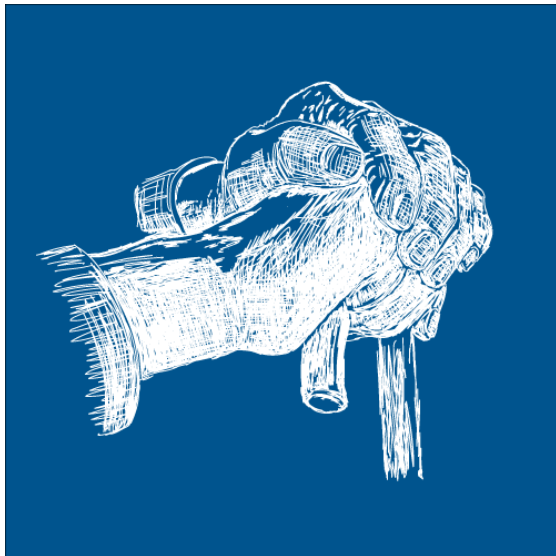




The Old Age Psychiatrist

Issue 77, May 2020

Old Age Psychiatry Faculty
Newsletter



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Update from the Editorial Team

by

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Hello everyone – what a beginning to a new year! We are in unprecedented and very challenging times indeed with COVID19 so hope you are all well and keeping safe. During these very difficult times we hope the articles in the newsletter will provide some food for thought and highlight the great work Old Age Psychiatrists do.

As always, the Chair's update and Prof Alistair Burns update are interesting reads. Unfortunately the Faculty Conference was cancelled this year due to COVID 19 – this was a disappointment for all of us with the exciting programme planned, however the safety of colleagues is paramount hence we look forward to another exciting one next year. The COVID update has information and links relevant to our practice.

The features section is varied with several interesting articles. Dr Martin Curtice writes on Premier League football clubs and their work with older people in local communities. This is the second part – the first one was published in January newsletter. Dr Haggard's article provides interesting contemplation on psychodynamic concepts in liaison settings. The article on creative activities for people with dementias is also very interesting.

For the more research-orientated readers, the usual updates such as Cochrane corner and research updates make good contemplation.

This edition has the top three entries from the essay competition. The topic for this time was 'Through the Ages – History's Role in Today's Old Age Psychiatry'. The Medical Student Essay Prize in Old Age Psychiatry is also published in this edition. The essays are fascinating to read and we hope it will encourage readers to submit for next year's essay competition.

As usual we round off with a film review, which highlights portrayal of dementia in films - the good and the not so good aspects of it.

We are still keen to run a series on Life after NHS for retired or semi-retired psychiatrists. So please contact me if you are keen to write about this.

Before I end, I must extend a special thank you to Dr Amanda Thompsell who will be ending her term as the Chair of the Faculty. She has been an inspiring

leader and advocate for us and will be missed immensely by the faculty and the executive committee members. We do hope that she continues to support the Faculty.

We also extend our congratulations to our new Chair Krish and Vice Chair Josie and hope to be able to continue to work with you.

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

I hope by the time this newsletter is published we would have been over the worst, meanwhile keep well and stay safe.

View from the Chair

by

Dr Amanda Thompsell

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

This, the last of my Chair's summaries, provides me with an opportunity to reflect on the last four years during which I have had the privilege to serve as the Chair of our great Faculty.

It has been an honour to work with so many wonderful colleagues and I would like to say a massive thank you to everyone who has supported me and the Faculty during this time. Not least I want to give a special thanks to the Faculty Executive members who have worked tirelessly to ensure that the mental health needs of older people are never forgotten.



The recent coronavirus has reminded us how events are never fully within our control. It was with great regret that I had to cancel this year's conference, especially when I know how much effort people had put in to preparing their talks and posters. But life goes on and we have already booked our Conference for 24-26 March 2021 in London where we can carry on where we left off. Please get this date in your diary.

With our reaction to the current health emergency at the very forefront of our minds it is easy to forget everything else that we have needed to cope with - and how superb we have been at doing this. These past four years have been a time where external events have had a tremendous impact on us. We have had to quickly adapt to new challenges and opportunities arising from organisational and legislative changes- and we have done so.

One of the great pleasures of the last four years has been how we have strengthened our close collaborative links with Faculties, Colleges and other organisations (regionally, nationally and internationally). We were practicing integration long before anyone talked about an integration agenda and are now well placed to play a leading role in its wider implementation.

But even before the challenges of the current emergency, I remain acutely aware that for all the progress that we have made, things have remained difficult on the ground. Our sub-specialty still does not get the recognition and resources that it deserves and needs. This can sap morale. However, despite this I have been regularly inspired by the determination shown by members who have seized the initiative and developed amazing and innovative services for older people across the four nations. We really are members of a wonderful specialty.

The centralised planning within the NHS now does at least formally recognise the importance of providing for the mental health needs of older people. This augurs well for our patients. Even so we will need to ensure that the promised extra funds reach our services. We need to continue articulating the value of our skills in the meetings where decisions are made. I hope that the various reports that have produced over the last few years (and which are on the Faculty website) will help you in arguing for the resources that your services need.

Developments since November 2019

Here is my usual round-up of what has been happening since my last update in November.

Frail, Lonely and Delirious. Our report on frailty: Position statement on frailty: ensuring the best outcomes for frail older people was published in January 2020. I thank everyone who contributed to it. It clearly demonstrates the value of our skills.

Other publications. In December 2019 the Faculty also produced, in conjunction with the British Geriatric Society, a report on loneliness: Position statement on loneliness and social isolation. Our report on delirium is due to come out in May 2020 but may well get delayed due to COVID 19.

IAPT Campaign. A campaign was launched in January 2020 by Age UK and NHSE&I to raise awareness amongst the public and healthcare professionals of the mental health needs of older people, and of the role of IAPT services in supporting them. A key part of the campaign was to encourage GPs, IAPT services and local charities to work jointly to increase IAPT referrals for older people living with depression and anxiety.

Mental Health Units (Use of Force) Act 2018. We made some progress in inputting to the draft guidance on the application of this new Act, but there remain some issues with troubling implications. We are monitoring the situation.

Section 49 Reports. Many of us have been finding the requirement (on top of our busy schedules) to write capacity reports ordered by the Court of Protection

under s49 of the Mental Capacity Act 2005 very frustrating. I recently went to see Wendy Burn again about this issue and I can assure you the issue is being taken very seriously by the College.

GIRFT. We have been liaising with Ian Davidson, NHSE&I's Clinical Lead for "GIRFT" (Getting it Right First Time"). He is leading the so-called "deep dive" visits of all the Mental Health Trusts to review Community and In-Patient Services for adults and older adults in crisis /needing acute care. Following the completion of these visits (which now will have to be by telephone) he will write a report with recommendations on best practice which will have funding implications. This could involve a significant shake-up of services and it is essential that our voices are heard. To get extra funding we need to give examples of what good can and does look like – this is your chance to show off so please take it. Whenever we hear of any of the deep dive dates we will disseminate them to members via the regional reps.

College Engagement Network. Another initiative by the College is the College Engagement Network (CEN). The CEN will comprise members as agreed by each Trust's medical director) from each of the 53 Mental Health Trusts in England. The CEN will look to improve the quality and delivery of mental health services by supporting College members at a local level. CEN representatives (who will be required to volunteer their time) will advocate for and provide locally professional advice on improvements in mental health services (across all the sub-disciplines represented within the College). The idea is that they will provide two-way communication, disseminating College and Faculty priorities locally and feeding back to the College local concerns so as to influence national policy. The network also aims to develop and maintain local networks, including developing links with service-user groups and other local partners. I urge you to find out who locally in your Trust has this role as it will be key that they understand the needs of older people.

Promoting our strategic aims

Here is a reminder of some of the other things we have been doing to promote our strategic aims during the period November to March.

1. To enhance National and International Profile Faculty of Old Age Psychiatry matters relating to Mental Health of Older people of all ethnicity

The RCGP (supported by NHSE&I) has published "Top Tips around Older People's Mental Health"<https://www.rcgp.org.uk/-/media/Files/CIRC/Toolkits-2017/Mental-Health-Toolkit-2017/Top-Tips-for-mental-health-problems-in-older-people.ashx?la=en>. We have supported this initiative, which is aimed at raising awareness amongst GPs. In a separate initiative the RCGP has produced an animated video on older people's mental health which is also on our website

<https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/news-and-resources>.

I contributed to the College's response to the proposed Primary Care Network Contract and I have also commented on suggestions around possible changes to s61 of the Mental Health Act.

Thanks to the persistent campaigning of Dr Ivenso it is now possible to access a PET scanner for people with dementia in Wales.

I continue to attend NHSE&I's Older People's Mental Health Expert Advisory Group and NHSE&I's Adult Mental Health Steering Group (which has re-formed after nearly a year) along with the National Transforming Adult & Older Adult Community Mental Health Care meeting to ensure that the mental health needs of older people are considered.

2. To attract and successfully retain within old age psychiatry the best doctors for every level of their profession

Excitingly we have had an opportunity (thanks to the Masonic Charity) to award a PHD scholarship. Our congratulations to Dr Donncha Mullin based in Edinburgh who won this against an exceedingly high standard of competition.

The work with ARUK on early dementia diagnosis continues. This is involving both focus groups and analysing the feedback on members' views. As a result of the coronavirus the focus groups have been postponed for the time being but they will be happening and the results will be disseminated.

The Faculty has also approved a new National Trainee essay prize starting this year. This will include a separate prize for CTs and one for STs.

We are currently developing an area on our website with resources for medical students (such as vignettes and videos) so that we can ensure that the medical students can get the best experience they can when they are with our services.

Finally and most importantly Faculty executive members have been working tirelessly in developing a curriculum for our specialty which is fit for the future.

3. To focus on our Membership engagement

Following concerns raised by the regional reps in November that old age psychiatrists are not shown liaison old age job descriptions, Dr Jim Bolton (Chair of the Liaison Faculty) and I wrote to Regional Advisors suggesting that where jobs are being advertised for liaison psychiatry posts that include a remit for assessing older adults the job descriptions should be sent to specialty advisors for both sub-specialties to ensure that the specific issues pertinent to each sub-specialty are considered.

We are continuing our focus on membership engagement with a new annual members' survey (having not done this in 2019), which will take place when this COVID 19 crisis is over. I am optimistic that the survey ultimately will be more useful and have more impact than in previous years as we will have some better tools for analysing the results to produce useful and actionable information.

4. To increase awareness of mental health conditions of older people of all ethnicities.

We are organising a joint one-day event with the BGS in London on 2nd December 2020 (virus allowing).

An APPG (All Party Parliamentary Group) for Older People's Mental Health was to look at older adults' mental health. Unfortunately, it has been a casualty of our recent turbulent political environment and its meeting to discuss this has been cancelled now three times. It would now seem it will be another casualty of the coronavirus.

I continue to liaise with Independent Age who published a report titled "In Focus" using qualitative and quantitative data to investigate the lives of particular groups of older people in England (e.g. carers), through the lenses of health and wellbeing, social connections and financial security. It has also included a focus on mental health and wellbeing which makes interesting reading.

I have been inputting into the position statement led by the Forensic Faculty on community sentencing and Mental Health Treatment Requirement (MHTRs).

Farewell

I want to take this final opportunity to repeat my thanks to all those on the Faculty Executive for their contributions. They are an inspirational group of people and I have felt very privileged to work with them.

Although I have thoroughly enjoyed my time as Chair I look forward to an exciting future for the Faculty knowing that I am leaving it in very capable hands on Dr Krishnan. I have worked alongside Krish on the Executive for many years and I am confident that with his leadership and the enthusiasm of the current and new members that are joining the Executive that the Faculty will go from strength to strength.

Update from Professor Alistair Burns

Professor of Old Age Psychiatry

University of Manchester

At the time of writing this (towards the end of March 2020), everyone was in the midst of the COVID-19 crisis and the restrictions on what we can do and where we can go, have just been announced. I am conscious that by the time you read this (in May 2020), life will have moved on significantly.

What anyone writes at this time risks looking prehistoric in a few days let alone in a few weeks or months and when you read this you will have the advantage of the retrospectroscope to judge what we have done and what we have said.

First and foremost, I would like to pay tribute to the leadership that our Old Age Faculty has shown in terms of communicating with members and providing advice and guidance. In very short order, Amanda and Krish produced comprehensive information on what we should all do during this time. There is always a tension between providing advice and having it codified as official guidance and I think the Faculty have trodden that line extremely well.

In my national role, I have done my best to provide that advice on older people's mental health and dementia (including, of course, younger people with dementia), and have been hugely impressed at the reception that that advice which has been included in guidance, has received. The patients, their families and carers whom we look after are, as we know, among the most vulnerable groups and this point has always been recognised and well received.

As we all know, as clinicians we may increasingly be asked to practise outside our immediate comfort zone, returning perhaps to some of those medical skills which we developed and honed as trainees and junior doctors. There is plenty of advice around about what to do and how we can be reminded about treatment and procedures. The GMC have written to all doctors underscoring the support that they will provide colleagues.

Most important, is the individual support and guidance we get from our professional colleagues across all disciplines. As the quote goes, "*all politics is local*", and often it is that immediate contact with the relatively small number of consultants in our clinical teams and other colleagues, which provides the day to day support – including those lighter moments which help us get through the days. The power of social media here is instant and apparent.

In terms of the advice I have been asked to provide, I appreciate all the comments that people have provided - often at extremely short notice - which has emboldened me to say that things that I have written have the support of a group of us.

In dementia, we highlighted:

- People with dementia being much more likely to develop delirium (perhaps 30 times) and the challenges of managing that with someone with the virus infection
- The issue of going into hospital is frightening enough and alerting staff to, when they can, take a little more time and use a patient centred approach as far as is practical in dealing with someone with dementia - obviously avoiding unnecessary hospital admission has a particular resonance at this time.
- Highlighting the clinical issue around dementia and particularly with understanding what can be quite complicated hand washing regimes.
- Appreciating that a person with dementia may have communication challenges and appreciating the need to identify signs as well as symptoms - as one of my colleagues put it "look beyond words".
- The issue of swallowing difficulties and the risk of dehydration and perhaps aspiration developing chest infections it think was important.

In terms of specific support, the thread was around:

- the needs for community support for people with dementia - perhaps providing volunteers with the appropriate advice when dealing specifically for people with dementia and cognitive impairment.
- The need to be aware of any advanced care plan or lasting power of attorney, which may indicate a person's wishes.
- Looking at the links with the voluntary sector - Dementia Connect and Dementia UK were very good examples.
- Appreciating the additional burden on carers - not forgetting that many of them will be elderly and in vulnerable group will be important.
- Finally, the issue of technology - seen by many as the answer to many things may be important.

End of life care, sadly, is a particular issue and many thanks to colleagues who helped craft the document emphasising:

- The need to be aware of a diagnosis of dementia in someone at end of life,
- The importance of knowledge concerning a health and welfare Power of Attorney and an advanced care plan,

- The prospect of somebody dying without their family or even families and relatives not being able to see a person is particularly important – we know that six out of ten people with dementia die in a care home.
- At end of life care, the concept of a terminal delirium with associated symptoms is important and specific advice should be sought – the British Geriatrics Society has produced information.
- Finally, there is often a concern from people regarding mental capacity and emphasising that this important aspect can be assessed relatively easily I think was a good message.

In terms of older people's mental health, everyone will be aware of the issue of loneliness and the fact that this would increase with the enforced isolation which is needed.

At a personal level, I (and I know a number of colleagues have done the same) began to do my clinics by phone. I was overwhelmed at the positive response that patients and their families had to this with the information that I had I was able to share the diagnosis of dementia over the telephone, something which would have been unheard of even a few weeks ago. People and their families responded extremely positively and it is remarkable the amount of resources and help, including prescriptions, one can gather electronically.

Changing the way we practise affects us all – my revalidation date has been postponed for a year and my car's MOT for three months!

In terms of other things which will emerge after the current crisis, the disease modifying treatments for Alzheimer's disease will be under review but all the work we have done will continue apace.

Picture Quiz

Just before the very significant restrictions on movement were announced, I was able to cash in my Christmas present which was a year's membership to the Penny Farthing Club.

This issue's quiz is a picture of me standing with a nervous smile next to my machine – it is more difficult than you think and the crash helmet came in useful.



The questions are:

- Where am I? Salford, Slough or outside Buckingham Palace?
- What height do you need to be to ride a Penny Farthing?
- How many times did I fall off during my two-hour induction?

Answers

- Buckingham Palace
- Apocryphally, it is 5ft 4in (yes, I am still talking feet and inches)
- 8-10

Old Age Psychiatry in the Time of Covid-19

by

Dr. Victoria Jones (Trainee Editor and Psychiatry Core Trainee), with thanks to Dr. Amanda Thompsell (Chair, Faculty of Old Age Psychiatry and Consultant Old Age Psychiatrist) for her guidance.

As I write this in March 2020, I don't know what the UK will be like when this is published in May. In such uncertain times, I like to be reminded of the kindness, compassion and pragmatism that abound in so many psychiatrists. As a Core Trainee, I personally am reassured and impressed by the leadership and sincere care for others shown by Old Age colleagues as we try to weather this dark storm. This article is intended not to give a round-up of latest news as, by May, it will be entirely superseded by new developments. Instead it will highlight where to go for information, acknowledge some of the changes we have seen so far, and generally serve to express the gratitude that we as junior trainees feel when our consultants continue to lead and inspire in such difficult times.

In terms of information from the Faculty, Amanda and Krish have dedicated a huge amount of time to developing College guidelines for Old Age Psychiatry at this time. The Covid-19 section of the RCPsych website is kept regularly up to date with latest guidance, and can be found [here](#). Furthermore, sweeping changes have been made to Mental Health Act legislation, though at time of writing these have not yet come into effect. Please make sure you have access to the most up to date information and ask if you're not sure. The Faculty are also going to upload useful information sent in by members for everyone to utilize so that we don't have to continually reinvent the wheel; this website can be found [here](#). If members have anything to contribute, please send it to Kitti; it will be reviewed by the Policy department and added to the website if appropriate. Finally, the Faculty are setting up a jiscmail account for members to sign up to for rapid dissemination of information, and the Faculty website will have the latest information on this. Please update Kitti if you change your email address as this mailing list will not be updated automatically in line with the College database.

In addition to generating vast swathes of new information on a daily basis, this pandemic has shown that we as the NHS can change and innovate. At time of writing, we are just a few weeks in however change has come apace to Old Age services. We are now contacting service users by phone to undertake memory assessments and catch up with family and carers; we are holding Tribunal hearings via teleconference; and we are showing that we can, and must, be

flexible and supportive, whatever our grade. Some of these changes may stay for good, as the NHS hurriedly embraces 21st century technology with unprecedented urgency. The pandemic has also highlighted a need to access increased physical health input on the wards at this time, which for some means undertaking new training or refreshing past knowledge. We hope that this will allow us to do the best by our patients and colleagues.

Though at times overwhelming and disconcerting, as well as downright frightening, this pandemic may allow for some positive change. It may lead us to integrate more closely and profoundly with our voluntary sector colleagues; it may mean that society appreciates more deeply the social support which older people might need; and it may remind us that we can be flexible as well as learn new skills. I hope that we continue to look after ourselves as we look after others; that we can scurry away for a few minutes of the day to be in the present and appreciate what we have; and that we can carry on with determination, courage, kindness and compassion, doing the very best we can. It is a privilege to work amongst you, and I am so grateful for everything that we do.

Older people, toffees and forever blowing bubbles, Part 2

by

Dr Martin Curtice, Consultant in Old Age Psychiatry

Coventry and Warwickshire Partnership NHS Trust

This is the second of two articles looking at Premier League football clubs charitable organisations and their work with older people in their local communities. In researching this topic I was helpfully put in contact with the Head of Community for the Premier League whereupon I was able to glean further information from speaking with more clubs in addition to Everton FC and West Ham United FC who were the subject of the first article. This article further describes the depth and breadth of charitable work with older people which include a variety of innovative and sustainable programmes.

Generation Gains

The charitable foundations of Southampton FC and Aston Villa FC, together with a large leisure organisation have been funded by the Zurich Community Trust as part of a programme entitled Generation Gains. This was an initial 2-year pilot study subsequently extended over each site due to its success. The programme was developed in partnership with Bath University as a research partner applying regular outcome measures and evaluation tools e.g. the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).

The Saints Foundation¹

As part of the Generation Gains funding stream the Foundation has provided three apprenticeships to NEETs (people with No Education, Employment or Training). The 2-year programme provides specialist training and qualifications to work with older people; the aim being these apprentices will eventually take on the work of the Foundation to provide programmes for older people with complex needs. The current programme, aimed at socially isolated older people, provides 12 sessions (incorporating group exercises and activities) a week across Southampton in local hubs including bases in sheltered accommodation venues (with some additional council funding support). In total around 270 people attend each week.

The Generation Gains programme is one of four older adult programmes provided by the Foundation. All programmes are free to users and there is no set engagement period, offering long term engagement which can be life-long (they did not want the usual drop off from time-limited interventions which are less

successful in terms of outcome measures). The main area of specialism of the Foundation is now falls prevention having been awarded a 5-year CCG contract for a Southampton cross-city falls prevention service. This will receive referrals from primary and secondary care and other agencies and services such as fracture liaison clinics, A&Es and ambulance services. The Foundation continues to look at long-term development by embedding and expanding current projects and to innovate and diversify into new areas e.g. COPD rehabilitation

The Aston Villa Foundation²

This programme for older people has two main aims – to reduce social isolation and to improve physical activity. The Generation Gains funding stream has enabled the development of an in-reach programme to 10 care homes in identified areas of social deprivation which was initially provided for free. A weekly programme of events is delivered by a small team of four staff. Outcome measures are actively sought so as to showcase the positive impact of the programme which essentially now 'sells itself' to other care homes e.g. mental health and well-being increased by 75%. To make this a sustainable programme care homes now pay towards the on-going running of it.

Burnley FC in the Community (BFCitC)³

Burnley FC is very much part of the social fabric of the town and is steeped in history being one of the founding English league clubs. The charity serves an area of high social deprivation and is closely involved with the club as meeting rooms and resources are used at the football ground. One stimulus for developing older people services was noting the club had a preponderance of older season ticket holders.

The regional award-winning 'Extra time' programme prioritises loneliness and social isolation and aims to increase participation in physical activity among older people. This programme is now for the over-50s having originally been for people over 65 but expanded due to its success. The programme runs a weekly group for 50 weeks of the year as a drop-in format where care home residents can also attend. It is a self-referral programme with close links to 17 GP practices for social prescribing. It provides social activities of a varied nature including mindfulness and learning the basics of different languages. Walking football for over-50s is also part of this programme (and is increasingly popular with other clubs as part of their well-being programmes). BFCitC also runs a monthly Dementia Café. This was initially set up and run in collaboration with the local Alzheimer Society. It has chosen to continue this after the Society needed to withdraw funding albeit it maintains close and supportive links. A Veterans programme is for all ages but has an older adult preponderance.

The charity provides feedback on an annual basis and reports to the Premier League biannually. Recent feedback has impressively shown main aims were

being achieved in that 100% of participants made new friends at the sessions and 92% confirmed the sessions helped them feel less lonely.

The power of premier league charities and older people

The Premier League charity organisations described in both articles are providing impressive support for older people, often life-long. Utilising the association with a football club was viewed as a huge positive particularly when attracting older men and breaking down barriers and stigma to them attending programmes. Everyone I met and spoke with was passionate, erudite and inspiring about their work with older people.

It is imperative these charitable organisations have a solid business base from which to operate. Funding streams often have a shelf life and so these charities are always innovating, looking for opportunities and future planning. All the charities were endeavouring at making programmes sustainable despite often starting off as collaborative ventures and then often needing to continue or even expand from charitable funding alone. The importance of developing good relationships with key stakeholders in the care of older people e.g. local authorities, CCGs, GP practices was paramount. The importance of outcome measures demonstrating sustained positive outcomes from the projects e.g. 12 months after a programme/intervention has finished, is also paramount in being able to develop comprehensive bids and 'sell' future proposals to obtain future funding. Collaboration with Universities in regards to this is also an important element. They all recognised the need to develop life-long programmes was imperative for the older people group as a whole.

All the charities make good use of social media in various forms to advertise and showcase their projects (whilst also trying to upskill older people in the use of social media) – Facebook^{4, 5, 6}, Twitter^{7, 8, 9} and YouTube^{10, 11}. AOI have developed a podcast^{12, 13}. The Saints Foundation are looking at trialling audio delivery of a falls prevention programme and exercises regularly on local radio.

There is much for older adult NHS services to learn from charities like these both clinically e.g. better use of embedded longer-term outcome measures, and, for managers e.g. innovation and future planning. If you are near a professional sports club then see what they do for their local communities and older people; you might be able to learn from them and share knowledge and experience. Also, consider inviting them to talk about their projects with older adult departments and multi-disciplinary teams (everyone I spoke too would be more than happy to do so!). I think there is more than enough established and exciting work already happening between Premier League charities and older people, and no doubt other professional sports clubs, to consider organising a

national conference in collaboration with the Old Age Psychiatry faculty and/or British Geriatric Society and other key stakeholders to enable networking and sharing of good practice.

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Acknowledgements

My grateful thanks to:

- Mr Paul Hedges (Health Projects Manager) from the Saints Foundation.
- Mr Ryan Hollings (Health and Welfare Manager) from the Aston Villa Foundation.
- Ms Abby Turner (Head of Health and Wellbeing) from Burnley FC in the Community.

Dementia and Dialogue: Liaison Psychiatry in Acute Care

by

Dr Matthew Hagger

Consultant Liaison psychiatrist, Camden and Islington NHS Foundation trust

Introduction

Dementia is highly prevalent in acute hospitals. Liaison psychiatry teams are involved with patients with dementia, supporting families and staff. This article looks at psychodynamic perspectives.

Liaison Psychiatry and Dementia

In the UK, Liaison Psychiatry has expanded and it is recognised that well funded and functioning Liaison teams can improve care, support hospital staff and save money. There are multiple pressures with acute hospital staff often having little background in mental health. Liaison practitioners are ambassadorial, feeding back assessments about an individual, challenging stigma and teaching.

Psychodynamics is primarily about relationships, including thoughts and feelings we have about one another with an emphasis on unconscious processes. These ultimately influence our reactions and behaviour in all situations, often outside awareness. Skilful handling and supervision of these can help. Liaison Psychiatry has psychodynamic origins and is complex and multilayered. Teams have to manage various tensions and anxieties. Emotions are being played out about serious illness, life-changing frailty and death. The quality of relationships that the Liaison team builds up with other hospital staff affects the milieu and the way patients are viewed.

The somewhat industrialised nature of modern medicine may worsen the experience for those with Dementia. Striking a balance between individual compassion and organisational efficiency is hard. In recent years various initiatives e.g. John's campaign has been adopted in many UK hospitals to improve dementia care.

The therapeutic nihilism surrounding dementia can be potent but also subtle. It can threaten one's "professional narcissism". People who enter medicine do so mainly altruistically. When working with someone with dementia, clinicians may need to adjust their expectations of recovery. One has to look at a patient's feelings of foreboding, dissatisfaction and loneliness. All staff may identify with

these and act out unthinkingly. This includes ignoring expert opinion or identifying strongly with one family member. A "double jeopardy" has been described in dementia of losing one's mind and being treated mindlessly.

With any referral there is much to decipher: why now? Is something unbearable happening (please medicate them)? What are the emotional reactions in the Liaison team e.g. at handover? Senior members of the liaison team may contain emotions affecting clarity of thought.

Having time and reflective space to think about referrals is really helpful. Thinking rather than unthinking action can provide a brake to manic activity to do everything one can rather than everything one should. Menzies Lyth's words about social defences in nursing staff are as relevant as ever.

Noticing how one feels and reacts when one first sees the person and when with them may give clues. What is and *isn't being said* by the person, staff and families? Personal history can reveal patterns of relationships that are repeating.

Psychodynamic concepts in Liaison settings

"Allen was admitted with a chest infection. Collateral from his family suggests possible dementia and they and staff appear fearful of him....."

Splitting and Projection

These are examples of more primitive ego defence mechanisms, these being unconscious psychological manoeuvres developing early in life to deal with anxieties. They can occur in a moment with a patient or between teams. Projection is attributing an unwanted part of oneself e.g. a thought or feeling onto another. These are then denied and located in another person. For those upon whom the projection is made, they may or may not respond strongly. A strong response implies "projective identification" when the projection has notionally found a "home". Clinicians are all human and may be subject to various projections that they will have to process mostly unconsciously whilst having to continue working. Splitting is about a struggle to manage conflicting parts of oneself. Colleagues may feel very differently about the patient reflecting the split.

A person with dementia who may be in a more regressed, fragmented state emotionally could use these two mechanisms to cope with their own difficult feelings e.g. conveyed by what and how they say something. A resurgence of defence mechanisms in dementia may indicate unresolved conflicts or feelings from early life.

Countertransference

Counter-transference can be taken broadly to be the feelings one has about the patient. There are various definitions of it. The feelings that arise within one can be as a result of the patient's treatment of oneself as a healthcare professional and may reflect relationships from early life.

Empathy with the patient, "tuning in" may be part of counter-transference also. Remembering and reflecting on the feelings one has in a non-judgemental way can be helpful.

Containment

A key factor in dementia care is containment. Older people are usually looked after by younger staff in hospital and this role reversal is challenging. Containment can come from a variety of sources acting in a holding manner for those who work directly with the person e.g. nurses. It can be an ability to hold uncertainty whilst enabling thinking to go on; being receptive and able to re-communicate something back to someone that they can process. A baby or young child needs a containing person who recognises his anxiety and can understand and tolerate it. Decisive action can also be containing. It can also be acknowledging the difficulty of a situation e.g. with the family. Measuring the ability of staff or a service to contain patients and themselves isn't straightforward. Staff that feel more contained in their everyday work will be more "present". Many staff do a very good job of managing their multiple demands but it is very easy to be pulled out of focus.

Narcissism

Psychodynamically narcissism is about struggling to relate to others with all the feelings e.g. envy, separation and dependence that this entails, thinking that one can manage oneself. It is important to consider both patients and our own. Ageing can exacerbate narcissistic type defences leading to rage and scathing refusals of help.

"Acting-out"

Acting out refers to a tendency impulsively to speak or act in a way that is related to an underlying anxiety. It may be aggressive and repetitive. The ability to sit with and think about feelings of hopelessness, disgust or hatred is very important. People will differ in their ability to do this and this relates to containment.

On-going review

Liaison clinicians will often have the opportunity to do this, providing more rounded information about the person to trace an arc of their hospital stay and

lives. Schwartz rounds where staff gather to look at emotional responses to a patient have sometimes focused on dementia. Staff who have provided good care often do many of these things implicitly in their work.

Conclusions

Liaison psychiatry teams hold an essential role in dementia care in acute hospitals. A good service can impact positively on individual patients and ripple beyond. Psychodynamics can enrich this process widening outlooks of all. Containment is probably the most active response in pressurised environments. Psychodynamics considers the uniqueness of an individual and relationships with others in a helpful and meaningful way.

This article is a condensed version of a chapter written by Dr Hagger as part of the book: "Psychodynamic Approaches to the experience of Dementia: perspectives from observation, theory and practice" (Editors Sandra Evans, Jane Garner and Rachel Darnley-Smith) which was published by Routledge in December 2019.

References: a full list is available on request from the author at mhagger@nhs.net

Getting Creative: Improving wellbeing for people with dementia, their care-givers and clinicians

by

Dr Charlotte Allan

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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Overview:

In 2019 – 2020 Newcastle Memory Assessment and Management Service was funded through a Health Foundation 'Innovation for Improvement' Grant to develop Creative Activities for patients, caregivers and clinicians. We developed a new, innovative partnership between an NHS memory clinic and a third-sector organisation, Equal Arts, a local creative ageing charity, to introduce arts-based activities into our clinical pathway.

The problem:

Creative activities have been shown to improve wellbeing and reduce stress in people with dementia and in their caregivers, but are not currently commissioned as a core part of NHS Memory services. Our staff have pressurised schedules and this leaves few opportunities for working creatively or focussing on their own wellbeing, yet supporting staff is critical to the smooth running of our service.

Intervention:

We developed a series of three 'Creative Age' groups for patients and caregivers at Newcastle Memory Assessment and Management Service. Each eight-week group was co-lead by professional artists and clinical staff, who worked together to introduce activities themed around: creative language, cyanotype print-making, working with clay, and glass-work. Simultaneously, Memory Clinic staff were offered the chance to participate in six creative sessions, using activities that mirrored the patient groups.

Results:

Our intervention developed a new paradigm for patients and caregivers, where living with dementia can be a positive experience, and a time for growth and renewal. Participants were proud of their creations, leading to an increased sense of wellbeing and confidence. They looked more relaxed, smiled, and developed peer-peer connections.

Staff sessions increased wellbeing through creating a sense of autonomy, belonging and competence, and encouraging joy at work. Staff had fun and described feelings of optimism and hope. Sessions strengthened relationships between colleagues, and allowed reflection on better communication and engagement with patients.

"I felt relaxed, involved and happy"

Patient

"It was a pivotal moment in his dementia journey and helped him accept his diagnosis, and realise there is life after diagnosis."

Caregiver

"I feel as if I know people in the team better and can communicate on a different level"

Staff member

Main outcomes:

- Increased post-diagnostic support for patients living with dementia, and their care-givers
- Prioritisation of staff wellbeing at work
- Strengthened relationships between colleagues, leading to improved patient care
- New opportunities for staff training, personal development and leadership

Lessons learned:

We were challenged by understanding the cultures of different organisations in respect of clinical governance and practical constraints. We overcame these difficulties through our shared commitment to improving care and support for people living with dementia, regular dialogue and appreciation of the expertise and talents of different professionals.

Next steps:

Experiencing first-hand, the positive benefits of creative activities for patients, caregivers and staff fostered tremendous energy for the projects' longevity. We are embedding creative activities into our post-diagnostic pathways through

training and support for key individuals. The project has had a ripple effect, with staff prioritising their own wellbeing, and we are developing new initiatives to promote resilience and wellbeing in own service, and those within Older Adult Teams in our locality.

Further Information:

A short 3-minute video is available which has further details about the project:

<https://vimeo.com/383579168>

Equal Arts creative Age Programme:

<https://equalarts.org.uk/our-work/creative-age>

Newcastle Memory Assessment and Management Service:

<https://www.cntw.nhs.uk/services/memory-assessment-service-newcastle/>

Innovating for Improvement Programme, Health Foundation:

<https://www.health.org.uk/funding-and-partnerships/programmes/innovating-for-improvement>



RCPsych Old Age Faculty Newsletter Essay Competition 2020

by

Dr. Victoria Jones, Trainee Editor,

RCPsych Old Age Faculty Newsletter team

For 2020, the essay competition theme was 'Through the Ages – History's Role in Today's Old Age Psychiatry'. We were thrilled to receive entries from around the UK as well as further afield and our judges did a fine job in selecting the winner and runners-up. The winners received a monetary prize, as well as, of course, worldwide fame and acclaim (!). We hope to have even more entries next year and would strongly encourage anyone interested to send in their contribution when the time comes.

We had three judges this year, and we are incredibly grateful for their time and input. Please see their biographies below:

Dr. Ross Dunne, Consultant Old Age Psychiatrist

Dr. Dunne trained in Trinity College Dublin (2005) and following Core Training he won a Research Training Fellowship (HRB) in Dublin for research into ECT, depression and memory. In 2012 he was awarded an NIHR Academic Clinical Fellowship (Dementia) in Cambridge, where he completed higher training in Old Age Psychiatry. Since joining Greater Manchester Mental Health Trust (GMMH) in 2015 he has recruited for and run disease-modifier trials in dementia. His clinical role is consultant for a 20-bedded functional and organic later-life unit and locality ECT Lead. In 2018 he became Clinical Director of the Greater Manchester Dementia Research Centre (GMDRC) where he's a Principal Investigator on NIHR and industry-funded trials and cohort studies in dementia and depression. Dr Dunne is also an Honorary Senior Lecturer at the University of Manchester, and he runs national workshops on Parkinson's, Dementia and Palliative Care for the Neurology Academy ©. Dr Dunne is a WEMSI©-trained Wilderness Physician, and if not at work will be up the nearest mountain. He thinks being an NHS consultant is very like navigating in a white-out.

Dr. Claire Hilton, Royal College of Psychiatrists Resident Historian and Consultant Old Age Psychiatrist

Dr Hilton trained in General Practice before moving to Psychiatry. Her MD was on psychiatric complications of sickle cell disease, with the research carried out in Jamaica. She was a consultant Old Age Psychiatrist in North West London for 18 years. Having always enjoyed history, she undertook a MA and PhD in history, completing her thesis in 2014. Her first monograph on the history of psychiatry [*Improving Psychiatric Care for Older People: Barbara Robb's Campaign 1965-1975*](#) was published open-access (Palgrave MacMillan, 2017). Palgrave will also be publishing her next book, *Civilian Lunatic Asylums during the First World War: A study of austerity on London's fringe*, also open-access, later in 2020.

Dr Raghupathy Paranthaman, Consultant Old Age Psychiatrist

Dr. Paranthaman completed his basic Psychiatric training in Liverpool and Oxford. He did his higher training in general adult and old age Psychiatry in Manchester. He gained his Diploma in Geriatric Medicine from Royal College of Physicians of London in 2006. He obtained his MD from the University of Manchester in 2012 after completing a study on late life depression and has published several papers in peer reviewed journals. Dr. Paranthaman is currently the Associate Head of Health Education England North West School of Psychiatry. He has held various management roles in the past including as Lead Consultant, Director of Medical Education and Old Age Psychiatry Training Programme Director.

RCPsych Old Age Faculty Newsletter

Essay Competition 2020 – Winning Entry

Through the Ages - History's Role in Today's Old Age Psychiatry

By

Dr Helen Allis, Core Trainee, South London and the Maudsley NHS Foundation Trust

For the last century, doctors have practiced psychiatry in the shadow of the asylums. The last 200 years have seen the rise and fall of institutions, and the mass movement of psychiatric patients out of hospital beds and into community care. No group was greater impacted by both life in the asylums and deinstitutionalisation than the older adult population; the realisation that older people had specific needs and vulnerabilities led to the eventual recognition of old age psychiatry as a speciality.

Legislative reform during the 1800's resulted in society's most vulnerable becoming the responsibility of the state (as opposed to the local community or parish) and they often ended up in the workhouse, or later, the asylum. Privately-funded and charitable mental asylums had existed for centuries, but state-funded asylums arose in the early 1800's, and by 1845 it was mandatory for every county to have one. The first public asylums were small but by the turn of the century, hundreds of vast asylums housed thousands of people¹. The 1845 Lunacy Act reflected a change in attitude towards the people inside the asylums and these "lunatics" became "patients".

Over the subsequent decades, the asylums continued to expand and conditions in some were notorious. From the 1960s, a swathe of investigations revealed the culture of harmful practice entrenched in institution life, and those on the

¹ The Growth of the Asylum - a Parallel World | Historic England [Internet]. Historicengland.org.uk. 2020 [cited 24 January 2020]. Available from: <https://historicengland.org.uk/research/inclusive-heritage/disability-history/1832-1914/the-growth-of-the-asylum/>

“psychogeriatric” wards fared particularly poorly². Through the first half of the 20th century, psychiatric services continued to prioritise the young and acutely unwell; the conditions of the elderly, often infirm and chronically ill, were accepted as inevitable and irreversible³. They were relegated to the ‘back wards’ and perceived as bed-blockers; when the Bethlem-Maudsley hospital first considered old age services, it was to “relieve the pressure caused by aged and infirm people” on the wards⁴.

In 1961, Enoch Powell made his Water Tower Speech, and a commitment to ending the era of the asylum. The hope had been a seamless move from institution to community care, but the transition was challenging, particularly for the elderly. In the 1970’s, as the asylums were emptied, hospitals filled with older mentally ill people with complex needs who continued to require institutional care. The Department of Health and Social Security and the Royal College of Physicians made recommendations to appoint a psychiatrist with a “specialist responsibility” for older people, but care of the elderly, particularly the mentally ill elderly, was heavily stigmatised throughout the medical profession including within the Royal College of Psychiatrists. Despite the increasing recognition of the need for specialist services, societal attitudes towards the elderly remained negative, and ageism and discrimination continued to influence service provision and policy. This stigma sadly persists today, as highlighted in the Royal College of Psychiatrists 2018 report “Suffering in silence: age inequality in older people’s mental health care”⁵.

Since 1948, the percentage of the population over 65 has almost doubled⁶, and whilst in 1948 the average life expectancy was 68 years old⁷, today a 65-year

² Robb B, *Sans Everything: A Case to Answer* (London: Nelson, 1967).

³ Hilton C. Psychogeriatrics in England: Its Route to Recognition by the Government as a Distinct Medical Specialty, c.1970–89. *Medical History*. 2016;60(2):206–228.

⁴ Hilton C. Age inclusive services or separate old age and working age services? A historical analysis from the formative years of old age psychiatry c.1940–1989. *BJPsych Bulletin*. 2015;39(2):90–95.

⁵ Suffering in silence: age inequality in older people’s mental health care [Internet]. Rcpsych.ac.uk. 2018 [cited 24 January 2020]. Available from: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d_2

⁶ Ageuk.org.uk. 2020 [cited 24 January 2020]. Available from: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/older_life_uk_factsheet.pdf

⁷ 6. [Internet]. Ohe.org. 2020 [cited 24 January 2020]. Available from: https://www.ohe.org/system/files/private/publications/312%20-%20Sixty_Years_NHS_9-2008.pdf?

old can expect to live another 20 years⁸. We are looking to a future where people with mental illness live into their 80s and demand for old age services will continue to mount. The Royal College is vocal in its advocacy for the protection of Old Age Psychiatry⁹ but history has shown us, through their treatment in the institutions, that the elderly and mentally ill are the most vulnerable to marginalisation and neglect. The trend towards ageless wards and services put specialist provision for the elderly at risk¹⁰ and recent investigations revealed “appalling standards of care” in private care homes¹¹. We must be cognisant that ageism remains entrenched in our society, that “combatting ageism is part of the remit of services for older people¹²” and we must be vigilant as a profession that the ever-growing number of mentally-ill elderly are not once again relegated to the back rooms of hospitals and care homes.

⁸ 7. Expectation of life, principal projection, UK - Office for National Statistics [Internet]. Ons.gov.uk. 2020 [cited 24 January 2020]. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/datasets/expectationoflifeprincipalprojectionunitedkingdom>

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¹¹ Murphy S. Companies running 'inadequate' UK care homes make £113m profit [Internet]. The Guardian. 2018 [cited 24 January 2020]. Available from: <https://www.theguardian.com/society/2018/nov/23/revealed-companies-running-inadequate-uk-care-homes-make-113m-profit>

¹² World Psychiatric Association. Old Age Psychiatry, Position Statement. 8. [Internet]. 2020 [cited 24 January 2020]. Available from: http://www.wpanet.org/detail.php?section_id=11&content_id=515

RCPsych Old Age Faculty Newsletter

Essay Competition 2020 – Joint Runner-up

Mary b.1831, Jessie b.1865, Elizabeth b.1901, Alice b.1938

By
Dr Madeleine Rosa, CT3 NHS Forth Valley.

14/05/1901, Mary

It is hopeless. I am to go into the asylum. This is the end. My mind is going. Senility of the mind the doctor calls it. He puts words to this fog that hangs over me. I cannot see through it, my mind is slow. I couldn't answer his questions. I forget what he asked me... He seemed to me so young and cold. The past few months feel like a haze. Just sitting in this chair paralysed by this feeble body and feeble mind. Jessie wept, but I cannot. I accept this now, as I saw my own mother waste away so shall I. She tells me it is a grand building with beautiful gardens but there are no pleasures for me now. I don't expect I shall see the baby again, Jessie will not bring her in to the asylum. I do not blame her. She cannot afford to keep me here so I must be put away. Perhaps it is best if I die and relieve her of the burden I have become.

31/10/1946, Elizabeth

Went to visit mother today. She's barely eating still and for the past week she's been in such a state of agitation the nurses are finding it difficult to manage her. The wards are bursting with other senile patients and mother is taking up a lot of their time. They say she has had to be restrained more than once, she now has so many bruises! It took a while to find her, she was not at her bed, but right up the other end of the ward, pacing backwards and forwards, continually asking to speak to the doctor. She is angry with me for putting her into the hospital and demands to be sent home, but what choice did I have? I've tried to explain so many times that she is ill but she doesn't seem to understand that she's not herself.

The doctor was kind when I finally managed to speak with him, but did not seem to have a plan for her. I told him that she spent some time in the asylum just after the first war and as far as I could remember she had been fine until father died at the beginning of the year. He stated that senility was an inevitable part

of growing older and he had seen other cases, such as mother, where the death of a spouse can set it off. It seems nothing can be done- any treatments like insulin therapy would likely be futile. He spoke of a new surgery called a lobotomy, which had been tried in a few cases of senility, but I don't like the sound of that at all! Oh how I wept! On seeing me in such a state the doctor then said he had a "slightly odd" friend from university, Dr Post, who he will write to regarding my mother as he takes an interest in the senile and he may have some other suggestion. I had to leave then to get back to the factory, they did not pay me this afternoon. I will return next week!

04/12/1975, Elizabeth

Started the tablets today. The doctor says they will make me better but I don't see how anything will help. I've told Alice to stay away and that I want to be with her grandma, Jessie. It's all my fault, I should not have brought her to the asylum. I deserve this.

02/01/2020, Alice

Finally home, not 100% yet but I feel a world away from a couple of months ago. It's hard to remember how things were, but James has said I was in a really bad way. Angela told me to carry on with this diary for now and get my feelings down on paper. It helps a little as James doesn't really like talking about it- can't teach an old dog new tricks! Although my "psychologist" Angela disagrees with this... at least she's trying her best with me. Such a lovely lady, even if she does give me homework to do. Dr Holden came to say goodbye. Nice fellow- he's the one that did my bloods for the ECT. He tells me "older adults" are not for him and he wants to be a forensic psychiatrist. I forget the name of my consultant, they had to get a locum in when Dr Arnold retired and I only saw her for five minutes to discuss my prescription. Covering lots of patients apparently. I don't like to complain though, I know I've been lucky, the ward wasn't so bad really. Yet another tablet to take but it'll have to do. Truly the hardest pill to swallow is the shame I feel about this whole debacle. The terror I felt when I heard that word "detained," I shall never forget it... all I could think of was what my mother went through spending months and months in that hospital. How she suffered! Nothing more they could do for her they said... I don't think psychology even existed for people of a certain age back then; nobody thought it would work, says Angela.

James says Mrs G from next door thinks I was in with pneumonia, I hope she hasn't guessed. At least she won't see me going to and fro from the support group as apparently the funding's just been cut.

I just want to get back to normality now and spend some time with Lucy and Evie, I haven't seen them in months. I owe a lot to them- remembering them stopped me from acting on those horrible thoughts. I barely even remember my

own Granny, she died in an asylum just after the war. I don't like to think of it, thank God things have changed and I can only hope Lucy and Evie never fall victim to this horrible illness.

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RCPsych Old Age Faculty Newsletter

Essay Competition 2020 – Joint Runner-up

Through the ages – history's role in today's old age psychiatry

by

Dr Ayesha Bangash

Consultant in Psychiatry for Older People, Calderdale Royal Hospital

Old age psychiatry in the UK: 1940s to 1950s

The two world wars, increasing longevity and falling birth rates boosted the numbers of older people. Since more women were in employment, it was difficult for them to take on caring roles. It was conceivable that older people would become users of psychiatric services.^{1,2} Until the early 1940s, psychiatrists assumed that all psychogeriatric illnesses were an inevitable part of ageing and therefore untreatable. Older people mainly by-passed assessment wards in hospitals and were admitted to long-stay wards. Potentially reversible physical and psychiatric disorders often remained undiagnosed.^{3,4} Psychiatrists involved in changing beliefs about psychogeriatric illnesses and thus influencing the development of old age psychiatry (OAP) around the world were mostly immigrants to England who had escaped the Nazi regime.^{5,6}

During the 1940s, psychiatrist Aubrey Lewis introduced a geriatric unit at London's Bethlem Hospital, probably the world's first psychogeriatric unit where the specialty of OAP was born. The research of psychiatrist Felix Post showed that depression could be distinguished from dementia and that acute physical illnesses in dementia could induce delirium. Post recommended using a holistic approach to managing psychogeriatric illnesses and advocated the roles of occupational therapy, psychology and social work in advancing the specialty. His teaching and academic success inspired many doctors such as Tom Arie to become psychogeriatricians.^{3,5}

During the 1950s, at Crichton Royal Hospital, Dumfries, rather than admitting older people to long-stay wards, patients of all ages were admitted to acute wards. This approach failed. Older people had different presentations of the same illnesses. Also, mixing the frail and confused elderly with acutely disturbed younger people was not conducive to wellbeing. In response to this issue, psychiatrist Sam Robinson established a comprehensive OAP service in 1958

that included assessment wards, a day hospital, and an outpatient clinic. The model eventually became the standard for a psychogeriatric service.^{4,7}

In England, short-term psychogeriatric assessment units within geriatric departments and long-stay annexes near acute and mental hospitals were formed in accordance with the Ministry of Health's 1950 report 'Care of the aged suffering from mental infirmity'. These were geriatrician-led. Lewis ran his psychogeriatric unit at Bethlem Hospital. This dichotomy in working practices lasted for several years, and may have undermined progress in developing OAP. However, *Services for Mental Illness Related to Old Age* produced by the Department of Health and Social Security (DHSS) in 1972, was formulated by psychogeriatricians in favour of a more community led service independent from geriatricians.⁵

During the 1950s, psychiatrist Martin Roth undertook research concluding that affective psychosis, late paraphrenia and acute confusion were each separate entities and independent of dementia thus laying the foundation for the management of functional illnesses.³

Old age psychiatry in the UK: 1960s to 2019

In 1969, Tom Arie established a joint psychogeriatric and geriatric service at Goodmayes Hospital, Essex and emphasised the importance of community-based treatments for older people.⁶

The RCPsych (Royal College of Psychiatrists) Group for OAP was formed in 1973 in order to implement ideas crucial to the development of the specialty. Despite the growing size of the elderly population over time, policies for older people would appear after those for younger people. Lack of recognition of OAP as a speciality until 1989 guaranteed a shortage of relevant data hence the difficulty in assessing the impact of policies and obtaining resources.⁸ During the 1970s, the DHSS recommended having a consultant psychogeriatrician in each district but progress was slow due to psychiatrists having either little interest in OAP or concern over its future as a specialty.^{3,4}

Mental health services had to be provided on the basis of need rather than age in accordance with the Equality Act that was enforced in 2010. The interpretation of this led to the gradual merging of general adult and older adult services to form ageless services. Psychogeriatric services risked becoming only dementia-led. The potential disintegration of OAP prompted the RCPsych's OAP Faculty to clarify their criteria of older adult services in 2013. It was felt that the criteria obviated concerns about age discrimination while ensuring that older people get their needs fulfilled.^{9,10}

In 2014, Health Education England decided to increase the number of psychiatry posts during foundation training in a hope to increase the numbers of future psychogeriatricians. By 2019, emerging evidence indicated that many ageless

services had reverted back to old age-specific services however a survey conducted by RCPsych's OAP Faculty showed that trainees' concerns over the future of the specialty had affected recruitment rates.^{11,12}

Protecting the specialty and the needs of older adults in the UK

In 2019, NHS (National Health Service) England published the NHS Long Term Plan, a ten-year vision for health services. RCPsych's OAP Faculty announced the launch of "Delivering the NHS Long-Term Plan's ambition of ageing well: Old age psychiatry as a vital resource."¹³ The implications for the Faculty were profound in that additional funding was being arranged to promote geriatric physical and mental health.¹⁴ The Plan focussed on "triple integration" of primary and specialist care, physical and mental health services, and health with social care which RCPsych supported.¹⁵ Arie's 1960s model of psychogeriatric and geriatric service integration had led to improved outcomes for patients.¹⁶ Despite the low numbers of OAP trainees over time, dual old age and general adult psychiatry training was more attractive for ensuring occupational security and broader expertise; OAP trainees being allowed endorsement for liaison psychiatry training in 2016 possibly impacted on dual training recruitment rates.^{17,18} The oldest baby boomers turned 65 in 2011. Psychogeriatric services were advised to adapt to increasing demands for managing late life substance misuse and mood disorders.^{19,20} History has not favoured adequate development of the specialty and psychogeriatric services but perhaps all is not lost. The 1970s adage for an old age psychiatrist was and will always be "occasional militancy . . . to gain for the elderly a fair share of scant resources, to put them to best use, to make do with too little while wheeling, dealing, and fighting for more."²

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Medical Student Essay Prize

Art as a Symptom and a Therapy in Dementia

By

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"So, who's that then?" the nurse asks, holding the notebook up to the light to reveal a self-portrait of a slightly rounder, slightly less wrinkled James.

James stares at it quizzically for a moment, his glasses half way down his long nose, before letting out a quiet sigh of confusion.

"You know, my dear, I honestly couldn't tell you."

James was a seventy-six-year-old gentleman with dementia and COPD who I met during a geriatric ward round in my first year at clinical school. His area on the ward stood out almost immediately as one of the more decorated I had seen in a hospital, the table next to his bed strewn with open notebooks and scraps of paper covered in colourful scrawls and doodles. Having asked a nurse about this observation, she informed me that the ward ran a weekly art workshop for the older patients and that James had taken to these sessions almost immediately, drawing ever varying depictions of both his own face and those of various animals. She commented that although his condition meant that he was often extremely agitated and distressed, repeatedly calling for nurses and doctors to tell him where he was and what was wrong with him, she had never seen James so quiet as when he was drawing. Yet, James' daughter had had no idea that he possessed any artistic inclination whatsoever, marvelling at how her father suddenly had a passion outside of his previous life as a hotel manager and occasional primary school football coach. James himself often forgot that the drawings in front of him were, in fact, his own, instead spending hours on the ward marvelling at them with a confused smile on his face. From this experience, it was clear to me that art had a special place for James in helping him to manage and cope with his dementia, encouraging me to explore the intricate relationship between dementia and artistic creativity.

Introduction

Dementia is a chronic disease characterised by a progressive decline in memory and other cognitive functions. First coined by the French psychiatrist Philippe Pinel (1), the term 'dementia' is often used to encompass an array of patterns of behavioural and neuropsychological deficits – including Alzheimer's disease,

semantic dementia and frontotemporal dementia – with 131.5 million people predicted to become affected by any form of dementia within the next thirty years (2). The disease mainly affects the old age population, generating a risk of 1:6 by the time a person reaches 80 years old (2). Thus, given our aging population, the burden of dementia in the U.K. is already great and only estimated to grow, leaving those affected to lose independence and become significantly reliant on family and caregivers for physical and mental support. In other words, dementia is a disorder that is bound to appear in any medical professional's career, highlighting the importance of gaining a solid understanding of how best to diagnose, manage and support these patients.

In saying that, dementia is not an overlooked disorder. On the contrary, search for the term "dementia" on PubMed.gov and you are met with over 10,000 pages of results, suggesting that dementia does have a solid literature base. Nevertheless, there is still much to be learnt about the disorder and its various forms. In particular, having tried to research the relationship between dementia and artistic ability following my experience with James on the geriatric ward, it soon became clear to me that researchers have paid somewhat little attention to changes in creativity within affected patients. Indeed, dementia is often described and researched in terms of loss - loss of memory, loss of cognition, loss of independence – whereas James showed me that, paradoxically, dementia might also be viewed in terms of gain regarding artistic creativity. This essay seeks to consider the synergistic relationship between art and dementia, focussing on art as both a symptom and a therapy.

Art as a symptom

When considering art as a symptom, it is important to explore how artistic creativity and output change during disease onset and progression. Regarding output, case reports outlined by Bruce L. Miller in the late 1990's paint a picture of patients with frontotemporal dementia becoming newly artistic, as I observed with James. A paper in 1996, for instance, sees Miller (3) recalling a businessman who, despite having never painted before, entered a period of "artistic brilliance" during his battle with dementia, and a similar case saw Victor J. Wightman proceed to paint all over his bathroom and bedroom walls before being diagnosed with frontotemporal dementia and amyotrophic lateral sclerosis (4). Reviews of the literature suggest an anatomical basis for this change in behaviour, with Palmieri (5) positing that in order for frontotemporal dementia to produce novel artistic compulsion, it must be restricted to the anterior temporal lobe (more lateralized in the left hemisphere) while sparing the frontal lobes. Indeed, such patients have been reported to gain all manner of artistic hobbies, including painting, sculpting, photography and even musical activities (5). Similarly, Midorikawa (6) described two patients with semantic dementia lateralized in the left hemisphere that began painting after disease onset, lending support to this neuroanatomical theory.



Artwork produced by Victor J. Wightman, who was diagnosed with frontotemporal dementia amyotrophic lateral sclerosis.

Alongside new onset artistic activity, different subsets of dementia patients have also been known to display different characteristic features within their artwork. Case studies of patients with frontotemporal dementia, for example, often describe artistic output characterised by colour and looseness, displaying high levels of abstraction and distortion.

This was replicated by Rankin (7), who, in the first study to use semi-quantitative methods to compare the visual art of groups of dementia patients and healthy older adults, found that frontotemporal dementia patients' drawings were consistently rated more bizarre and disordered than those of normal controls. While case reports of patients with Alzheimer's disease also suggest being more abstract, this change occurs more gradually, with such patients revealing a declining ability to represent subject matter in a representational fashion as their disease progresses. This is demonstrated remarkably well by considering the work of William Ütermohlen, who, over the course of his battle with Alzheimer's disease, produced a series of self-portraits (see below) that display steady reductions in realism, form and colouristic variation, the latter another classical feature of artwork produced by patients with Alzheimer's. This is also somewhat reflected in Rankin's study, which found that art production by Alzheimer's patients did not show any consistent differences from the art produced by healthy normal controls except in their use of fewer, more muted colours (7). Importantly, the Alzheimer's subjects tested were quite early in their disease progression, and so it could be argued that this is representative of the less pronounced artistic deficits that occur early on in Alzheimer's disease. Admittedly, however, there was no data for patients at a later stage in disease progression, and so this cannot be definitively concluded.



A timeline of self-portraits drawn by British artist William Utermohlen, who was diagnosed with Alzheimer's disease in 1995. The images span from 1967 (far left) to 2000 (far right).

Diagnostically, these differential patterns of artistic creativity could be used as indicators of disease type and stage, which is important when considering disease progression, prognosis and treatment. The development of spontaneous bursts of visual creativity, for instance, might suggest that a patient is suffering from frontotemporal or semantic dementia, a diagnosis that could be further supported by the production of colourful art that lacks realism or form. Conversely, artwork that gradually deteriorates in terms of realism, detail and colouristic freedom would indicate Alzheimer's disease. Most recently, researchers at the University of Liverpool analysed more than 2,000 paintings from seven artists and found that patterns of change in the fractal dimension of the paintings differentiated artists who suffered neurological deterioration from those of normal aging controls, positing that these changes became noticeable when the artists were in their 40s (8). Hence, art might be a useful early diagnostic predictor for dementia.

It is important to note, however, that the current literature base on art as a diagnostic tool is severely limited; not only does the small number of artists investigated in the aforementioned study make the conclusions drawn somewhat tentative, with the lead author herself admitting that she doubts her work points to an early test for dementia, but the characteristic features of artistic output within different types of dementia are not absolute. Willem de Kooning's artwork, for instance, has been used to show that artistic creativity can actually increase in Alzheimer's disease, with similar improvements also seen in other case studies (9). Furthermore, a paper by Budrys (10) describes a patient with the Neuronal Intermediate Filament Inclusion Disease variant of frontotemporal dementia in whom artistic output gradually devolved towards child-like primitivism, similar to that typically described in Alzheimer's patients (10).

Nevertheless, while several standardised clinical criteria for diagnosing dementia already exist that have been found to have good accuracy, most of the diseases causing dementia can only be definitively diagnosed by observing characteristic neuropathological changes on post-mortem examination or brain biopsy, and a report in 2012 estimated that almost 60% of people with dementia have not been formally diagnosed (11). Hence, artwork analysis and monitoring could be a useful, non-invasive diagnostic indicator for dementia, highlighting it as an area worthy of further research.

Art as a therapy

Over the course of disease progression, 80% of dementia patients experience neuropsychiatric symptoms such as apathy, irritability, agitation, depression and sleep disturbances. These symptoms are extremely detrimental to the patient's overall health and wellbeing, having been shown to increase the risks of poorer prognosis, earlier institutionalisation, increased caregiver burden and increased costs of care (12). Although the prescription of "chemical restraints" such as antipsychotics is one option for managing these symptoms, these drugs are not without their risks. Ballard (13), for example, found that antipsychotic treatment in Alzheimer's patients increases the risk of oedema, chest infections, accelerated cognitive decline and cerebrovascular events, while Steinberg and Lyketsos (14) showed that dementia patients taking second-generation antipsychotics display a 1.5 to 1.7 times increased mortality risk. It is not surprising, therefore, that NICE guidelines only recommend offering antipsychotics to dementia patients who are at risk of harming themselves or severely distressed (15), encouraging doctors to instead consider non-pharmacological alternatives. Given this line of argument, art therapy appears well-positioned as a potential non-pharmacological option for treating neuropsychological symptoms in dementia. Although the scientific literature concerning the utility of art therapy in dementia is somewhat limited, the studies that have been conducted over the last two decades generally paint a favourable picture, finding art therapy to enhance quality of life in dementia patients by improving their anxiety, self-esteem, morale, personal satisfaction and sociability (16). So, what is it that drives these positive changes?

Using art as a vehicle for communication

"I concur with the idea that even in advanced dementia there is a person alive inside, and I am committed to finding ways to help get them out."

– Dr. Brad Hyman of Massachusetts General Hospital

First, and perhaps most important, is the ability of art to act as a medium for communication. Time and time again, we are reminded as medical students that communication is key to being a good doctor, forming the heart of any doctor-patient interaction. Yet, we are seldom taught how to approach situations in which a patient might be suffering from declining or diminished communicative abilities, generating barriers and frustration that may compromise the quality of care. Perrin (17), for example, found that people with dementia are significantly deprived of human interaction and that much of their contact is superficial or brief, leading to a growing sense of deprivation, isolation and detachment. Unable to express these strong emotions verbally, dementia patients might attempt to get their message across physically; pacing, for example, serves as stimulation, while agitation or aggressive behaviours might be a response to pain or discomfort (18). Unlike verbal communication, however, artistic ability often remains intact in dementia patients, providing them with a safe platform for self-expression and communication via which they might be better understood and validated by others. Johnson, Lahey and Shore (19), for example, described a case-study of an elderly lady with dementia who would add layer upon layer of paint to her paper during art therapy sessions, finishing with a layer of black or brown paint on days when she was particularly anxious. The researchers noted that the lady generally appeared “satisfied with her painting though unable to verbally express the despair and disorganization that is represented in her work,” highlighting the importance of art as a vehicle for overcoming communicative barriers in dementia.

Using art to encourage social interaction



The National Gallery of Australia's (NGA) Art and Dementia program in action.

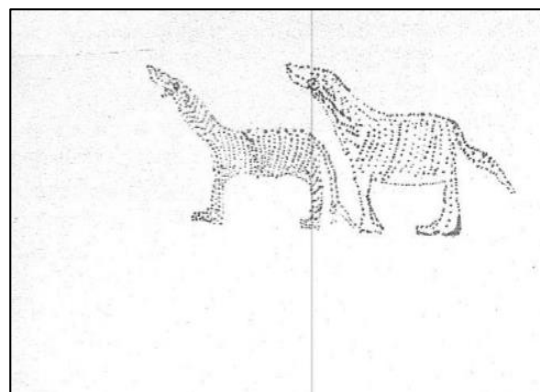
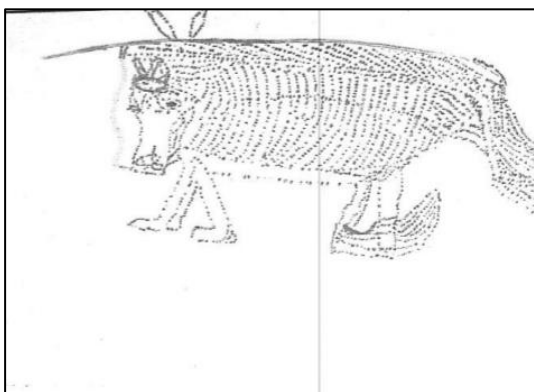
Another potential mechanism via which art therapy might exert its beneficial effects on dementia patients is by promoting sociability. Given the combination of cognitive decline and behavioural aberration, living with dementia can lead to isolation and social detachment by making it hard for patients to maintain and build relationships. In art therapy, however, the presence of an art therapist and other individuals is a simple way of

encouraging social interaction. A paper published this year, for instance, studied an alternative form of art therapy in which groups of up to six people with dementia, along with a carer or family member, attended visits to the National Gallery of Australia for six weeks (20). During these visits, qualified art educators lead discussions on specific pieces of art with the aim of inspiring

meaningful group conversations. By monitoring the patients for six weeks after the intervention, the researchers found a more dynamic salivary cortisol rhythm in response to the art gallery visits, indicating a positive effect on psychosocial stress. This was further supported by questionnaires conducted pre- and post-program, which showed reductions in self-reported depressive symptoms and verbal fluency. Hence, the researchers concluded that this study further supports the notion that initiatives focussed on increasing and encouraging social engagement are integral to higher levels of wellbeing for those with dementia, with art a useful medium for enacting this effect.

The benefits of art could extend beyond the patient

For every patient with dementia, there are several family members or informal caregivers that are often overlooked when considering how to manage dementia. These individuals are frequently deeply affected by the psychosocial and physical costs associated with caregiving, leading to increased psychological and physical morbidity when compared to non-caregiving controls (21). Crucially, dementia there is some anecdotal evidence for this effect in the literature. Kamar (24), for example, described a patient called Steve who had Alzheimer's disease that had significantly deteriorated over the last six months. His wife reported that he was often restless, depressed and verbally abusive at home, making it difficult for her to cope. Following intervention with an art therapist, his wife was equipped with dots on a page that she could give Steve when he was especially agitated or aggressive. Although initially dubious, she reported several weeks later that this strategy was extremely effective at calming him down at home,



Two examples of "dot-based drawings" produced by Steve. (Kamar, 1997)

demonstrating the relief that art therapy can provide to caregivers. In fact, art therapy activities that involve caregiver attendance could provide further benefits, as demonstrated in the aforementioned study of the National Gallery of Australia's Art and Dementia program. Here, carers reported improvements in overall quality of life following the six-week intervention, which was suggested to occur due to social inclusion (20), highlighting art therapy as a means of providing both patient and carer with a route out of isolation.

The beneficial effects of art therapy might stretch even further than the caregiver. Being a psychiatric condition that mostly afflicts the elderly, dementia patients are especially open to stigma stemming from both mental health and ageism. Although a review by the Mental Health Foundation highlighted the limited literature base concerning the community impact of arts activities, such endeavours have been proposed to possess the potential to break down negative stereotypes by raising awareness in the wider community, thereby reducing stigmatising behaviour and fostering social cohesion (25). In particular, creative outputs could help to counter the frequently held assumption that people with dementia are unable to express their individuality in a way that can be understood by others, allowing communities to engage with and comprehend dementia patients on a deeper level. Given that socially inclusive societies are important for the quality of life experienced by people with dementia (26), this community effect could, in turn, help to counteract the negative psychosocial effects often experienced by dementia patients, highlighting the unifying benefits of facilitating dementia patients to communicate through art.

Is all of the evidence positive?

Despite the favourable literature discussed above, the small pool of available research means that a strong evidence base for art therapy's efficacy in diverse dementia populations has yet to be established. This is further limited by the low quality of the current literature, as exemplified in a recent systematic review that concluded that while art therapy might overall be associated with statistically significant positive effects compared with control, the trials available were generally of poor quality (e.g. small sample sizes) and therefore likely to be at high risk of bias, threatening the internal validity of the included studies (27). Thus, a common remark of most reviews currently is the urgent need for a much greater quality and quantity of research in order to draw definitive conclusions on art's therapeutic potential.

It is also important to note that not all the literature concerning art therapy is positive, with several limitations having been highlighted. Kahn-Denis (28), for instance, wrote that "...art may sometimes become yet another layer of confusing activity for the elderly individual," causing patients to become uncomfortable and self-deprecating. Similarly, Harlan (29) observed that art therapy can be met with resistance or withdrawal, often stemming from patients perceiving the activity as "humiliating or infantilising." With careful consideration and training, however, art therapists could be taught a number of techniques to overcome these hurdles. Weiss, Schafer and Berghorn (30), for example, highlighted the importance of determining how much an individual can manage on their own before choosing art media and activities in order to minimise confusion, emphasising that where help is needed, therapists should always look for ways to assist that retain an individual's independence, thereby preventing patients from feeling patronised. It has also been recommended that art

therapists be educated about different types of dementia and the nature of deficits that patients might present with in order to plan activities accordingly (31). To give an example, knowledge of “sundowning” – a phenomenon whereby dementia patients can show sharp increases in agitation towards the end of the day – could prove extremely useful when scheduling session times. Even with patients who are extremely resistant to participation, therapeutic benefit could still be achieved through encouraging them to stay and watch (32), as this provides them with a means for social interaction. Hence, a more systematic approach to art therapy could help to overcome some of these limitations.

Conclusion

As I have outlined in this essay, the link between dementia and art is an intricate one worthy of greater attention. Whether eventually useful as a diagnostic indicator or not, the emergence of artistic ability in patients with dementia deserves recognition as a means of celebrating and validating those parts of the patient that are still intact in a disease characterised by significant loss. Importantly, using art to showcase dementia patients as people capable of mastery, emotion and communication could help to breakdown the stigma often associated with declining cognitive function in old age, demonstrating the potential impact that art could have on wider communities. From a therapeutic perspective, the development of effective non-pharmacological interventions is a major area of development for improving the lives of those with dementia, and art therapy is well placed as one potential option. Despite currently suffering from an under-developed evidence base, the patient benefits observed in published case reports and anecdotal experiences such as mine with James cannot be ignored, and so I would urge my fellow medical students to properly consider creative avenues of therapy as we set out on our clinical careers. As commented by one author (33), “By and large, the overarching goals in being able to successfully work with [people with dementia] includes an improvement in quality of life through increased communication, validation, reminiscence, stimulation and the preservation of identity. What better way to accomplish this than through a creative venue?”

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Cochrane Corner

by

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A departure this time in two respects. Firstly, taking a break from dementia, I am writing about a review published by Cochrane's Common Mental Disorders Group, which is one of our 'sister' groups in Cochrane's Mental Health and Neurosciences Network. Secondly, none of the 10 trials in the review included any older adults. Nevertheless, it addresses a question which is core to our practice, and the lack of any high-quality evidence in our patient group is an important gap to recognise.

The review of **Pharmacological interventions for treatment-resistant depression in adults** by Davies *et al* was published in December 2019 (1) (<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010557.pub2/full>). The authors note various limitations of earlier systematic reviews on this topic, which variously are out-of-date, included non-randomised or uncontrolled studies as well as RCTs, covered only a narrow range of interventions, or used a restrictive definition of treatment resistance. This review looked for the most reliable evidence (RCTs only) and sought to address the pragmatic question of what the next step should be for a patient with unipolar depression who has not responded to a minimum of 4 weeks treatment with an antidepressant at the recommended dose. The age range of patients eligible to be included was 18-74. The interventions could be any of:

- increasing the dose of antidepressant monotherapy;
- switching to a different antidepressant monotherapy;
- augmenting treatment with another antidepressant;
- augmenting treatment with a non-antidepressant.

All of these strategies were compared with continuing the baseline antidepressant treatment. The primary outcomes were change in score on depression rating scales and all-cause dropout.

The review included 10 trials with 2731 participants. This is a disappointingly low number of trials for such an important question. The authors identify the major reasons for exclusion of trials as not applying diagnostic criteria for depression at the time of randomisation and ineligible comparators.

The mean age of participants in the included trials was 42-50 years and 7 of the trials specified an upper age limit of 65. Definitions of treatment resistance varied somewhat, but in most of the trials it was based on inadequate response to 4 or 6 weeks of at least one antidepressant at or above the recommended dose. Only two trials specifically excluded the most treatment-resistant patients, that is those who had not responded to three or more antidepressants during the current episode.

- There were no eligible trials of increasing the dose of the initial antidepressant.
- One trial investigated switching to a different antidepressant (fluoxetine to mianserin). There was no evidence from this trial of an effect on either depressive symptoms or dropout, although the evidence was rated as low quality.
- Two included trials investigated augmentation with a second antidepressant (mirtazapine, mianserin). The trial of mirtazapine augmentation was the only one in the review that was not industry-sponsored. There was high quality evidence that augmenting an SSRI or SNRI with mirtazapine had little or no effect on the Beck Depression Inventory (BDI-II) score (MD -1.7, 95% CI -4.03 to 0.63). Dropout rates were low in both groups: 2% in the mirtazapine-augmented group; 3% in the control group. In contrast, there was moderate quality evidence that augmenting fluoxetine with mianserin probably improved depressive symptoms (MD on HAM-D -4.8, 95% CI -8.18 to -1.42) without evidence of an effect on dropout (19% dropouts in the mianserin-augmented group; 18% in the control group).
- The remaining seven trials investigated augmentation of an antidepressant with buspirone (one trial, no evidence of efficacy) or various atypical antipsychotics: cariprazine (one trial), olanzapine (one trial), quetiapine (3 trials) or ziprasidone (2 trials). The olanzapine trial had only 20 participants, the result was imprecise and the overall quality of the evidence it provided was low. There was high quality evidence for cariprazine and quetiapine, and moderate quality evidence for ziprasidone, of a beneficial effect on depressive symptoms over 8-12 weeks of treatment. The effects on symptoms scales were small and of uncertain clinical importance, although they were backed up by evidence of higher rates of response and – for cariprazine and quetiapine – also of remission. However, dropout rates were higher in all antipsychotic-treated groups than in controls, although this did not quite reach statistical significance for quetiapine.

Obviously, we rarely see depressed patients in secondary care who do *not* meet the broad criteria for treatment-resistance used here. It is sobering to be reminded of the lack of high quality evidence for the drug strategies we might suggest to GPs or use ourselves after referral, including no RCT evidence at all in older adults. It is unlikely that the upper age limit of 74 in this review led to the exclusion of any trials conducted exclusively in older patients; a systematic review on treatments for refractory depression by Cooper *et al* in 2011, which focused on patients aged 55 or older, found no RCTs to include (2). It is also notable that all the 'positive' trials were industry-sponsored.

The Common Mental Disorders Groups also have a 2018 review on **Psychological therapies for treatment-resistant depression in adults** (3) (<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010558.pub2/full>), which is well worth reading alongside this one. It uses the same definition of treatment-resistance and finds some promising evidence that psychotherapy as the 'next step' after a failed trial of antidepressant monotherapy may be beneficial, although again the evidence base excludes the older population.

1. Davies P, Ijaz S, Williams CJ, Kessler D, Lewis G, Wiles N. Pharmacological interventions for treatment-resistant depression in adults. Cochrane Database of Systematic Reviews 2019, Issue 12. Art. No.: CD010557. DOI: 10.1002/14651858.CD010557.pub2.
2. Cooper C, Katona C, Lyketsos K, Blazer D, Brodaty H, Rabins P, et al. A systematic review of treatments for refractory depression in older people. American Journal of Psychiatry 2011;168:681-8.
3. Ijaz S, Davies P, Williams CJ, Kessler D, Lewis G, Wiles N. Psychological therapies for treatment-resistant depression in adults. Cochrane Database of Systematic Reviews 2018, Issue 5. Art. No.: CD010558. DOI: 10.1002/14651858.CD010558.pub2.

Research update

by

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Prevalence and correlates of major depressive disorder, bipolar disorder and schizophrenia among nursing home residents without dementia: systematic review and meta-analysis

Fornaro et al, *The British Journal of Psychiatry*, Jan 2020 edition (online first – March 2019)

The number of elderly people residing in nursing homes is increasing, and uncertainty exists regarding rates of major depressive disorder (MDD), bipolar disorder and schizophrenia within this population.

This study carried out a systematic review and meta-analysis of prevalence and correlates of MD, bipolar disorder and schizophrenia spectrum disorder among nursing home residents who did not have dementia. Electronic databases were systematically searched, and 32 observational studies identified 2110 people diagnosed with MDD (out of a total 13394 nursing home residents). This resulted in pooled prevalence of 18.9% ((95% CI 14.8 – 23.8). Paucity of data meant that prevalence of bipolar or schizophrenia spectrum disorders could not be reliably pooled.

This review was limited due to the high heterogeneity of the studies and populations included, and furthermore the authors identified further need for additional information with regards to potential confounding factors (including non-psychiatric medical comorbidities and pharmacological resources used). Overall the study concluded that MDD is highly prevalent amongst nursing home residents without dementia, and mental health resources focussing on prevention, early recognition and management of MDD are warranted.

Clinical effectiveness of the START (STrategies for RelaTives) psychological intervention for family carers and the effects on the cost of care for people with dementia: 6-year follow-up of a randomised controlled trial

Livingston et al, *The British Journal of Psychiatry*, Jan 2020 edition (online first – July 2019)

The START intervention reduced symptoms of depression and anxiety of carers of relatives with dementia over a 2-year period and was found to be cost

effective. This follow-up aimed to assess clinical effectiveness and impact on costs and care home admission 6 years down the line. The initial trial was a randomised, parallel group, superiority trial with carers of people with dementia randomised either to START (manual-based coping intervention) or to treatment as usual. The primary outcome was affective symptoms as determined by the Hospital Anxiety and Depression Scale, total score (HADS-T). Secondary outcomes included service cost and care home admission. 6-year follow-up showed that, compared with treatment as usual, the intervention group showed significantly improved scores on HADS-T. Patient- and carer-related costs were not significantly different between the two groups. The paper concludes that START is clinically effective, and this effect is still present 6 years on. This is the first intervention of its type with long-term clinical and possible economic benefit.

Changing prevalence and treatment of depression among older people over two decades

Arthur et al, *The British Journal of Psychiatry*, January 2020 edition (online first – October 2019)

Depression is a leading cause of disability worldwide and older people are especially susceptible to poor outcomes. This was a retrospective cohort study investigating whether prevalence of depression and antidepressant use have changed over the course of two decades amongst older people. This study used data from the Cognitive Function and Ageing Studies, which included information from two population-based cohort studies of people aged >65 years with baseline measurements for each cohort conducted two decades apart (1990-1993 – CFAS I, and 2007-2011 – CFAS II). Depression was assessed by the Geriatric Mental State examination and diagnosed with an automated algorithm.

The results showed a non-significant decline in age-standardised depression prevalence between CFAS I and CFAS II. However, at the time of CFAS II, more than twice the proportion of the population were taking antidepressant medication than in CFAS I (risk ratio 2.79, 95% CI 1.96 – 3.97, $P < 0.0001$). Among care home residents, prevalence of depression was unchanged but use of antidepressants increased from 7.4% to 29.2%. This study concluded that there was a substantial increase in proportion of the population taking antidepressant medication across the two decades for people >65 years, however there was no evidence for a change in age-specific prevalence of depression between the two cohorts.

Film review: Head full of Honey (2018)

reviewed by

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Director: Til Schweigerid

Head full of Honey is an English language remake of the 2014 German hit of the same name. This film is a comedic drama about a road trip with a difference - a 12 year old girl travels across Europe with her Grandfather, Amadeus, who has dementia. Her aim is to help remember by taking him to Venice where he met his late wife.

There are moments of authenticity in Nick Nolte's depiction of Amadeus, a vet becoming increasingly aware of his deteriorating memory. His eulogy at his wife's funeral is a checklist of common symptoms such as word finding difficulties, tangentiality, repetitiveness and some disinhibition. A move to his son's house in England produces some great scenes of him almost burning down the house when he bakes her favourite cake for his late wife and the aftermath of this incident.

But as the film progresses Amadeus' symptoms appear to be out of context to the stage we would normally expect in dementia – particularly when he smears butter all over his face at a restaurant but then is able to have an insightful conversation about his memory loss with grand-daughter soon after this.

I found myself becoming irate at the how Doctors were portrayed in the film. For example a specialist in chest problems discusses how to manage a person with dementia with a 12 year old girl who has turned up to her appointment unaccompanied, as her grandfather had forgotten to take her. This in turn leads to the unplanned road trip to help heal her grandfather's dementia. When Amadeus's son finally takes him to a specialist, wearing a white coat, there is no actual history taking, or cognitive testing before a diagnosis is made. I was taken aback by the portrayal of the police's unsympathetic attitude when Amadeus's son tries to report him and his granddaughter missing in contrast to the well-co-ordinated response from my local police when a vulnerable older adult goes missing. These are striking inaccuracies given the film is set in England.

The film highlights several issues such as carers' stress, how do young grandchildren cope with dementia and the impact of dementia on families with great flair but the solution suggested is a cinematic ideal.

I would recommend watching this film for its beautiful cinematography but not for an accurate portrayal of a person's journey with dementia.