48% experienced increased levels of anxiety since quarantine had begun, and that 12 individuals received an increase in antipsychotic medication and 7 required an increase in benzodiazepines. The level of burden experienced by caregivers after 4 weeks of quarantine was higher compared to before, and this was statistically significant in those with severe dementia. Prior to quarantine there was no significant difference in the degree of burden when stages of dementia were compared.

The report indicates that this is the initial phase of research into the effects of quarantine on people living with dementia and their carers, and it is clear on the limitations of this type of small scale survey based entirely on self-report. It does however highlight some concerning, albeit not altogether surprising, indications of increased anxiety experienced by the patient, and increased stress by the carers due to quarantine. The need for larger scale research in this area, and the possible increased use of psychotropic medication for example, is



essential for adapting care for people living with dementia during the pandemic and understanding possible longer term impacts.

**Changing prevalence and treatment of depression among older people over two decades. Arthur et al, British Journal of Psychiatry<sup>2</sup>.**

This paper used data from two large-scale population-based cohort studies of people ages 65 and over performed two decades apart in the UK. The first study, Cognitive Function and Ageing Study I (CFAS I) took place between 1990 and 1993 and the second (CFAS II) between 2008 and 2011.

The methodology of the two prevalence studies was largely identical and involved a screening interview followed by a further assessment interview. In CFAS I this was done as a two stage model with a subset of the screening group selected for the second interview, whereas in CFAS II both the screening and the further interview were done together. Both studies used the Geriatric Mental State examination and the Automated Geriatric Examination for Computer-Assisted Taxonomy algorithmic (AGECAT) approach to make relevant diagnoses, including depression. CFAS I had 7635 participants with 1457 going on to have the assessment interview, while CFAS II interviewed 7762 respondents.

The significant findings of this work include a relative but not statistically significant decrease in the prevalence of depression in older people in the CFAS II. The estimated prevalence in CFAS I was 7.9% followed by 6.8% in CFAS II. Prevalence of depression was highest in women in both studies, but there was no change across the age groups. The use of antidepressant medication was increased almost threefold (4.2% in CFAS I and 10.7% in CFAS II). Interestingly there was a noticeable difference in the two studies when looking at untreated depressive symptoms. In CFAS I 6.8% of respondents met diagnostic criteria for depression but were not receiving antidepressant medication compared to 4.7% 20 years later. Inversely, 2.7% were receiving antidepressant medication but did not meet diagnostic criteria at the time of CFAS I compared to 8.8% in CFAS II. This could of course represent individuals who have been successfully treated and continue on their antidepressant medication.

The study notes important limitations including the fact that psychological therapies were not considered in the data collection, despite there being evidence for them being used more widely during the period of time in CFAS II.

The authors highlight that the natural history of treated and untreated depression in later life remains poorly understood. They proposed possible explanations for the increased use of antidepressants despite there being no significant change in prevalence of depression as perhaps being related to better recognition and subsequent prescribing, perhaps over-diagnosis or treatment of symptoms that are do not reach case level threshold for the study, and the use of antidepressants in conditions other than depression.

**A dose response relationship between accelerometer assessed daily steps and depressive symptoms in older adults: a two-year cohort study. Hsueh et al. Age and Ageing<sup>3</sup>.**

In light of the theme of this edition of the newsletter and the burgeoning research into the impacts on older people of lockdown and quarantine, it is perhaps reassuring to see evidence of the benefits of a simple intervention that can still be carried out in spite of tight restrictions. This two-year cohort study looked at depressive symptoms in older people, as assessed by the Geriatric Depression Scale, and the possible benefits of their daily step counts.

A total of 285 older people were recruited initially in 2012 and 274 of these continued with the second stage of the study in 2014. The participants were split into three groups depending on daily step counts as measured by an accelerometer, and the presence of depressive symptoms was measured again after 2 years. The study suggests that each 1000 step increase in daily walking was associated with reduced depressive symptoms, once adjusted for covariates. In terms of specific step counts, they proposed that 3500 – 6999 steps per day is associated with a protective effect but that 7000 or more steps a day could provide the greatest protection against depressive symptoms.

The study did not look at individuals who met diagnostic criteria for depression and it is therefore important to view results such as these carefully in terms of which groups of older people to whom they might be most helpful. Nevertheless, it is an important reminder of the wide ranging benefits of simple exercise such as walking, particularly when older people are perhaps (but not always) more limited than other demographics due to COVID-19 restrictions.

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# Book Review

By

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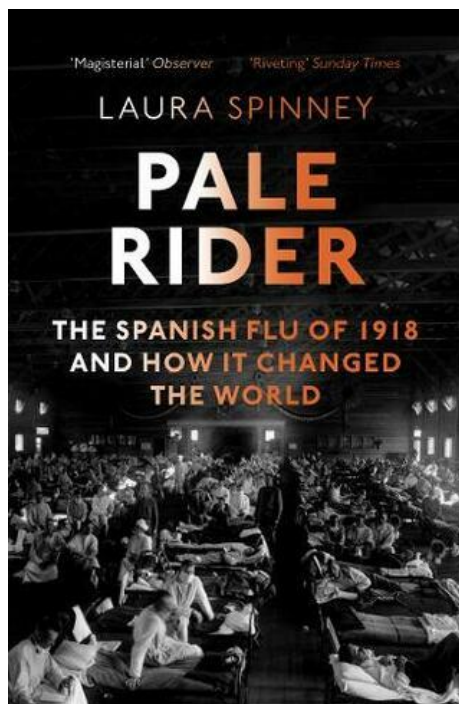
## **PALE RIDER:**

### **The Spanish Flu of 1918 and how it changed the world.**

Author: Laura Spinney

Vintage, ISBN 978-1-78470-240-3

<https://www.waterstones.com/book/pale-rider/laura-spinney/9781784702403>



An historical account of the Spanish flu and its impact on the world is perhaps an unusual choice for a newsletter dedicated to older people's mental health but perhaps appropriate given this month's theme. No doubt, there will be many books dedicated to analysing the current Covid-19 pandemic and responses by various governments in the future, but for now we can learn from the last pandemic.

Laura Spinney's *Pale Rider*, an historical account of the pandemic of 1918, was written two years ago before the world had even heard of coronavirus but this book is eerily prescient. Many of the chapters in the book could easily be describing the predicament we find ourselves in today. The book is a fascinating trip from the origins of Spanish flu in the battlefields of World

war 1 and its spread across the through world through globalisation and the continuing impact through successful waves.

Spanish flu' which surprisingly did not originate in Spain which led to the change in the nomenclature of future pandemics affected young people between the ages of 20 to 40 and spread quickly through marching troops, ships and cross country travel killing millions. The book highlights ,unwittingly, the parallels

between the Spanish Flu and covid-19 for example food shortages in shops , doctors and nurses tending to the ill despite the high risk of illness and death to themselves to the measures taken to control the virus. These measures included quarantine, cordoning of infected people and area, masks to control what was a novel virus at the time.

I would recommend this book not just for Laura Spinney's writing which brings to life a dry topic but mainly for the description of the long term positive outcomes that took place after the pandemic including the start of the idea that eventually became the national health service, the beginning of geriatric medicine, the legalisation of adoption amongst many and one can hope that similar positive changes in society and health could occur in the future as a result of Covid-19.