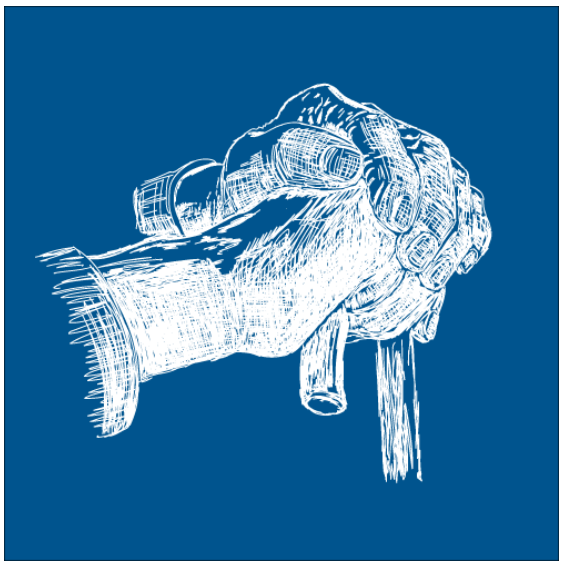
The Old Age Psychiatrist

Issue 75, September 2019

Old Age Psychiatry Faculty Newsletter



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In this issue

Update from the Editorial Team

by

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September always seems like a time of opportunity and new beginnings, and this newsletter is full of both. We hope you will feel inspired, not just by what you read, but also by the opportunities open to you.

Our feature article this time is from Martin Brown, Volunteering in (Partial) Retirement, who has been discovering that there are opportunities to learn new skills at any time in your life and commending volunteering not just in retirement but also early in your career.

If you are still in training you might also like to consider the role of Faculty Trainee Representative.

Our faculty supports a range of prizes and bursaries, so if you are interested in entering for a prize or considering the new PhD Studentship in Old Age Psychiatry, you can find more details below.

If research is more your interest, there are research grants available from the Dunhill Trust, and you can find more information below. If you are interested in published literature and research, the College Library is able to offer you support.

Finally, if education is what you are seeking, this autumn, Alzheimer's Research UK will host their inaugural Clinical Conference as part of their work through the Dementia Access Taskforce.

So, while you contemplate all those opportunities, you might like to read the view from our Faculty Chair, Amanda Thompsell, the runners-up in this essay competition, and our usual integration update, research update and Cochrane corner. As usual we round off with a book review.

Let us know what you think of the newsletter, and, as always, we love to receive articles to consider for future newsletters.

View from the Chair

by

Dr Amanda Thompsell

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

As the NHS Long-Term Plan moves into its implementation phase, with the recent publication of the NHS Long-Term Plan Implementation Framework the implications for psychiatry (in England) in general, and for old age psychiatry in particular, become clearer. The implications for our Faculty are profound - large amounts of additional funding are being earmarked to promote different aspects of the health of older people, with focuses that include ageing well, community response models, primary care networks, frailty, dementia and long-term conditions.

These are all areas where old age psychiatrists have the experience and expertise to lead. Your Faculty sees its job as to make sure that this is realised and we have been working on various projects that highlight the needs of older people and our ability to innovate to meet those needs.

So much is going on that I scarcely know where to begin, but here is a taster of some of the things currently in progress or recently completed.

We have completed the work on Health Education England's core competencies for older people's mental health and this is now being piloted.

We have been writing a report on frailty which should serve to remind people of the leading role that old age psychiatrists have in relation to this topic.

We have been active in consultations concerning changes to the Mental Health Act and the implementation of the recent amendments to the Mental Capacity Act. Dr Hugh Series has been continuing to support the Faculty with the Liberty Protection Safeguards Code of Practice and is drafting the section relating to capacity.

We have also been active in promoting the various important reports that we have been involved in. These include:

- CR222 *Caring for the whole person. Physical healthcare of older adults with mental illness: integration of care* which was produced with help from our Geriatrician colleagues.
- *CR218: Bridges not walls: Good practice guidance for transition and cooperation between mental health services for older patients*
- *PS02/19: Position statement on the provision of liaison psychiatry services across the lifespan* - a report produced by Liaison Faculty but which they kindly involved us with.

Whilst all of this has been going on we have made sure that we have not lost focus on our strategic aims, and some of the activity with this in mind is summarised below.

To enhance the national and international profile of the Faculty of Old Age Psychiatry on matters relating to mental health of older people of all ethnicities

We have been engaged with colleagues in other disciplines and with voluntary organisations to combine efforts for the greater good of older people. Some recent and ongoing examples include:

- I continue to attend NHS England's Older People's Mental Health Advisory Group and Older People's Forum to help ensure older people's mental health is considered - this is especially important given the ageing well agenda.
- We have been working with the Neurological Alliance and on an opinion piece with the Association of British Neurologists on the potential benefit within particular disease areas of a combined approach to service provision. I attended the Mental Health and Neurosciences Leaders Away Day run by NHSE's National Neuro Advisory Group to discuss the interplay between neurological conditions and co-morbid mental health conditions and our role as old age psychiatrists.
- I attended a roundtable discussion arranged by The Richmond Group (a collaboration of 14 of the leading health and social care organisations in the voluntary sector) on frailty.
- We have had some encouraging media coverage in relation to our paper that challenged stereotypes about older adults (especially in relation to accessing eating disorders) and we have been continuing to raise the issue of the impact of alcohol on older people in several interviews and articles.

- Finally on this point, members of the Faculty Executive are contributing to an upcoming College report on autism and another on personality disorders and psychological therapies, ensuring that these specifically consider the needs of older people.

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

Part of our role is to explain and promote the exciting and fulfilling career that is old age psychiatry. With this in mind:

- We are working on the video to explain the role of old age psychiatrists.
- We are working on a document that will consider the key role of Old Age Psychiatrists in delivering the long-term plan
- Again, looking to the future, we have been working with the Alzheimer's UK on a research project involving a survey and focus groups. This should help us get a better understanding of what the future could look like if new treatments are developed. All members of the Faculty should be receiving a survey form and I would encourage you to complete and return this, please.
- Finally, on this topic, I am very pleased to report that The Masonic Charitable Foundation has generously agreed to fund a PhD Studentship in Older Peoples' Mental Health.

To focus on our membership engagement

Our annual Faculty survey is one of the most important ways we have to ensure that we are reflecting what our members want. We have simplified the form and it should be with you after the summer. Please could I encourage you to complete this.

Even though I, for one, am still energised after hearing the ideas from our last Faculty Conference, it is already time to start planning the next one. This will be in London in March 2020. Some of the ideas are a session on data and one on ECGs. Any further ideas would be welcome. Following feedback, it has been agreed to reinstate a more social element to this - maybe something more exciting than the traditional dinner. Jack the Ripper tour anyone? Again, if you have any ideas, we would be pleased to hear them.

On the question of conferences, there are a few other interesting meetings coming up.

We have a European refresher course for Consultant Old Age Psychiatrists in Nottingham with the European Association of Geriatric Psychiatrists on 3rd and 4th October. It has a great line up on international speakers and the price has been kept as low as possible.

The College Quality Network Older Adult Mental Services is holding its' Annual Forum on 15th November 2019 and it is going to be about Looking at the Older Adult Mental Health Landscape: What the Future holds for in-patient services? The theme will be around Innovation and Adaptation

Independent Age's inaugural conference will take place on 17th October 2019 in London. This is going to have a dedicated section on older people's mental health.

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

We work closely with other organisations to get our message out about the mental health conditions of older people. Some recent or ongoing examples (in addition to others mentioned above) include:

We have been working more closely with RCGP and their two clinical fellows in raising awareness of mental health issues in older people and they have been making presentations to other GP colleagues and developing "top tip" advice.

There is ongoing work around psychological approaches for BPSD with the British Psychological Society.

I spoke at the Faculty for the Psychology of Older People (FPOP) British Psychological Society conference on age inequality and they are producing a report on age inequality

We have continued to liaise with BGS who helped promote our report on the need for physical health issues and are also working with BGS on a one-day conference in Autumn 2020 and a position statement in relation to loneliness

We have been liaising with The Diabetic workstream of NHS England and hopefully they will have a section in their report about older adults.

Final thoughts

I was delighted to be asked to present one of the awards at the first national awards for Older People's Mental Health and Dementia held by the Positive Practice in Mental Health Collaborative on 11th July in Bristol. These awards are intended to showcase the great work undertaken by older people's mental health and dementia services. I found this to be an awe-inspiring event. It was impossible not to be impressed by the dedication and leadership shown by the old age psychiatrists and their multidisciplinary teams in meeting the complex mental and physical needs of the older people in their care.

The occasion made me question why as a profession we have been so diffident? We should be shouting about the quality of mental health care that we give to older people and the holistic approach to care that we provide.

With the NHS Long-Term Plan moving into its implementation phase, and with old age psychiatry being central to its focuses on mental health, on older people and on integrated care, now is the time for us to find our voice.

Volunteering in (Partial) Retirement

by

Dr Martin Brown

Consultant Old Age Psychiatrist

Retiring from full time NHS work has given me the opportunity to take on new challenges. At the Old Age Faculty business meeting in March 2017 someone had advocated for a charity by the name of Dementia Adventure (DA). I had never heard of them before, and subsequent discussions with many colleagues working in Hampshire confirmed I was not alone.

Dementia Adventure, as the name suggests, is a charity running holiday opportunities for people with dementia and their carers. Additionally, they are increasingly involved in a wide range of educational initiatives, to carers and a range of other organisations. In 2018 DA offered 33 holidays which supported approximately 120 people living with dementia and their carers. The holidays take place in a wide range of settings around England and in late 2018 DA ran two holidays for the first time in Portugal. Each holiday is led by an Activities Coordinator (an employee of DA) and in addition to the people living with dementia and their carers, the holiday is supported by three volunteers.

Dementia Adventure hold an excellent two-day induction course in their headquarters in Essex, mandatory for all regardless of professional background. At the induction I attended there were student nurses, a social worker specialising in Learning disabilities, an Occupational Therapist from an Old Age Psychiatry background and the former chief executive of a children's hospice. The first day included sessions on "what is dementia", communication, managing practical dilemmas encountered on holidays and an excellent practical session on living with perceptual impairments. The sessions were all delivered in a skilled fashion. The second day was primarily on managing first aid, CPR, choking and other issues. This was delivered by a man whose enthusiasm at 5.15 was no different from what it had been at 9.15. It was of much higher quality than the yearly mandatory training I have experienced in the NHS. It included practical sessions on safe use of wheelchairs, enlightening for someone who has limited hands on experience.

The holidays in England are five days in duration, Monday to Friday. In the last 12 months I have attended two holidays, firstly to Ireby in the Lake District and secondly to Devon. One of the couples (a man with early onset Lewy Body dementia and his partner, a nurse) by chance were attending both holidays. The other six people living with dementia encompassed a wide range of ages, diagnoses, level of dementia and physical health needs. On the second trip, one young lady was present aged in her late 20s with a progressive neurological

syndrome secondary to a lipid metabolism disorder. In the Lakes two of the ladies were wheelchair dependent and needed personal care twice a day and this was arranged privately and went without hitch. Not surprisingly arranging care is not always as straight forward and DA welcome nurses and student nurses as volunteers who might be able to provide some personal care.

The activities were varied and there was always a Plan B when the weather did not behave. On the Lake District break the experiences included an ascent of Latrigg, a steamer boat trip on Derwent water, a visit to a slate mine, a visit to an alpaca farm, picnic lunches at beauty spots and a visit to the Keswick Pencil Museum (home to the Guinness records certified world's biggest pencil!). The ascent of Latrigg to get spectacular views of the lake neatly shows the attitude of DA to inclusivity. The fact two people were in wheelchairs did not stop both making the ascent with a mixture of pushing and pulling. At the pencil museum a member of the public tried to read the motif on our Dementia Adventure tee-shirts. Her belief was that the DA stood for "Determined and active", which whilst not being what was printed on the shirts was a rather apt way of describing the attitudes to any unexpected challenge. In Devon visits included Sidmouth Donkey Sanctuary, to local gardens and a river cruise on the Ex.

My experiences have been immensely positive. Although I had personal family experience of family members with dementia, this was so different from the normal clinical contact with patients and carers one gets in the day job. I learnt so much from immersing myself in people's lives for a 5-day period. Obviously, your time is given for free but DA ensure that all volunteers would not be out of pocket for expenses.

We all know of patients and carers for whom regular holidays have been a pleasure in retirement and who resent the loss of opportunity that the advance of dementia entails. On my breaks there was

only mild agitation, this in itself was an interesting exercise in the flexible use of distraction. But on some trips some people living with dementia present with significantly more agitation but the team have the skills to manage most situations. Only once in the previous two years was the decision made to abandon a resident's holiday on the account of their perplexity. Contrary to the anticipation that the different environment would cause all sorts of issues, it was a real pleasure to see both the people living with dementia and their carers grow in confidence as the weeks progressed.

Any drawbacks? None really, though one lesson I had to learn is that of course I was not there to be a doctor. Inevitably carers are keen to discuss various issues. It did strike me that perhaps a couple of people were not necessarily on the best medications, but I had to be careful to talk in general terms rather than being too suggestive of future management options.

My purpose for writing the article is I suspect many colleagues will have shared my lack of knowledge of this organisation up until now. I recommend sign posting your patients and carers to their website in the hope others can benefit as much as those I met. The holidays are heavily subsidised with guests paying about one third of the cost for their first holiday in a given year. Secondly, I would commend to any colleague the opportunity to be a volunteer, it will give you skills you may never have had before and it is certainly an experience I wish I had at the beginning of my higher training rather than the end of my consultant career.

Further reading: Living well with dementia (Lancet Neurology)

Vacancy – Faculty Trainee Representative

by

Helen Hopwood

ST5 Camden and Islington

In November 2019 my role as one of the Faculty's trainee reps will be coming to an end. We are looking for an enthusiastic volunteer to take over and help out the other rep, Dr Chloe Pickup (Med Ed Fellow in North East London). Chloe will be continuing until March 2020, which is the Old Age Faculty conference, where a new rep will be selected.

To give interested readers a flavour of the work, we participate in meetings with members of the Executive Committee (with oversight to the whole faculty) and Special Advisory Committee (who are responsible for training issues) – the date of the next Exec meeting is 26 November. We are part of a team organising the trainee day of the Old Age Psychiatry conference in March, which will be held in London.

We are producing an exciting video along with Choose Psychiatry to help recruitment into the speciality.

Finally, we are currently in the early stages of developing a Good Practice Guide for Foundation training posts, to help improve Foundation trainees' experience of the speciality. A replacement trainee rep would be immensely helpful in helping to continue these projects. I have found my time so far (18 months) as rep very enjoyable, insightful and rewarding, and can highly recommend the role.

Those who are interested (ST4 and above), please express your interest to helen.hopwood@doctors.org.uk, chloe.pickup@nhs.net or alex.bailey@nhs.net.

Old Age Faculty Prizes and Bursaries

Forthcoming deadlines

- 21 October: Lifetime Achievement Award - This award is to honour the career of an individual who has made an outstanding contribution to the field of older people's mental health. The award is nominations-based.
- 31 October: Overseas bursary to attend the Faculty Residential Conference in March.
- 1 November: Felix Post Prize - essay prize for consultants or non-consultant grade career psychiatrists, working in non-academic units. Prize: £500
- 1 November: Philip Davis Prize - essay prize for Foundation Doctors who are Associate Members of the College, CT 1–3, ST4–6 or members of the College below the rank of consultant psychiatrist. Prize: £300
- 31 December: Medical Student Essay Prize. Prize: £250

New PhD Studentship in Old Age Psychiatry

The Masonic Charitable Foundation (MCF) funded PhD Studentship in Old Age Psychiatry

The Royal College of Psychiatrists is pleased to offer the Masonic Charitable Foundation funded PhD Studentship to support for 3 years a UK based trainee psychiatrist to complete their PhD/MD.

The MCF is committed to supporting research in older people to gain a better understanding of the issues relating to mental illness in older age. The topics are given below only as examples:

1. Gather and analyse prevalence data of depression in the older adults living in care homes and the community.
2. The impact of frailty and/or loneliness on the mental health of older people.
3. The association between other diseases or disorders (such as diabetes) and the prevalence of mental illness in older adults.
4. Define and assess approaches on how best to educate care home staff to recognize depression in the older adult and provide treatment.

More details are available on the College website

Applications via email to Kitti Kottasz by 31 October 2019.

Dunhill Medical Trust

by

Kapila Sachdev

Consultant Old Age Psychiatrist, East London Foundation Trust

The Dunhill Medical Trust's research strategy focuses on the needs of older people in the UK and those with age-related diseases, or with disabilities, or requiring rehabilitation as a result of ageing.

In 2013/14, the Trust launched a strategic programme aimed at improving health and social care for older people, following the findings of the 2013 Francis Report into the failings at the Mid Staffordshire NHS Foundation Trust.

The programme, which consists of a number of strands, will commit up to £3m to making a real difference to the lives of older people.

The projects include:

- Developing a network of care
- Educating the workforce
- Improving the care of frail of older people
- OPCII Research training fellowships

More about research grants is available on the Dunhill Medical Trust website.

RCPsych Library – Faculty of Old Age Psychiatry

The College Library provides OpenAthens accounts to members, to help them support and develop their practice. The accounts allow access to a wide range of databases and journals and ebooks, specifically chosen for psychiatrists.

The collection is built completely on member recommendations, so if you cannot find something you need, just let us know.

- **Databases** – the College provides access for members to Medline, PsychINFO and Embase.
- **Journals -** Lancet Psychiatry, the American Journal of Psychiatry and European Psychiatry.
- **Books** – We have a physical library and members are welcome to borrow books, which we will send out in the post for free. We also provide access to online versions of the BNF and the Maudsley Prescribing Guidelines.

For any articles not available through our own subscriptions, we offer inter-library loans, finding what you need in another library and sending it out to you by email.

We also offer a free and unlimited literature searching service for those who do not have the time or confidence to search through the medical databases. This can also be combined with training for anyone who wants to refresh their skills.

You can find all these resources on the College website, or get in touch with us directly via email. You can also telephone us on 020 3701 2520 or 020 3701 2547.

Alzheimer's Research UK inaugural Clinical Conference

In autumn 2019, Alzheimer's Research UK will host their inaugural Clinical Conference as part of their work through the Dementia Access Taskforce.

This exciting event will be multi-specialty, offering support for clinical practice and providing insight into innovation and relevant research progress in Alzheimer's disease.

The Conference will feature sessions on topics including:

- Mild cognitive impairment diagnosis.
- Innovation in the field.
- Clinical trial research.
- Risk reduction.
- Scope for change in the future of clinical services for dementia.

Professor Alistair Burns, National Clinical Director for Dementia in NHS England is chairing the conference.

You can register your interest in the event taking place in London on 12 November here.

As part of the Taskforce Alzheimer's Research UK is also undertaking a project working alongside the Royal College of Psychiatrists.

This work will be to develop a better understanding of perceptions of earlier diagnosis and detection of Alzheimer's disease, current detection and diagnostic techniques, and how this may impact on current clinical practice.

Integration insights

by

Kapila Sachdev

Consultant Old Age Psychiatrist, East London Foundation Trust

Over the recent few months integrated services and discussions of these have gathered momentum. In addition, there has been significant development of Primary care networks. The deadline for General practices to agree with primary care network boundaries was agreed in May 2019 and the first set of money has been released in July.

With all these interesting developments around us what often comes to mind is what does it all mean and how will these systems interact with each other. Kings fund had an interesting article on this titled "A two-way street: primary care networks and integrated care systems". The main themes of the article were:

1. Primary care networks have been described as the building blocks of integrated care systems. According to the NHS long term plan every ICS will have full engagement with primary care network.
2. It is important to consider how the voice of PCN can be most effectively be brought into ICS. Traditionally the acute sector has had louder voice but there is a recognition of the need to tip the balance to the care delivered in community settings. PCN can bring detailed knowledge of populations thereby helping to have a system fit for local contexts and needs.
3. The challenges are in the form of the ICSs will be catering to a large population and may have up to 60 PCNs and there should be a system in between ICS and PCN. The other challenge is that some ICS are already well developed while others are still in the process of formation. The NHS long term did not set clear expectations and organising principles around this.
4. The importance of two-way communication rather than ICS issuing directives to PCN will be a way forward. It will be important that ICS bring partners together to set a clear strategic vision for a local health and care economy so that all parts of the system are working in the same direction. ICS have an important role to play in training and retraining staff to work in community systems and developing shared care records would be also an important aspect for the ICS to work on.

The article ends well talking about ICS and STPs considering "What we can do for our PCNs to support them to improve health and well-being of our local population."

Reference

A two-way street: primary care networks and integrated care system by Anna Charles

Too old to be a geek

by

Dr Sarah Abd El Sayed, CT3, Worcestershire Heath and Care NHS trust

Dr Gabra Hanna, Consultant Old Age Psychiatrist, Worcestershire Health and Care NHS trust

A flood of new artificial intelligence (AI) capabilities are being used in health care diagnosis and treatment.

Artificial intelligence is the capability of a computer which has been made to respond in a manner resembling human intelligence. It is still impossible to write programs that allow computers to think independently. Instead, computers can be programmed to learn from experience, just like humans do. Although some data analysis techniques are described as "learning", machine learning involves "programming a digital computer to behave in a way which, if done by human beings or animals, would be described as involving the process of learning." As a practical matter, all useful artificial intelligence is built on machine learning, and nearly all machine learning is built on neural networks.

Artificial intelligence has an important role to play in Old Age Psychiatry, although elder care robotics is still in its infancy and thus there are very few real-world implementations of AI currently. The idea behind elder care robotics has been around for many years. Its relevance has increased as the gap between the number of available caregivers and the world's aging population widens.

In 2017, The Independent reported about a robot, named Stevie, which was designed to look a bit (but not too much) like a human, with arms and a head but also wheels. This was because it was designed to exist alongside people and perform tasks that may otherwise be undertaken by a human. Giving the robot these features helps people to realize that they can speak to it and, perhaps, ask it to do things for them. Stevie can perform some tasks autonomously, for example reminding users to take medication. Other tasks are designed to involve human interaction. For example, if a room sensor detects a user may have fallen over, a human operator can take control of the robot, use it to investigate the event and contact the emergency services if necessary. Stevie can also be used to help users stay socially connected. For example, the screens in the head can facilitate a Skype call, eliminating the challenges many users face when using telephones. Stevie can also regulate room temperatures and light levels, tasks that can help to keep the occupant comfortable and reduce possible fall hazards.

PARO is a fluffy robot in the shape of a baby seal that uses artificial intelligence technology to learn from its surroundings. It can also respond to its name. PARO

has been studied by the University of Brighton regarding its potential use as a therapeutic intervention for people living with dementia and learning disabilities. PARO has been shown to reduce stress and encourage people to be more sociable and motivated. However PARO cost £30million to develop.

Computer scientists at the University of Lincoln are part of a major international robotics project – ENRICHME – which aims to help elderly people stay independent and active for longer. The team at Lincoln is part of a large European consortium developing humanoid service robots that could be deployed in care homes and 'extra-care' housing'. The project will eventually see service robots integrated with 'smart home' technology. Smart home technology provides inhabitants with advanced automation systems, which incorporate sophisticated monitoring and control functions in order to provide round-the-clock feedback to elderly users, carers and health professionals. The pioneering robotics project funded by an EU Horizon 2020 grant aims to test the ability of robots to support ageing populations and their carers. The robots will be designed to help with tasks such as locating lost objects, facilitating video calls with family and friends, issuing medication reminders and encouraging activities that improve quality of life such as physical exercises and mental puzzles. This will enable people with mild cognitive impairments to live more independently for longer. ENRICHME will also enable caregivers and professional staff to identify evolving trends of cognitive impairments and to detect possible emergencies. This includes monitoring sudden changes in mood which might indicate deterioration, or the need for family or health services to step in.

However critics have warned that machines should not replace human interaction. They call for funds to be spent on the care crisis instead as the number of older Britons increases. Supporters of AI argue that advances in technology do not intend to replace carers. Robots are not designed to replace anyone's job, rather to complement the team by increasing the workforce and allowing a robot to be present with someone who would otherwise be by themselves.

Current AI implementation in the form of elderly care robots, however, is still nascent and before completely substituting human counterparts in tasks, many technological and ethical hurdles still need to be overcome. A report by the UNESCO's World Commission on the Ethics of Scientific Knowledge and Discovery (COMEST),discusses how the preservation of human dignity and privacy falls into ethically uncharted territory for robots currently. Some examples of ethically unclear situations which call for robot constraint mentioned in the report include:

- If an elderly care robot is tasked to remind patients to take their medicine, the underlying robot intelligence needs to be aware of what to do in the event of a patient refusing. This is especially difficult for current AI platforms since a patient may be refusing the medicines for a legitimate reason. On the other hand passive reminders are also

impractical because replacing of a human nurse counterpart is not achieved.

- Situations could also arise where a caregiver uses a remote-controlled robot to restrain an elder, giving rise to moral and legal ambiguities.

Thus, there still exists a dichotomy of tasks that robots are able to do significantly better than their humans counterparts, yet there are tasks that they simply cannot do at all. Collaboration and integration between researchers, private industry, investors, and the government will be key in the years to come.

What role will technology play in old age psychiatry in the future?

by

Dr Asha Devi Dhandapani

CT1 Psychiatry, Betsi Cadwaladr University Health Board, North Wales

“Woohoo!”!!!

The sound echoed in the hall, making all to turn around to have a glimpse of the source of that shrieking sound in the exhibition. My daughter was on cloud nine. She could not contain the excitement. I would never have expected her to anyways.

It was very difficult to hold her in the exhibition today. What was making her so excited? The most admirable inventions!! A few of them which she had dreamt of a couple of years back. Having to see them in real and being demonstrated was a definite dream come true.

I still remember the day, when she came crying from her school. "Mummy, Paige's grandpa is lost! She is inconsolable. I don't want my granddad to go away like that" Sob! Sob! The true innocence in her face and dramatic comparison was an emotional drain. Since that time, I have seen her whizzing to the library and off to the museum in search of some information that could be of help. Many papers were utilized and her room was cluttered with designing inventions to keep her granddad safe at home.

While we stood looking at a professional demonstrating another invention, I went back again to the memories of my daughters' tactics. I laughed at her innocence then for having invented a jingling bracelet. The bracelet had a million bells (I know I am fabricating this), that sounded more like as if Santa was on his way. The jerking of my blouse, made me realize that I was still in the exhibition. The description of the mobile phone with a tracking device is not unknown, but the updated versions that can help us know the wearers sleeping pattern, hydration, temperature and of course the heart rate. This could be one device which I would bet on. I am hoping that blood pressure, falls indicators and very soon these could help detect stroke and intracranial haemorrhages too.

"Oh! Did I take my antihypertensives today?" I heard the man behind the stage asking someone. Out he comes and shows us the device. It looked like a Fitbit. It was indeed a Fitbit. He flaunted it to us to show how it could detect a person taking his medications. It could sense the opening of a bottle and taking the

tablet out and swallowing too. Indeed a miracle device. I thought I should book one for me, not for the future but the present time...!!

Grinning slyly, we walked over to a stall that had a video display. Self-driving cars!!! "That is one for you mummy" whispered my daughter. My thoughts were verbalized by her. There is a new road ahead as self-driving cars are on the verge of hitting roads all across the globe. I remember an advert a few months back that autonomous vehicles have been tested for years and that California has proposed regulations to allow fully self-drive vehicles to go on public roads. This would be life changing if it has started already.

"Come on darling, let us go and have something to eat!" saying this I took her hands into mine. Off we went searching for some titbits and that was when I realized I had left my wallet in the car. "How I wished that there was something available for people like me to seek misplaced items". I whisked her to the car park. I could hear her muttering under her breath. "Mummy, I have decided to invent something for you! I started imagining the clutter in big scale now. The clutter to help her granddad, changed over to help me. I was intrigued by this thought. She went on to explain to me. "So mummy, you seem to misplace your keys, mobile phone, wallet, TV remote and...." I cut her statement and glared at her. “It’s ok mom, but, that is the truth.”

“How about me inventing a small radio frequency transmitter that could help you to trace your misplaced item. It could flash with strange colours and loud beeps”, she looked at me with her innocent round black eyes; the sight of which could melt any rock. We went back to the stalls again and enjoyed our snacks. Slurp! She emptied her juice.

Walking towards the last stall, we could see many children hovering around something. We waited for our turn and at a distance could see a Robot. Robots in future could be the caregivers. It could definitely relieve the pressures currently put on hospitals and care home. I wonder if it would be economical? But maybe the government could subsidize the rates for the citizens. I wish the robots could act and behave as companions. I wish they could reassure and comfort the old and elderly. Nothing can compensate a human being, but this could be an alternate. I have heard that Hasbro cats and dogs are replacing live pets in nursing homes. This would mean bringing interactive companionship and happiness without the responsibility of vet care and bills. This would also mean no contamination for people who are allergic. Having spoken about the Hasbro pets, I believe that there would be many Therapeutic Robots on the horizon sooner than later. These could reduce stress and anxiety and improve relaxation and motivation too.

With pride we returned back home, having spent an astounding 4 hours in a Science exhibition and gaining inordinate knowledge. Older people often would prefer to remain in their own homes, thus maintaining their autonomy, independence and connection with their family and friends. This would also

mean fewer burdens on the NHS, Nursing homes and care home. Thus the resources could be used to the rightful people. I do agree this would mean expenditures in the form of research and training the elderly population to utilise the complicated gadgets and some amount of intrusiveness by devices. But definitely, older people may be more receptive to have this technological monitoring and enable their ageing at their own homes rather than elsewhere away from their home.

Lucas' Tale

by

James Warner

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Lucas almost purred. The Personal Hygiene, Activity, Nutrition and Therapy Operational Matrix (PHANTOM) Mark 3 was definitely an improvement on the old Mark 2. Not only did it clean those out of the way crevices well, it applied moisturiser in a way that was ever so slightly sexually suggestive. The conversation tool was much more sophisticated too. It was a boon to the care industry. Lucas reflected that care delivery by the Phantom 3 was probably better than most human carers. "Is that heresy?" he pondered.

The interactive artificial intelligence matrix meant discussions with the Mark 3 could become very animated (if a robot is ever "animated") and quite heated at times. Care by a real intellectual, thought Lucas. The Mark 3 could discuss politics, the arts and business with the server updating the robot continually on all the news.

Lucas loved the lively discussions the Mark 3 was capable of. He was keen to discuss England's recent entry to the United States of Europe as a subsidiary of Scotland. He was also interested in the disappearance under the sea of much of Lincolnshire and East Anglia and the impact on food security. But most importantly he needed to discuss the fact the age dependency ratio had just hit 2:1. How could any society survive when there was one dependent person for every two workers, even with all the advances of automated care? There will simply be insufficient economic input to maintain society.

Lucas had strong views on this. Surely euthanasia must be considered at some point and this needed debate! Generations had shied away from this. Lucas knew this was the elephant in the room no one was prepared to bell. "I'm mixing metaphors again", Lucas reflected.

Bathing done it was time for Lucas to dress. Again the Mark 3 excelled at this. The real sticking point for the Mark 2 was underwear. That robot never got the hang of the fact pants had an orientation! Y fronts are not comfortable if put on back to front.

Now all clean and dressed Lucas's mind turned to Tea! Lucas was particular about his tea and the Mark 3 did a perfect cup. Freshly buttered toast and a

smear of marmite: the personalised life story included a whole catalogue of information on dietary likes and dislikes. Perfect!

Tea safely delivered and drunk, Lucas waited for the poison coursing through the body of his charge (apparently a 67-year-old with dementia called Jack - Lucas cared not) to take effect, thankful his makers had eliminated Asimov's first Law from his programme.

The Actuaries Society predict that by 2051 in the UK there will be nearly 700 people who are economically inactive for every 1000 in work.

The Cathedral

by

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Claire looked pensively over the hills rolling past the window as the car soundlessly ferried her and Donna over the winding roads to Galloway Forest. It was to be Claire's first visit to Mossdale Dementia Village, at edge of the woods, on the shores of Loch Ken, since she had checked her father in the week before.

Donna had recognised something of herself in Claire, who was struggling to live with a father whose very identity seemed to be falling apart in front of her. Donna's mother was around fifteen years older than Claire's dad. Although they had experienced very different journeys with dementia, both women had found this seismic change in their loved ones jarring and strange. Donna's mum, Lucy, had become increasingly disorientated, forgetful, and clumsy until she received a diagnosis of Alzheimer's Disease from her GP. Now, several years later, on a good day she was chatty and content, but showed little recognition for her daughter, or else called her by the name of her own late sister. Finding Mossdale had been a godsend, the lifting of a great weight. The constant nagging concern about her mother's happiness and safety was washed away with the gentle lapping of the loch. When, in the staff room, Claire tearfully walked through the story of her father, Michael, who had just been diagnosed with the rarer frontotemporal dementia, it was all Donna could do to support her friend.

Michael, a bookish financial auditor, who loved the Reader's Digest, hated surprises, and struggled to speak in anything less than a stiff formal tone even to his own daughters, had suddenly embarked on several scandalous flings with young women in their twenties while his wife died of cancer. After her death, he stopped speaking entirely, gave up caring for himself, and spent all his time making sketches and bizarre sculptures in the study previously devoted to filing tax returns.

Understanding something of Claire's anguish, Donna recommended the cutting-edge new project in which her mother was living. Mossdale was specially adapted for people with dementia. Human-like machines took care of washing and clothing guests, freeing up the flesh and blood staff to provide more complex emotional and medical care. Meanwhile, residents could socialise in cosy, familiar environments furnished like the Scotland of their youth, with music and television from the noughties and tens piped into entertainment rooms. Claire was ready to try anything.

With a soft hum, the car pulled into the parking bay. Donna and Claire walked across the tarmac and through the village entrance. They were greeted by an employee at a booth who handed them the glasses that would be necessary for

experiencing some of the facility's unique sensory treatments and sent on their way to the Billy Connolly Cottage Complex on the Eastern edge of the village.

Mossdale was mapped out over cobbly car-free streets, broken up by big clear signs, checkpoints manned by uniformed members of staff, and bushy green spaces. Elderly people were loitering around in gaggles of four or five, some on foot, some zooming around with electric frames and chairs.

The women walked through the door and entered a spacious, high-ceilinged lounge. It was decorated like an Ikea showroom, from a bygone era when their chairs, desks, and lamps were ubiquitous. A group of ladies in their eighties were chatting excitedly among cosy Stocksund sofas in the centre of the room.

"Margaret!" – one of the ladies pushed herself up on her frame with surprising speed and hobbled towards Claire and Donna.

"Margaret?", asked Claire.

"My dead aunt", said Donna through her big smile.

She embraced her mother – a little woman with big eyes and curly hair, dyed a dark brown.

"I have something to show you!", Lucy said, taking Donna by the hand and leading them to her room.

"Put those glasses on", Donna whispered. Claire obliged.

Lucy's room was small and cosy – rugs, fairy lights, and little potted succulent plants.

"Ready, Margaret?" asked Lucy, fiddling with a digital display on the wall.

Suddenly, the beaming apparition of a smartly dressed older man, with thick-rimmed glasses and a well-groomed beard appeared in the centre of the room.

"It's dad!", exclaimed Donna, looking tenderly towards the hologram.

As the clip played, the man was telling an anecdote about Lucy falling into a shallow pond during a family holiday. Donna and Lucy watched him recount further memories with big wet eyes and wide grins before he waved goodbye and vanished back into the electric ether. After small talk and hugs, Donna and Claire dropped Lucy off with her friends and, with some trepidation, headed towards Michael's room.

As the door slid open, Claire was surprised to see her father with clean, combed hair and an ironed shirt. He was wearing some sort of headset and moving his hands through the air, at the back wall of a sparse, tidy room. A robotic carer

kept digital watch over him from the corner, while a woman in her early-forties wearing a "Psychiatrist" badge observed his work intently.

"You must be Claire!", said the doctor with a warm smile, "put your glasses on, he's been preparing something!"

Claire slipped the spectacles on and the room was transformed. Stained glass panels flowered into life on the walls, showing recreations of familiar photos of Claire's family over the years, arranged as if they were sacred, in a sweeping composition that flowed across the room. Claire could see what Michael was doing with his hands now – chiselling with digital tools. Stretching above him, dominating his chapel, was an intricate marble sculpture of the family, both girls frozen in time as young children, which Claire knew was inspired by a picture taken at Christmas-time twenty years ago. She kept this photo on her desk at work. The figures were snuggled close together, laughing. Michael downed his tools, looked up at Claire and, without words, smiled softly. Something moved in her. He was her father, and there was still so much to learn about him.

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Research Update

by

Victoria Jones

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Influence of Positive and Negative Dimension of Dementia Caregiving on Caregiver Well-Being and Satisfaction With Life: Findings From the IDEAL Study

Quinn et al (on behalf of the IDEAL study team), *American Journal of Geriatric Psychiatry*, August 2019 (online first)

There is a rising acknowledgement of carer burden and stress both in and outside of the medical community, and within this context this cross-sectional study aimed to identify the potential impact of caregiving on caregiver well-being and satisfaction with life (SwL). The paper used time-point data from the Improving the experience of Dementia and Enhancing Active Life (IDEAL) cohort study with data collected between July 2014 and August 2016. This study involved 1283 informal caregivers of people living in the community with mild – moderate dementia recruited from 29 sites across the UK. Multivariate linear regression modelling was used to investigate positive and negative dimensions of caregiving, caregiver well-being and SwL. Positive dimensions included caregiving competence, and perceptions of positive aspects of caregiving. Negative dimensions include caregiving stress, and role captivity. Results showed that lower well-being and lower SwL were aligned to low caregiving confidence, perception of few positive aspects of caregiving, high stress, and high role captivity. On further analysis only positive aspects of caregiving and caregiving stress retained independent associations with well-being and SwL. Limitations to this study include demographics of the cohort (predominantly white British), and future research could look at caregivers from different cultural backgrounds and how this affects experience of giving care.

Mild Behavioral Impairment as a Marker of Cognitive Decline in Cognitively Normal Older Adults

Creese et al, *American Journal of Geriatric Psychiatry*, August 2019 (online first)

Mild behavioural impairment (MBI) is defined as a 'neurobehavioural syndrome characterized by later life emergent neuropsychiatric symptoms (NPS)' and represents an at-risk state for incident cognitive decline and dementia in people with mild cognitive impairment. This study aimed to determine if MBI is associated with progressive changed in neuropsychological performance in people without significant cognitive impairment. A total of 9931 patients involved

in the PROTECT study (a longitudinal 25-year online research study), who did not have MCI or dementia, undertook a substantial neuropsychological battery at baseline and at one year. This battery assessed attention, reasoning, executive function and working memory. MBI was ascertained using self-administered checklists (MBI-C), and 949 participants (10%) were found to have MBI. This group of people had worse cognitive baseline and greater decline over one year compared to other participants, with a significantly higher decline in working memory in the MBI group. Limitations include that it is a self-selecting recruitment strategy which led to overrepresentation of women and those with a higher education level; furthermore there are no measures of verbal episodic memory which are sensitive to age-related cognitive decline. The study concluded that MBI may be an earlier marker of neurodegenerative disease than MCI and therefore MBI may represent a new target for dementia clinical trials or prevention studies.

Neighbourhood Greenness and Depression Among Older Adults

Perrino et al, *The British Journal of Psychiatry*, August 2019 (online first)

This retrospective cohort study examined the relationship between neighbourhood greenness and depression diagnoses amongst older adults in Miami, Florida. The study analysed 249,405 beneficiaries enrolled in Medicare, of which 9% had a diagnosis of depression. Multilevel analyses assessed the relationship between neighbourhood greenness (using satellite imagery) and depression (using Medicare claim data). This study concluded that higher levels of greenness were associated with lower odds of depression, even after adjustment for demographic variables, income, and health comorbidities. When compared to residents residing in the lowest areas of greenness (lowest third), residents from the middle third (i.e. middle level of greenness) and highest third (highest levels of greenness) had 8% and 16% lower odds of depression respectively. Self-selection of individuals' neighbourhoods is a potential source of bias, and the results of this study are somewhat limited to the Miami area given the specific sociodemographic, climate and geography characteristics of this location. This study adds to the growing body of evidence that nature and neighbourhood greenness have a positive relationship with well-being, and that as clinicians we can encourage access to nature and green spaces when making recommendations to patients regarding self-care.

The Association of Late-life Depression with All-Cause and Cardiovascular Mortality Among Community-Dwelling Older Adults: Systematic Review and Meta-Analysis.

Wei et al, *The British Journal of Psychiatry*, August 2019 (online first)

Depression in older adults is increasingly recognised as a global public health issue which is associated with increased morbidity, suicide and decrease in function. Late-life depression is associated with increased mortality and this

systematic review and meta-analysis of prospective cohort studies examines the associations of late-life depression with all-cause and cardiovascular mortality in community settings. 61 prospective cohort studies were included in this study. Late life-depression was associated with an increased risk of all-cause and cardiovascular mortality. These results were heterogeneous across studies which differed in age, gender, location, follow-up duration and methods used to assess depression. This study highlights the importance in firstly preventing depression in older adults, and secondly optimising treatment of older adults living with depression in order to reduce risks around mortality.

Cochrane Corner

by

Jenny McCleery

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As disappointing results for potential novel therapies for Alzheimer's disease continue to accumulate, we are left with the same small armamentarium of drugs we have been using for years in memory clinics. In this context, it is all the more important that we have a good understanding of the evidence about how to use them safely and to maximum effect. McShane and colleagues have updated their systematic review and meta-analysis on memantine (1), examining a range of clinically important questions, including whether memantine is differentially effective in mild, moderate and severe AD dementia; what is the effect of co-prescription with cholinesterase inhibitors (ChEIs); whether memantine is effective against agitation; and what effect it has in non-AD dementias.

They went to great lengths to collect both published and unpublished studies and data, including unpublished subgroup data for participants with different severities of dementia. They were able to include 44 studies with nearly 10,000 participants. The updated 2018 NICE dementia guideline (2) drew on data and evidence syntheses shared by the Cochrane review authors. However, when discussing their results, the Cochrane authors also identify some gaps in the updated NICE guidance on use of memantine and challenge the strength of some of the recommendations made by NICE for non-AD dementias. This is a long, but very readable review, with many results of interest to people prescribing for dementia; I would strongly recommend taking the time to read it in full.

Among the headline findings is that, although there is high certainty evidence of small clinical benefits for memantine over placebo in moderate-to-severe AD dementia [evident for *clinical global rating*: 0.21 CIBIC+ points (95% confidence interval (CI) 0.14 to 0.30); *cognitive function*: 3.11 Severe Impairment Battery (SIB) points (95% CI 2.42 to 3.92); *performance of activities of daily living*: 1.09 ADL19 points (95% CI 0.62 to 1.64); and *behaviour and mood*: 1.84 Neuropsychiatric Inventory (NPI) points (95% CI 1.05 to 2.76)], there is also moderate certainty evidence that in mild AD dementia (MMSE 20-23) there is probably no benefit from memantine for cognitive function, ADL or behaviour and mood, and lower certainty evidence that there may be no clinical global benefit. This suggests that we should not follow the US, where - despite the fact that the FDA has not approved it for mild AD - 45.7% of patients with mild AD at

the academic centres which make up the Alzheimer's Disease Neuroimaging Initiative (ADNI) were being prescribed memantine in 2011 (3).

In 2011, NICE concluded that there was no evidence that memantine prescribed with a ChEI was any more effective than memantine alone. However, the evidence now available on concomitant treatment has led to a change in NICE recommendations in the 2018 guidance (2). In McShane et al's review, six trials (1855 participants) reported data on patients taking memantine and a ChEI, and 9 trials (2215 participants) reported data on patients taking memantine monotherapy. The effects of memantine were similar in both datasets, with the possible exceptions of a smaller effect on cognition and a slightly larger effect on behaviour and mood in the patients also taking a ChEI. NICE now recommends that patients already taking a ChEI for AD dementia should be offered co-prescription of memantine in severe disease and that this should be considered in moderate disease.

Safety data from the included trials were reassuring. There is high-certainty evidence showing no difference between memantine and placebo in the proportion of participants experiencing at least one adverse event: RR 1.03 (95% CI 1.00 to 1.06), regardless of subtype or severity of dementia. There is moderate-certainty evidence that memantine is 1.6 times more likely than placebo to result in dizziness (6.1% versus 3.9%), low-certainty evidence of a 1.3-fold increased risk of headache (5.5% versus 4.3%), but high-certainty evidence of no difference in falls.

Three studies (one unpublished, one in institutionalised patients) examined the effect of memantine on patients with moderate-to-severe AD dementia and agitation. There is moderate certainty evidence that memantine is not effective as a treatment for agitation (e.g. Cohen Mansfield Agitation Inventory: clinical benefit of 0.50 CMAI points, 95% CI -3.71 to 4.71). On the other hand, there is also moderate certainty evidence that people taking memantine are somewhat less likely to experience new-onset agitation (RR 0.81 (95% CI 0.66 to 0.99); 25 fewer people per 1000 (95% CI 1 to 44 fewer)).

Space here precludes discussion of results in non-AD dementias, which are generally of lower certainty due largely to smaller amounts of data, but again these are worth looking at in the full review.

For information on our reviews as they appear, follow us on Twitter at @CochraneDCIG.

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Book review: Three Things About Elsie

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Published by The Borough Press

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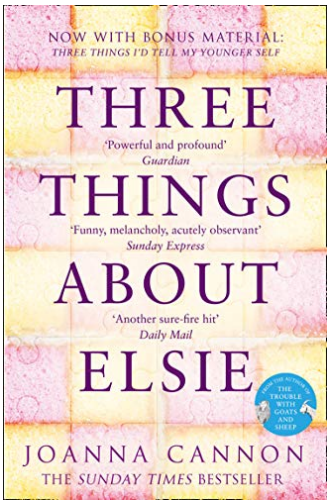

84-year-old Florence lives in Cherry Tree, an almost perfect residential facility for older people with independent flats, a little shop, meaningful activities and even a little Zen garden. Florence is a little repetitive, prickly, doesn't always take part in social activities and talks to her friend, Elsie, who may or may not be real. Florence has friends and likes living at Cherry Tree but worries she may be asked to move, as the manager has suggested that Cherry Tree may not be the best place for her. Florence's life and routine are thrown when a charming, new resident moves to Cherry Tree as he reminds her of a man she thought had died a long time ago.

The themes in the book struck a chord with me as an old age psychiatrist and made me think about situations I deal with every day in my working life in a different light. The author, Joanna Canon, was a psychiatrist and this experience shines through in her novel 'Three things about Elsie'. People in a residential setting who love where they live but are a little out of place and don't quite fit in, and staff at residential homes who struggle to manage people with dementia and the difficulty they have when they have to consider moving residents to other places that can better manage a person's needs. A scene describing Florence's bewilderment when she opens the door to her kitchen cupboard to store her newly bought cake only to have several cakes falling out is well described and when she thinks someone has been moving her things in her flat gave me pause to think. Her fear of being moved to 'Greenbank' is palpable through the book.

The book is not just written from Florence's point of view but also from the point of view from the manager at Cherry Tree and her frustration in a unappreciated job trying to make balance the needs of the improving the quality of care for residents against the owners views as well as a handy man with no formal qualifications but a gift in dealing with Florence and the other residents and their problems.

I would recommend this book not only as an alternative view of some of the common problems we deal with as old age psychiatrists but because of the tantalising mystery underpinning the book, 'Who Is Gabriel Price' , and the residents of Cherry Tree attempts at solving this despite Florence's failing memory.