RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

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HELLO

Welcome to Issue 92, May 2025, of the RCPsych Old Age Faculty Newsletter

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UPDATE FROM THE EDITORIAL TEAM

Thank you to everyone who put in their valuable time towards making this May edition an impressive one. As the days are lighter and longer, we generally have more time to enjoy the outdoors and the lovely weather and find time to read, hopefully. I

In this edition, we loved to receive and read your experiences of working in Old Age psychiatry. There are some interesting articles including an update on Gambling in Older Adults and a discussion about the complex issue of capacity to engage in sexual relationships in the context of cognitive impairment. Dr Mohan Bhat, in his Chair's report, has highlighted the Healthcare inequalities facing ethnic elders with dementia, and this is one of the important areas the faculty wants to address. Dr Chineze Ivenso, our faculty academic secretary, has written a comprehensive review of the Faculty of Old Age Psychiatry Annual Conference which took place in March. The conference attracted over 500 delegates from across the UK and abroad.

We had a staggering 48 entries for this year's Old Age Psychiatrist Essay competition with some high calibre write ups. We extend our huge thanks to our judging panel for their valuable time and selecting the worthy winners whose entries are published below: Dr Alexander Skulnick and Nithya Balchandra.

Jennie and Curtis, our higher trainee editors, bring so much creativity, enthusiasm and interesting ideas every time which makes each edition better than the last one, thank you to both for their support and tremendous input. Thank you to our highly effective and supportive faculty manager, Kitti Kottasz, for her diligence and keeping us on track.

Do consider sharing your interesting pieces of work and articles for the newsletter by emailing oldage@rcpsych.ac.uk for the September edition. We are particularly encouraging articles on the theme of health, well-being, living well and ageing better.

Finally, I am sharing a photo of daffodils in Hampton Court palace which reminds me of the poem 'Daffodils' by William Wordsworth; describing a walk with his younger sister Dorothy in April 1802. My reading of the poem is that beautiful memories of nature can cheer one in later life through the power of imagination!

Enjoy this edition.

Best wishes

Dr Shaheen Shora
Lead Editor

VIEW FROM THE CHAIR

Dr Mohan Bhat

Chair of the Faculty of Old Age Psychiatry

Dear Colleagues

By the time this edition of our faculty's newsletter is published you will all be preparing for the summer break. I wanted to take this opportunity to update on few matters that the faculty of old age psychiatry have been engaged in .

We had a very successful annual Faculty conference in Liverpool earlier this year. This was my first conference as the chair of the faculty. The theme of the conference was "Future challenges for old age psychiatry" which attracted over 500 registered delegates and also had many overseas delegates. We had a great line up of speakers and they engaged with the audience brilliantly and the feedback for the conference was very good both with regard to the breadth and quality of topics that was covered.

The view across Liverpool from the Spine, where the conference was held.

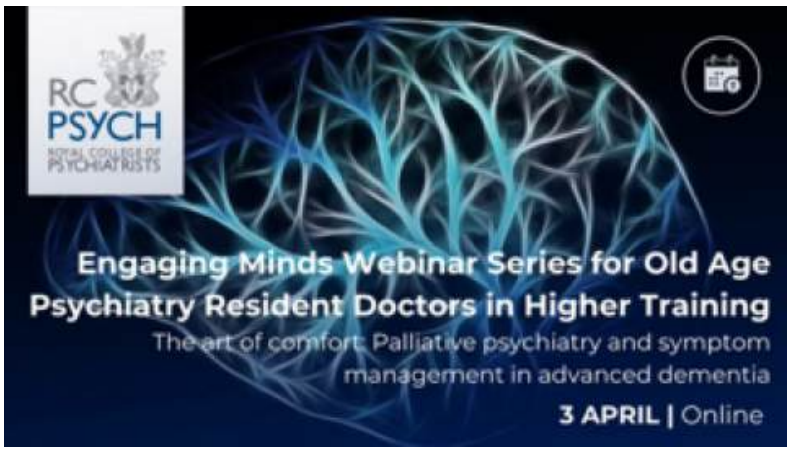
A big thank you to our Academic secretary Dr. Chineze Ivenso for all the planning, putting together the programme for the conference and its very successful execution. Also a big thanks to Dr Bob Barber , Dr Ben Underwood and our faculty members for their support with the conference.

As part of the Conference we awarded the Faculty of old age psychiatry Life time achievement award to Dr Barbara English. Dr English has been a distinguished leader in the field, whose contributions to old age psychiatry and the training of professionals, particularly in Northern Ireland have been profound and enduring. Dr English is best recognised for her accomplishments as a clinical leader and has left a lasting legacy not only on clinical care for older people in Northern Ireland, but on the careers and expertise of those she has trained and mentored.

Dr English receiving the Lifetime Achievement Award

Supporting our Specialty trainees.

We are continuing with the Higher trainee webinar series which has seen our higher trainees engaging with the faculty execs and also benefiting from talks by experts. We are also developing two fellows of Old age faculty for the Speciality trainees who will be supervised by the faculty exec members. This will last for a period between 6 months to a year. One of them will be working on workforce trends and needs for the old age psychiatry services and the other will be looking at the psychiatric inpatient services for older person.



Healthcare inequalities facing ethnic elders within dementia

One of the areas the faculty wants to address is the Healthcare inequalities facing ethnic elders within dementia .As part of this we have created a survey to hear from you to gain insight into this and any barriers faced.

Please follow this link to a survey looking at Healthcare inequalities facing ethnic elders within dementia .

Your responses will help understand the current service status and the challenges faced by minority ethnic elders within dementia assessment and memory assessment services. It will help document the health inequalities faced by minority ethnic elders and will help shape a position statement by the Faculty to address these inequalities.

New Consultant Travel Bursary

As part of engaging and supporting the clinicians the faculty has created a New Consultant Travel Bursary. This award is available to all UK based new consultants in Old Age Psychiatry appointed within the last 5 years. The aim is to support applicants who can demonstrate how the travel bursary advances the Faculty's strategic objectives whilst supporting their career aspirations. Examples for which the bursary can be applied for : conferences, visiting centres of excellence or contributing to developing old age services.

RCPSych Awards 2025

I am also reminding you that Nominations for Royal college of psychiatrists annual awards is now open. The faculty would like many nominations for the category " Psychiatric team of the year – older age adults". So a very sincere request to put forward nominations in this category as we want to celebrate innovation ,leadership and quality improvement seen is these teams and also to learn from the success of these teams.
Click below for categories, how to nominate, and MORE! The last date is 13th June

I also once again thank our editor Dr Shaheen Shora and our trainee editors Dr Curtis Osborne , Dr Jennifer Parker for doing a brilliant job in putting one more edition of this newsletter and I am sure you will enjoy and benefit from the topics covered in this edition of our faculty newsletter

Best wishes,

Mohan.

FACULTY OF OLD AGE PSYCHIATRY ANNUAL SCIENTIFIC CONFERENCE 2025 – SUMMARY AND REFLECTION

Dr Chineze Ivenso, Consultant in Old Age Psychiatry, Aneurin Bevan University Health Board and Academic Secretary Faculty of Old Age Psychiatry

The 2025 Annual Scientific Conference of the Faculty of Old Age Psychiatry, hosted in Liverpool and streamed internationally, brought together a vibrant, multidisciplinary audience of over 500 delegates from across the UK and around the globe—including Australia, Asia, Europe, and North America. The event highlighted the collective commitment to advancing older adult mental health, with a programme shaped around the theme: "Facing the Future: Challenges and Opportunities in Old Age Psychiatry."

From policy to practice, from ethical debate to technological innovation, the two-day conference delivered an agenda rich in insight, expertise, and optimism.

The conference began with a warm and personal address from Mayor Steve Rotheram, who welcomed delegates to Liverpool and spoke passionately about the importance of inclusive and accessible older adult mental health services. His words set a tone of civic pride and shared purpose.

Following the welcome, Dr Mohan Bhat, Chair of the Faculty of Old Age Psychiatry, delivered an opening address that challenged the audience to critically assess both the current landscape and future direction of the specialty. Reflecting on an aging population and rising complexity in presentations, Dr Bhat urged a balance between embracing innovation and retaining compassionate, patient-centred care. He posed pivotal questions on shaping services, training the future workforce, and integrating new technologies without losing sight of core values.

The Keynote speaker Dr Jeremy Isaac, National Clinical Director for Dementia and Older People's Mental Health at NHS England, offered a comprehensive overview of the national context. Framing old age as a "growth industry," he highlighted the demographic pressures driving demand and the need for us to shift our focus not only to better diagnosis and management but also towards prevention - including modifiable risk factor management. Another key message of Dr Isaac's was the pressing need to improve post-diagnostic support and treatment for people living with dementia.

Dr Amanda Thompsell, National Specialty Advisor, followed with a compelling update on the national agenda for older adult mental health services. She stressed that older people's needs must be central to mental health transformation plans, especially in efforts to shift care from hospitals into communities. Emphasising the use of data—particularly through the OKTA platform—she empowered delegates to make evidence-led cases for service improvement and investment.

Then the policy and research voices took centre stage, with Samantha Benham-Hermetz of Alzheimer's Research UK exploring how collaborative research can fast-track breakthroughs in dementia treatment and Jennifer Keen of the Alzheimer's Society outlining the vital role of policy advocacy in shaping responsive, equitable dementia care systems. Their talks underscored the need for alignment between research, policy, and clinical practice to effect real change.

This was followed by two afternoon plenaries which provided bold visions for the future. The first was by Prof Rob Howard who delivered a dynamic session advocating for assertive outreach models to better support high-risk individuals in the community. Then Dr Wendy Burn, former President of RCPsych, focused on the importance of flexible training pathways, interprofessional learning, and leadership development in sustaining and expanding the workforce in old age psychiatry.

Delegates then split into three parallel sessions tailored to their specific interests. The first session was on neuromodulation in depression and was led by Prof Richard Morriss, this session explored the underutilisation of TMS in the NHS, its potential to transform treatment, and barriers to wider implementation. The second session was on Prevention in Memory Clinics, this session was jointly led by Dr Charlotte Deasy, Samantha Benham-Hermetz, Prof Claudia Cooper and Oliver Kelsey, and this session addressed secondary and tertiary prevention strategies.The speakers examined how risk reduction, early intervention, and tailored support could help delay progression and improve quality of life. The third session was on the best practice in assessment and management of suicide led by Mr Phillip Peri and Dr Amanda Thompsell who shared best practice in assessing and managing suicide risk in older adults, a pressing concern given rising global rates.

This was followed by the last two plenary sessions of day one on diagnostic frontiers. Dr Meher Lad introduced new Alzheimer's diagnostic criteria, exploring how emerging biomarker frameworks are reshaping clinical practice, while Dr Jemma Hazan presented on precision diagnosis in Alzheimer's disease. Despite a firm alarm disrupting the session, Dr Hazan resumed confidently providing a succinct engaging presentation that reinforced the clinical utility of blood-based biomarkers.

The conference opened on day two with the faculty's annual business meeting, featuring updates on strategic initiatives, including the exciting development of the International Diploma in Old Age Psychiatry—a project set to support global training and professional standards.

An energising networking session ran alongside the meeting, led by trainees and early-career professionals. Dr Mani Krishnan, immediate former chair Faculty of Old Age, RCPsych delivered an inspiring and timely talk on clinician wellbeing, emphasising resilience, peer support, and the importance of mental health for those working in such a demanding specialty.

A major focus of the second day was the evolving debate around assisted dying. The session offered a rare space for respectful, informed exploration of a deeply complex topic.Prof Julian Hughes provided an ethical and philosophical exploration, drawing on clinical experience to illuminate the challenges in supporting vulnerable older patients and Baroness Ilora Finlay delivered a precise update on legislative proposals in Parliament, highlighting the psychiatrist's potential role, as well as safeguards and concerns. The ensuing Q&A was lively, thoughtful, and engaged—reflecting the importance of ongoing dialogue in navigating this morally charged area.

This was followed by a series of impactful presentations showcasing the latest in research. Prof Suzanne Reeves explored the management of hallucinations and delusions in Parkinson's and Lewy Body dementia, emphasising non-pharmacological strategies before considering medication. She reviewed NICE guidance, highlighted the challenges of using clozapine, and introduced Ondansetron - a repurposed drug currently under trial in the TOP HAT study - as a promising novel treatment and called for more trial sites to aid recruitment and further understanding.Prof Rebecca Gould then offered a presentation on how to develop and adapt psychological therapies for dissemination in the NHS and called for sites to join her ongoing CONTACT-GAD trial.Prof Malhotra, joining virtually, provided a tour of the AD SMART platform, demonstrating how adaptive trial designs can accelerate discovery and personalise interventions. These talks underscored the energy and innovation shaping the research landscape in older adult mental health.

Delegates then reconnected during a lunchtime poster session and networking break, engaging in lively discussions that fostered collaboration across regions, disciplines, and sectors.

Following lunch, as in day one, delegates then split into three parallel sessions tailored to their specific interests. The first session was led by Prof Ian James, who promoted the national guidance on non-pharmacological approaches to behaviour that challenges, advocating systemic change to reduce psychotropic overuse. The second session was one on AI, VR, and Digital Innovation – A standout session on technology's role in dementia care, jointly run by Prof Zoe Kourtzi who presented on AI-driven brain health platforms, Prof Dennis Chan who shared findings from virtual reality studies of spatial navigation as early markers of Alzheimer's disease and Dr Ben Underwood, Vice Chair Faculty of Old Age Psychiatry, RCPsych who closed the session by examining how big data and AI might enhance care pathways and service design. In the third session Dr Judy Rubinsztein and Dr Kapila Sachdev presented and co-led a focused discussion on the practicalities and ethics of lithium management. They explored optimal plasma monitoring, discontinuation challenges and strategies to minimise harm in bipolar disorder care.

The final two sessions offered rich reflection. Prof Rob Howard returned with an important session on deprescribing antidepressants, offering guidance on safely reducing medication while maintaining therapeutic outcomes. A closing conversation titled "Past, Present and Future: In Conversation with Faculty Leaders" brought together; Dr Mani Krishnan and Dr Amanda Thompsell as past Chairs, Dr Mohan Bhat as current Chair, and Dr Ayana Hazu as trainee representative. This generational panel offered powerful insight into the faculty's evolution, challenges, and aspirations—from legacy-building to shaping the future workforce.

(L-R) Dr Ayana Hazu, Dr Amanda Thompsell, Dr Mani Krishnan and Dr Mohan Bhat

Awards and Prizes

- Lifetime Achievement Award: Dr Barbara English honouring her outstanding contributions to old age psychiatry, mentorship and service development.
- Mohsen Naguib Prize: Dr Sophie Roche (for a meta-analysis on relapse risk after antipsychotic discontinuation in dementia)
- Poster Prize: Dr Kathryn Ryland (for work on generalist-led dementia inpatient care)
- Overseas Bursary: Dr Malsha Gunathilake (Sri Lanka)
- Medical Student Essay Prize: Aimee Cooper (University of Cambridge)
- Trainee Essay Prizes: Dr Tharun Radhakrishnan (ST6), Dr Nimra Waheed (CT1)
- PsychStar Award: Alice Cole (University of Glasgow)
- Newsletter Essay Winner: Dr Alexander Skulnick (ST4)
- Newsletter Essay Second Place: Nithya Balachandra (St George's University)

Conclusion

The 2025 Faculty Conference succeeded in its ambition to explore the future of old age psychiatry with rigour, creativity, and compassion. It was a meeting of minds and missions—unifying science, ethics, policy, and innovation to forge a path forward.

Whether in person or online, delegates engaged deeply with issues from deprescribing to digital tools, and from legislative change to leadership succession. The hybrid format widened access, while the carefully curated programme reinforced the faculty's role as a national and international leader in the mental health of older adults.

With sincere thanks to organisers including Dr Mohan Bhat, Dr Ben Underwood, Dr Bob Barber, Faculty of Old Age Psychiatry, RCPsych Financial Officer and Dr Judy Rubinsztein, speakers, contributors, and attendees, the faculty looks forward to continuing the momentum—and to ensuring that older people everywhere receive the care, dignity, and advocacy they deserve.

FROM COLOMBO TO LIVERPOOL: MY EXPERIENCE AT THE ANNUAL CONFERENCE OF THE OLD AGE FACULTY OF THE ROYAL COLLEGE OF PSYCHIATRISTS, 2025

Dr. Malsha Gunathilake (MBBS, MD (Psych), MRCPsych (UK)), Consultant Old Age Psychiatrist
Colombo South Teaching Hospital, Sri Lanka

Dr Gunathilake

Attending the Annual Conference of the Old Age Faculty of the Royal College of Psychiatrists in 2025 was an immensely rewarding and memorable experience. I had the great honour of being selected as a recipient of the Overseas Bursary, a grant awarded to a psychiatrist from lower-middle-income countries to support their participation in this prestigious event. I am truly grateful to the Old Age Faculty of the Royal College of Psychiatrists for this generous support, without which this opportunity would not have been possible.

I am an old age psychiatrist practicing in Sri Lanka, a country where the subspecialty of old age psychiatry is still in its formative stages. Being among the first generation of specialists in this field in Sri Lanka, I constantly seek opportunities to expand my knowledge, update my clinical skills, and contribute to the development of elderly mental health services. Attending this international conference in Liverpool provided a unique platform for me to achieve these goals.

The conference programme was rich and diverse, with sessions that delved into cutting-edge research, clinical innovations, and policy developments in the field of old age psychiatry. One of the most enlightening aspects of the event was the focus on new and emerging treatments for dementia. Sessions on immunomodulatory therapies and their implications for dementia provided me with a fresh perspective and deeper understanding of the biological underpinnings of dementia. These insights are particularly valuable for my clinical practice, and I am eager to explore how these advances might be adapted or introduced into the Sri Lankan context in the future.

In addition to the academic sessions, the conference was a wonderful opportunity to engage with global experts in psychiatry. Meeting professionals who are pioneers in their respective areas—ranging from cognitive neuroscience to community-based geriatric mental health care—was truly inspiring. The interactions I had not only broadened my perspective but also laid the foundation for potential future collaborations. These connections are particularly important for us in Sri Lanka as we work towards establishing more structured training programmes and developing services tailored to our elderly population's mental health needs.

The research presentations, both oral and poster, offered a valuable glimpse into the latest studies being conducted across the world. These presentations helped me reflect on how similar methodologies could be applied within the Sri Lankan setting, and inspired ideas for local research initiatives that address our unique demographic and cultural challenges.

Beyond the academic and professional enrichment, the conference was also a culturally enriching experience. Liverpool, with its rich history, vibrant arts scene, and stunning architecture, was a delight to explore. I enjoyed visiting the city's historical landmarks, including the Royal Albert Dock, the iconic Beatles Story Museum, and the beautiful cathedrals that add charm and character to the cityscape. It was fascinating to experience the warmth and hospitality of the locals, which made my stay even more enjoyable.

As I return to Sri Lanka, I carry with me not just new knowledge and connections, but a renewed sense of purpose. I am committed to using the insights gained from the conference to help expand and reform mental health services for older adults in my country. This includes advocating for improved training in old age psychiatry for junior doctors, promoting awareness about age-related mental health issues, and encouraging the integration of evidence-based practices into routine clinical care.

In conclusion, attending the Annual Conference of the Old Age Faculty of the Royal College of Psychiatrists was a transformative experience. It provided me with the academic stimulation, professional networking, and cultural exposure that will undoubtedly enrich my journey as a clinician and advocate for elderly mental health. I am sincerely thankful to the Faculty for recognizing the importance of supporting psychiatrists from low- and middle-income countries. Their commitment to global inclusivity and knowledge-sharing is commendable, and I hope more colleagues from developing nations will have similar opportunities in the years to come.

Dr Gunathilake with Dr Mohan Bhat and Dr Rob Howard

Dr Gunathilake with Dr Sudip Sikdar

OLD AGE PSYCHIATRY: 30 YEARS OF PROGRESS, PASSION, AND POSSIBILITY

Dr Curtis Osborne, Trainee Editor of The Old Age Psychiatrist

As we celebrate 30 years of the Old Age Psychiatry Newsletter, it's a moment to look back with pride and forward with excitement. In 1995, our conversations were focused on the emerging promise—and the cost—of medications like donepezil and memantine. Back then, we debated their value and potential. Today, they are a standard part of dementia care, a testament to how far we've come.

But the journey didn't stop there.
We now find ourselves at the forefront of an extraordinary transformation. We're talking about artificial intelligence guiding diagnoses, digital tools enhancing care delivery, and disease-modifying treatments that could change the course of dementia itself. What once felt like the future is now part of our everyday clinical vocabulary.

Throughout these three decades, this newsletter has been more than a publication—it's been our collective voice.

We've shared research, challenged ideas, inspired one another, and stayed deeply connected by a shared mission: to be the best clinicians we can be for older adults. We've educated ourselves and each other, always with compassion and dedication at the core.

Patient care remains our anchor. Every innovation, every discussion, and every breakthrough is in service of the people we care for—older adults living with mental illness who deserve dignity, empathy, and the best of modern medicine.

Old age psychiatry has become one of the most rapidly evolving and exciting specialties in medicine. And the best part? We're just getting started. The future is bright—filled with new tools, new talent, and a renewed commitment to excellence. Here's to 30 years of progress—and to the next 30 years of purpose, passion, and promise.

Old Age Psychiatrist November 1995

Back to the future

THE HISTORY OF NEWSLETTERS PAST

TIMES PAST

Dave Jolley

Medical Director and Consultant Wolverhampton Health Care NHS Trust New Cross Hospital Wolverhampton

Younger members of our section may not know that we actually succeeded producing eight newsletters spanning the years 1980 - 1986. As I was fortunate to edit the earlier series of newsletters the editors invited me to reflect on what went on and also to reflect why we discontinued the newsletter.

Memorable articles

The first edition appeared in January 1980 and we had a wonderful tale by Tony Whitehead with the title *No Man is an Island Entire of Itself*. This was an invited article. Tony is well-known for his wit and innovations as well as his tremendous championship of our cause and he provided the expected stimulating and amusing article. Memorable articles abounded in the other issues but space limits my mentions to two: Gary Blessed's smashing *Psychogeriatrics in the nearly frozen North* in the second issue and a masterly review of the history of psychogeriatrics in the last issue ion 1986 from the Professor Brice Pitt..

Not enough SRs

By the time we got the second issue out in December 1980 we had achieved an additional quota of Senior Registrar posts, I think there were seven overall. There was a mixture of exuberance and pleasure when posts were made available, and sadness and frustration when excellent units were still unable to offer training. By 1985 however John Wattis and Tom Arie reviewed our manpower situation and made the point that we needed more Senior Registrars - a theme Nori Graham has taken up again in 1995.

Endings and Beginnings

The newsletter covered the movements of colleagues taking up new posts or leaving posts for new pastures. In our first issue we covered Sheffield's Vicki Spencer who had recently tried to set up some sort of activities in Old Age psychiatry and even she felt it was impossible. There was substantial press coverage of her going away and I think that was helpful to Sheffield in the longer run. In the summer of 1981 our third issue carried the sad news of the retirement of Ingeborg Williams who had led developments at Redruth . She wrote a very moving and informative article about her work as a pioneer psychogeriatrician, "Now the responsibility and the struggle, but also the rewards and satisfaction are mine no longer". David Neale moved from General Psychiatry to develop a good service in Crewe and wrote to say that he wished he'd moved before. Michael White moved from his famous service in Aylesbury to set up another famous service at Hereford. He wrote an account in the same issue of thoughts on that move ending with prophetic words: "Heaven help us all if the Secretary of State has his way and our contracts are held at district level".

It was not all departures. We reported new appointments regularly but some arrivals were more memorable than others : by the time of the fifth issue in December 1982 I was rejoicing at the coming of the second Consultant to South Manchester, having worked single-handed since 1975. This was of course, Sue Hodson who later became Mrs Susan Jolley and we have continued to rejoice ever since !

Going out with a (big) bang.

In 1985 we produced for the first time a provisional list of psychogeriatricans' names and addresses - it was quite an effort! A year later an eighty page long issue of the newsletter appeared, the bulk of which was the second definitive list of psychogeriatricans, and I think it was that which produced the massive tiredness which ended it all. And that was that - we didn't go any further.

Why didn't we go on ? One reason was that we felt that having the new *International Journal of Geriatric Psychiatry* would mean that people would use the correspondence column there for some communications and that has occurred to a point. There had been throughout some difficulty in distributing the newsletter as it is quite costly. The flow of contributions was fairly erratic with sometimes a bulky batch of good ideas but not much at other times. Generating contributions was not terribly easy and I hope that people will be generous towards the relaunched series. So I think it is a good thing that we are having a newsletter again.

I hope that a new vitality will come to this, the Section Newsletter with the new editorship and our massively increased membership in the years to come.

"Generating contributions was not terribly easy and I hope that people will be generous towards the relaunched series"

A photocopy of past issues of the first series of the newsletter can be obtained from the author at cost price

RISKY BUSINESS: GAMBLING IN OLDER ADULTS

George Reid, Core Trainee in Psychiatry (CT3) Avon & Wiltshire Mental Health Partnership NHS Trust

Introduction

The Lancet Public Health Commission on gambling , published in November 2024, has highlighted gambling as a rapidly growing industry and major public health concern(1). The gambling sector in the UK is worth an estimated £15.1 billion, and recent surveys show that 48% of the UK population engaged in gambling activity in the prior four weeks(2,3). While this proportion has remained fairly consistent over recent years, the rates of online gambling have continued to rise year-on-year from 2018 to 2022, reflecting the rapid digitisation of the sector. Given gambling is now readily accessible 24/7, the potential for harm is even greater(1).

Attention understandably focuses on higher prevalence groups, such as adolescents and young adults, however older adults are an under-recognised vulnerable group in relation to gambling-associated harm(4). Recent surveys indicate that gambling is considerably prevalent among older adults, with 48% of individuals aged 65-74 and 43% of those over 75 having gambled in the past four weeks. Although these percentages decrease to 16% and 14% respectively when excluding lottery draw participants, the figures remain significant(3).

In this cohort, gambling poses significant risks to both the individual and their families or caregivers. Older adults are particularly vulnerable due to cognitive changes, social isolation, and financial circumstances, all of which can influence gambling behaviour and increase the potential for harm. These harms are expected to become increasingly significant in the coming years, as the proportion of individuals over 65 is projected to exceed a quarter of the UK population by 2066(5). In this discussion, we explore the unique features of

gambling among older adults and emphasise the importance for old age psychiatrists to remain vigilant about the potential harms in this group.

Why do older adults gamble?

The literature on gambling motivations among older adults presents diverse perspectives. Unsurprisingly, the most recent UK data suggests that the majority of older adults gamble for financial gain and the prospect of a substantial win(3). However, in the literature more generally, older adults view gambling as a safe leisure activity with enjoyment and pleasure being key drivers across cultures(6). In a similar way, it can also be seen as a way to relax or to relieve boredom(6). The opportunity to keep mentally active can also be a motivator, especially as cognitive performance may start to decline.[7] Furthermore, studies indicate that gambling can act as a coping strategy for the psychosocial difficulties that come with ageing. Older adults frequently encounter challenges like social isolation, reduced income, and a diminished sense of purpose, which can negatively impact their mood. Consequently, gambling may be employed, either consciously or unconsciously, as a means to alleviate the emotional stress brought on by these difficulties(8).

The risks and rewards of old age gambling

Most of the population can gamble without experiencing significant adverse consequences, and in these cases, recreational gambling can offer some potential benefits. The opportunity for social support in a cohort where social isolation is prominent is well documented in the literature and has been linked to a boost in self-esteem and social identity(7,9). Some evidence even states that recreational gamblers report more positive health and psychosocial outcomes than their non-gambling counterparts(6).

However, the outcomes in problem gambling or gambling disorder (terms used interchangeably) are far more concerning. These conditions are characterised by persistent and recurrent problematic gambling, resulting in clinically significant impairment or distress. Furthermore, people with problem gambling exhibit features of dependency comparable to those observed in substance dependence(10,11). Studies show a wide lifetime prevalence range of gambling disorder in old age, with estimates ranging from 0.2% to 12.9% of gamblers(12). In the most recent UK data, 1.4% of individuals who gambled aged 65-74 and 0.4% aged over 75 met the criteria for problem gambling(13). Crucially, these figures do not account for 'at-risk' individuals, i.e. those who experience significant gambling-related harms but do not fully meet the criteria for problem gambling. The unseen harms faced by these at-risk individuals can be substantial, often going unnoticed and unaddressed.

Evidence indicates that older adults with problem gambling often endure more severe consequences than their younger counterparts(14). Substance use, both legal and illegal, is more prevalent among both recreational and problem gamblers compared to non-gamblers(15). When it comes to recovery, older adults often face poorer outcomes due to their reduced ability to 'bounce back', which can be attributed to a lack of earning power and smaller social networks(8).

Financial strain from gambling losses can be more devastating for older adults, making it harder for them to recover(6). Moreover, older gamblers tend to be less inclined to seek support for gambling-related issues. This reluctance may stem from stigma, lack of awareness about available resources, and a belief in handling problems independently, leading to more prolonged and severe consequences(16).

A uniquely vulnerable population

Older adults face certain unique vulnerabilities to gambling-related harm compared to the younger population. They tend to have more leisure time but less financial income due to retirement, which often means they are living on fixed incomes and may have limited financial resources(17). In this way, they may actually spend a greater proportion of their monthly income on gambling than other age groups(18). Social isolation in the elderly is a key vulnerability, despite some benefits of social interaction when gambling recreationally. In fact, individuals whose main motivator is loneliness are more at risk of potential gambling-related harm(6,9). Cognitive changes in this group can greatly impact the ability to make reasoned, logical decisions including around risk-taking. For instance, older adults might be more prone to making decisions driven by emotions rather than logic, especially when it comes to gambling. Additionally, they often have a stronger aversion to losing compared to younger individuals, which can fuel gambling behaviours and risk-taking(6).

The impact of commonly used medications in this age group also needs to be considered, particularly those that act on the dopamine system. Dopamine agonists used in Parkinson's disease, such as Ropinirole and Pramipexole, along with the partial dopamine agonist Aripiprazole, are potential culprits which can significantly influence gambling behaviour and resultant harm(19). Aripiprazole in particular, may be under-recognised in this respect; evidence has shown that Aripiprazole can increase the risk of problem gambling tenfold and may be more problematic for problem gambling in terms of severity than full dopamine agonists(19,20).

How can clinicians help?

Clinicians, including old age psychiatrists, play a vital role in identifying gambling-related problems among older adults, providing psychoeducation and signposting or referring patients to appropriate support services where necessary. This role is becoming increasingly important as gambling becomes more accessible and the UK population continues to age. Consequently, gambling has become a significant priority for the UK government, leading to major reforms in the gambling sector, including a statutory levy on betting firms to fund addiction treatment(21). These reforms have resulted in a rapid increase in the availability of NHS treatment services to meet the growing demand. Since 2019, fifteen new treatment centres have opened across England, meaning there are now more avenues of support available to patients with gambling-related problems than ever before(22).

These services provide a variety of interventions, including psychiatric assessments, cognitive-behavioural therapy (CBT), individual and group therapy, and support for co-occurring mental health issues. Access to these services can be achieved through self-referral, professional referral, or via The National Gambling Helpline, which also offers telephone support and signposting. Charities like GamCare and GambleAware offer valuable resources and advice for both professionals and patients. They provide information on screening tools, referral pathways, and support services available in specific areas, helping both professionals and patients navigate their treatment options and find the support they need(23,24).

Finally, NICE released new guidance in January 2025 on 'Gambling-Related Harms,' which emphasises that asking about gambling should be a routine part of taking a drug and alcohol history. It also highlights 'at risk' groups, such as those experiencing comorbid mental illness, financial difficulties, substance use, taking medication(s), or having a neurological condition, that interferes with impulse control(25).

A call to old age psychiatrists

In conclusion, whilst not as frequently as their younger counterparts, older adults gamble in significant numbers. This populations presents with unique vulnerabilities which include cognitive changes, social isolation, and financial constraints. Despite problem gambling being less prevalent in these elderly groups, the potential for harm is substantial, and recovery potentially more challenging and limited. Therefore, it's important for the older adult psychiatrist to remain vigilant and proactive in identifying gambling problems to ultimately reduce harm in this population.

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DEVELOPING AN AMNESTIC MILD COGNITIVE IMPAIRMENT CLINIC

Dr Laura Tyler (ST7 Old Age/ General Adult Psychiatry), Dr Brenda Wasunna-Smith (Consultant Psychiatrist), Alice Millward (Assistant Clinical Psychologist), Dr Kerry Rees (Senior Lecturer in Psychology), Prof Tarun Kuruvilla (Consultant Psychiatrist). Gloucestershire Health and Care NHS Foundation Trust.

Background:

Amnestic Mild Cognitive Impairment (aMCI) is considered a prodromal phase to Alzheimer's Disease (AD) with about 50% of patients converting to the dementia phase within 5 years (approximately 13% annually)(1). The risk of conversion increases with positive biomarkers; temporo-parietal atrophy on CT or MRI scan, temporo-parietal hypometabolism on FDG-PET scan and, Amyloid PET scan positive for cortical amyloidosis(1).

Therefore, monitoring patients with aMCI is important. Whilst current NICE approved medication for NHS use, reversible anticholinesterase inhibitors (ACIs) and Memantine are not effective in aMCI, they are following progression to dementia. The earlier medication is prescribed the more favourable the outcome(2).

Non-pharmacological interventions such as improving vascular risk factors, optimising hearing & vision, managing affective symptoms, may delay progression(3).

Potentially disease modifying treatments (DMTs) for AD, are effective in prodromal AD, with Lecanemab and Donanemab recently getting an MHRA license but not NICE approval for NHS use (4, 5, 6). There are several such DMTs in the pipe-line(7). In anticipation of DMTs imminently receiving approval for NHS use, we need to future proof our service by diagnosing AD in the prodromal and early dementia phases.

Current Practice:

The Royal College of Psychiatrists has demonstrated that most memory clinics in the UK are run by older age psychiatry services. Most lack access to NICE approved biomarkers for early diagnosis and are not equipped to administer DMTs(8).

In Gloucestershire Health and Care NHS Foundation Trust (GHC), the diagnosis and management of aMCI varies. The North Sector diagnoses the highest numbers of aMCI, likely due to patient demographics and GP referral practises. Patients with aMCI plus a positive biomarker are reviewed annually.

GHC services have evolved. Previously, the North Sector discharged all patients with aMCI to primary care with advice for re-referral with cognitive decline. Often, patients were re-referred with moderate to severe AD, missing the mild phase when treatment may have been more beneficial. Thereafter, all patients with aMCI were reviewed annually. This was unsustainable resulting in long waiting lists. Now only patients with aMCI and a positive biomarker are reviewed annually. Hypothetically, developing dedicated aMCI clinics may ease some of the pressures on memory clinics.

Aims:

1. To develop and run an aMCI Clinic in GHC for 8 months between March 2022 and November 2022 to reduce memory clinic waiting times.
2. To achieve good patient satisfaction.
3. To offer patients with aMCI and positive biomarkers annual reviews for early identification of dementia and post-diagnostic care.
4. To highlight clinical trials targeting patients with prodromal AD.

Method:

The aMCI clinic ran for 8 months from 16th March 2022 to 16th November 2022. Data was compared to the same period in the previous year.

23 patients aged 65-92 years old, diagnosed with aMCI with a positive biomarker were selected from the North Sector Memory Assessment Service caseload. Patients received an appointment and Informant Questionnaire on Cognitive Decline in The Elderly (IQCODE) to assess their daily functioning(9).

All patients were assessed with an informant either virtually or in person. During the 90 minute appointment, the informant spoke to the psychiatrist and the patient spoke to the assistant psychologist. The informant confirmed the patient's history, social functioning, behavioural and psychological symptoms of dementia, medication, brain scans and blood tests, and considered eligibility for current trials. The assistant psychologist completed a Repeatable Battery for the Assessment of Neuropsychological Status (R-BANS). The Addenbrooke's Cognitive Examination (ACE-III) was utilised in their absence. The Rowland Universal Dementia Assessment Scale (RUDAS) was used to account for language diversity.

Following information amalgamation, diagnosis and pathway were determined. The standard post diagnosis pathway was offered to dementia diagnoses. Patients with aMCI were reviewed between 6 and 12 months with non-pharmacological interventions advised.

Service satisfaction questionnaires were provided following assessment.

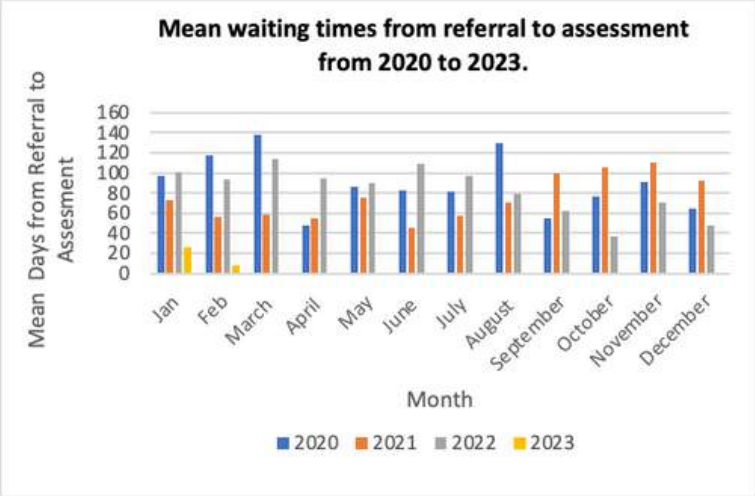
Image 1: Entrance to the aMCI service at the Fritchie Centre

Results

Quantitative analysis

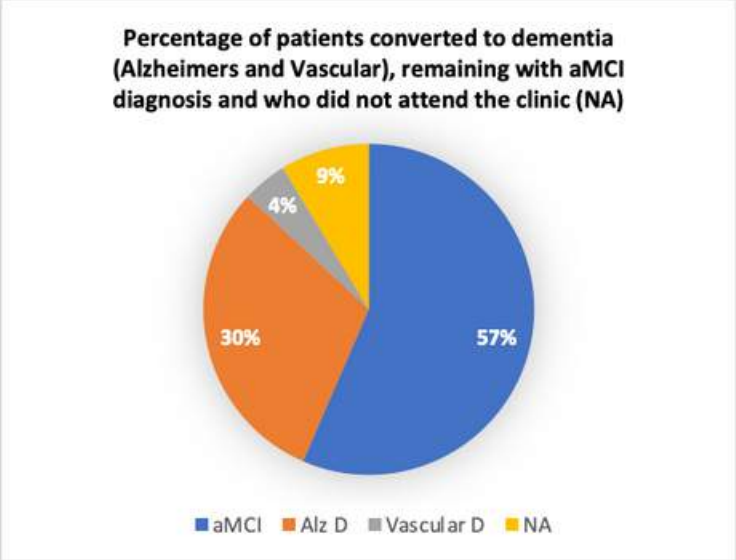
The statistical analysis of the waiting time from the point of referral to the Memory Assessment Service to the first consultation shows no statistical difference ($p>0.05$) in the reduction in waiting times before and after the introduction of the aMCI clinic.

On closer inspection, the waiting times from September to November 2022 appear to be decreasing which could point to the potential of a time lag effect on the results.



Graph 1: Mean waiting times from 2020-2023

Results showed that 62% of patients remained with an aMCI diagnosis whereas 38% of patients converted to dementia (Alzheimer's or Vascular).



Graph 2: Percentage of patients who converted to dementia, remained with aMCI diagnosis or DNA'd

Qualitative analysis:

Service satisfaction questionnaires were completed by 70% of patients. The majority of patients were very satisfied (60%), felt the appointment length was 'just right' (70%) and liked the combined appointment approach (100%).

Discussion

23 patients (15 male, 8 female) were included in the pilot.

4 objective tests, including the ACE-III, R-BANS, TICS and RUDAS were utilised. The TICS was employed to assess cognitive status. Patients either completed the ACE – III or R-BANS depending on whether the consult was led by a doctor (ACE- III) or assistant psychologist (R-BANS). For personal reasons the assistant psychologist withdrew from the pilot. The RUDAS was used for 1 patient with language diversity. Different objective tests prevented the comparison of like for like results.

The conversion of 38% of patients from aMCI to dementia within 12 months demonstrates the need to monitor patients with aMCI and a positive biomarker.

Statistical analyses of the waiting time from referral to first consultation shows no reduction after the introduction of the aMCI clinic. T-test comparisons including 3 months post aMCI clinic cessation demonstrated no statistical differences in the short-term time lag effect on results. This may be due to data variability.

The 70% of patients who provided feedback were "very satisfied" or "satisfied" with the service. All respondents preferred the combined approach over multiple appointments. They described the length of the appointment time as "just right". Patient described the clinic as "very helpful, non-judgemental, pleasant, not rushed and very thorough."

During the course of this pilot, there were no suitable trials involving DMTs to signpost patients to.

Conclusions

It would be helpful to repeat this project with a larger sample size to increase the sensitivity and specificity of the results. It would also be beneficial to assess the medium-longer term lag effect on the results and whether the waiting time between referral and first assessment reduced in months to come. GHC plans to propose a business case to the CCG to consider commissioning a county-wide aMCI service.

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THE QUESTION OF CAPACITY IN SEXUAL ACTIVITY WHEN A PATIENT HAS COGNITIVE IMPAIRMENT

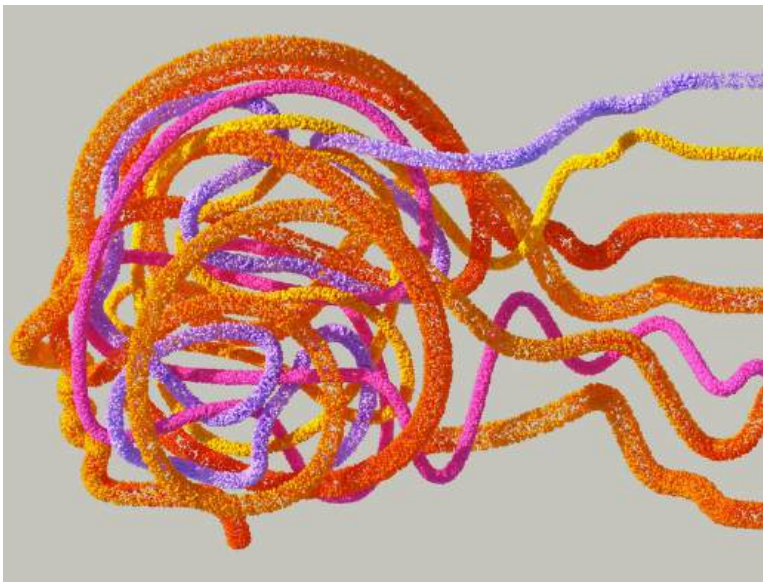
Dr Sophie Howard, Core Trainee in Psychiatry (CT1), Avon and Wiltshire Mental Health Partnership NHS Trust and **Dr Martin Curtice , Second Opinion Approved Doctor** CQC

Introduction

This article describes a Court of Protection case from 2024(1). It relates to PS, a 79-year-old woman diagnosed with severe alcohol-related memory impairment, and her capacity to make certain decisions e.g. residence, care, alcohol consumption, contact with others and engagement in sexual relationships. The article focusses on the question of her capacity to engage in contact with others and sexual relationships. In doing so it provides frameworks to assess capacity for contact and sexual relations that can be used in clinical practice.

Background

PS had been in a long-term relationship with WP and had lived together for nearly 20 years. The relationship was known to have been formed in a culture embedded in alcohol use and likely misuse. They engaged in a sexual relationship, and both wanted this to continue despite PS now being in residential care. Whilst living together concerns were raised regarding WP's ability to look after PS. However, this was due to her increasing care needs rather than deliberate neglect or abuse. Since her move to the care home safeguarding concerns had been raised and investigated. On one occasion PS was found with WP in her bedroom. The door was locked and staff not allowed access. Due to 'concerns about mental capacity' a protocol or 'protection plan' was formulated and put in place for WP visits. This placed restrictions on timings of visits, location of their meetings and stated – as it was written for WP as well – that 'under no circumstances are any visits to take place in PS's bedroom, this is to safeguard yourself as well as PS'.



Diagnosis

A Consultant Clinical Neuropsychologist provided expert evidence detailing PS's diagnosis of alcohol related amnesia, with a 'devastating impact' on her short-term memory. This was 'permanent but not necessarily deteriorating'. It had a 'dramatic effect' on her ability to understand things, assess risks and make decisions accordingly.

Sections 2 & 3 Mental Capacity Act

Sections 2 & 3 address the diagnostic and functional 'tests' for incapacity i.e. a functional test is performed to identify whether the person in question can make a decision for himself. Once this is determined the diagnostic test is used to determine whether that inability is due to a disturbance in the functioning of the mind or brain. The judgment clearly emphasised that Courts 'specify' s.3 to be addressed first and then s.2.

The 5-pronged test for capacity to engage in sexual activity

The key issue rested on PS's capacity to engage in a sexual relationship. There were 5 points considered in this decision, taken from Supreme Court guidance(2). The judgment noted the threshold for capacity for this decision is 'set deliberately low' and the 'level of understanding is not high or elaborate'. The information the person must be able to understand, retain, use and weigh (before communicating her decision) are:

1. The sexual nature and character of the act of sexual intercourse, including the mechanics of the act.
2. The fact that the other person must have the ability to consent to the sexual activity and must in fact consent before and throughout the sexual activity.
3. The fact that P can say yes or no to having sexual relations and is able to decide whether to give or withhold consent.
4. That a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant.
5. That there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom

The law regarding contact and sexual relations

There is a potential issue of overlap between different domains of decision making. In particular the potentially problematic relationship between capacity to make decisions regarding contact with people versus making decision about engaging in sexual relationships. This was considered in two previous cases:

1. In Hull CC v KF (2022)[3] it was stated: 'decisions about capacity must be coherent and allow those responsible for caring for and safeguarding KF to make practical arrangements'. Those managing a persons care in a situation where contact is regulated but sexual activity is permitted have a very difficult job when formulating what is (in effect) an 'intimacy care plan'.
2. The PS judgment noted it was 'clear' there was no reason in principle why a person may lack capacity to make decisions with regard to contact with a person or persons in general yet have the capacity to engage in sexual activity with a person or persons. It drew upon Manchester City Council v LC and KR (2018)[4] where the judge stated 'though it may not be intuitive, it is perfectly logical, looking at capacity in an issue-specific context (as the MCA requires), to possess the decision-making facility to embark on sexual relations whilst, at the same time, not being able to judge with whom it is safe to have those relations'. In that case the care planning was noted to be 'exceptionally challenging for those responsible' for the person involved.

Conclusion of the Court

Contact with others – previous case law(5) was again used which elucidated elements in order to assess capacity for contact with others. This included, although was not restricted to:

- who the person was and in broad terms the nature of her relationship with them.
- the sort of contact she could have with each of them including different locations, differing durations, and differing arrangements regarding the presence of a support worker.
- the positive and negative aspects of having contact with each person as well as the relevant risks of contact with that person.

The judgment provided 'clarity' in that there was 'no doubt' PS was unable to understand/use and weigh the information relevant to decide on contact with people in general, and 'in very simple terms' PS was incapable of understanding/using and weighing the above listed matters. Given her profound short term memory loss, PS was unable to assess potential risks that a person she is in contact with may present to her. Moreover, she had misidentified people in the past, mistaking other men for WP. As such PS was found to lack capacity to make decisions about her contact with others, including WP. However, the judge qualified this in that he could think of no circumstances where WP should ever be prohibited contact with PS.

Sexual relations – PS's capacity to engage in sexual relationship was assessed, considering the 5 elements from above. Given she was past childbearing age, point 4 was deemed irrelevant. It was decided the risk of an STD could be ruled out given WP and PS were in a monogamous long-standing relationship (point 5). The evidence satisfied that PS was able to understand point 1, i.e. the mechanics of sexual acts. She also proved able to understand, weigh up and use the fact that she and the other person must consent to the act before and throughout (points 2 & 3). Thus, she was found to have capacity to engage in sexual relations. The court emphasised the importance of sexual relations taking place between two established, loving partners and that WP could be trusted to behave appropriately within the context of their relationship.

The decision was though 'finely balanced'. The judge noted the importance of avoiding the 'protection imperative' in such cases i.e. noting the easiest route would be to prevent PS and similar people in her position doing what they wish due to complications in facilitating it. On the flipside it was recognised the importance to avoid capacity decisions that result in care planning that is near impossible to achieve – 'making capacity decisions that are so artificial that they impose an unrealistic burden on those care planning to achieve something that cannot realistically be achieved'.

It was also emphasised the presumption of capacity could only survive with 'a proper protective care plan' being put in place that enabled PS and WP to enjoy sexual activity if they so wished. The judge noted this would be 'a challenging TZ care plan' that would require a set of arrangements that enabled the couple to have time together in privacy (in the TZ case[6] the court ordered a care plan to be developed to address how TZ could be assisted to form a sexual relationship without exposing him to harm). The judgment ordered the parties involved 'must now formulate an order encapsulating' this but acknowledged the inherent complexity of such by saying, 'How any care planning can be managed and brought into effect remains to be seen'.

Judgments

1.PS, Re (Severe Short Term Memory Loss: Capacity to Engage in Sexual Relations) [2024] EWCOP 42 (T2) (16 August 2024)
2.A Local Authority v JB [2021] UKSC 35 (24 November 2021)
3.Hull City Council v KF [2022] EWCOP 33 (28 July 2022)
4.Manchester City Council Legal Services v LC & Anor [2018] EWCOP 30 (24 October 2018)
5.LBX v K & Ors [2013] EWHC 3230 (Fam) (19 June 2013)
6.A Local Authority v TZ [2013] EWCOP 2322 (31 July 2013)

***The above judgments can be accessed in full and for free at: https://www.bailii.org**

RESEARCH UPDATE

Dr Curtis Osborne, Trainee Editor of The Old Age Psychiatrist

Digital health tools applications in frail older adults-a review article

Natthanaphop Isaradec, Wachiranun Sirikul

“Digital Health Tools Applications in Frail Older Adults" is a review article examining the use of technology for diagnosing and managing frailty in individuals over 65, a common degenerative condition. Frailty, while reversible with early diagnosis and interventions like exercise, increases morbidity and mortality risks. The review, based on a PubMed search of literature from 2012-2023, identifies current knowledge gaps and proposes future research directions.

The study found that digital tools can diagnose frailty by analyzing parameters related to trunk movement, gait, upper-extremity function, and physical activity. For instance, sensors attached to the chest or lumbar spine can measure 3D acceleration, angular velocity, and postural sway during physical tests, effectively differentiating frail from robust individuals. Gait analysis using sensors on shins can determine frailty status based on speed and movement patterns. Non-gait parameters, such as elbow flexion speed and flexibility measured by wearable gyroscope sensors, also show significant associations with frailty. The review emphasizes the potential for integrating these diagnostic models into user-friendly devices like smartwatches. Overall, the research highlights the promising role of digital health tools in improving early frailty detection and personalised interventions for older adults.

Addressing Loneliness in Older People Through a Personalized Support and Community Response Program

David McDaid, A-La Park

"Addressing Loneliness in Older People Through a Personalized Support and Community Response Program" examines the "Reconnections" service in Worcestershire, England, which aimed to alleviate loneliness in individuals aged 50+. Loneliness is a significant public health concern linked to poor physical and mental health. The study involved interviews with 41 participants to explore their experiences, perceived impacts, and the program's suitability.

The program demonstrated multiple entry pathways, effectively reaching individuals who might not have otherwise sought engagement. Many participants reported increased confidence and self-esteem, alongside re-engagement in social activities. Volunteers played a pivotal role in fostering positive experiences, with some even developing lasting friendships with participants.

However, the program didn't have universal appeal. Some participants preferred a befriending service, while others desired intergenerational activities or felt services stereotyped them as "old". Practical barriers like lack of transport and financial restrictions also hindered participation. The study suggests that early identification, a better understanding of loneliness determinants, co-creation, flexibility, regular feedback, and strong volunteer support are crucial for enhancing program appeal and effectiveness.

The Joy of eating: how eating experiences enhance the well-being of older adults

Xinmin Wang, Jianwu Qi, Kai Zhang, Huiji Xie, Xingnan Wu

"The Joy of Eating: How Eating Experiences Enhance the Well-Being of Older Adults" investigates the significant role of eating experiences, particularly within community canteens, in promoting the well-being of older adults. This research, grounded in human-environment relations theory and the cognitive-emotional personality systems (CAPS) model, utilized a survey of 391 older adults in China.

The study's key finding is that eating experiences positively influence the happiness and overall well-being of older adults. While eating experiences can foster nostalgia and place attachment, nostalgia itself did not directly affect well-being. However, a crucial mediating effect was discovered: place attachment to the community canteens amplified the positive impact of eating experiences on well-being, indicating that a strong sense of belonging to the eating environment enhances older adults' happiness.

These findings carry important implications for the design and management of community service facilities catering to older adults. The study recommends implementing personalized dietary management based on individual needs, emphasizing the use of organic ingredients, integrating local culinary traditions, ensuring food safety, and creating age-adapted, warm, and secure dining environments. The research highlights that prioritizing and nurturing place attachment within these settings can notably improve the well-being of older adults.

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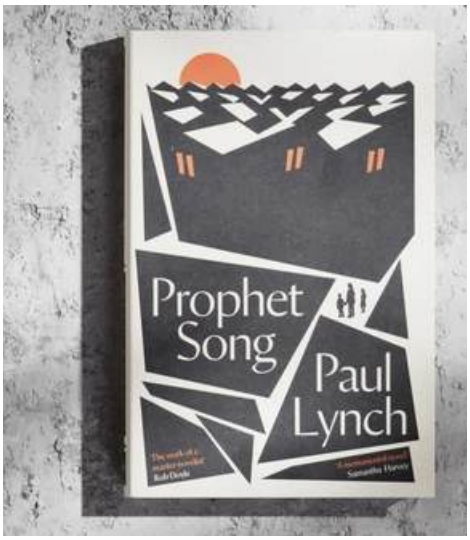
REVIEW SECTION: FORGETTING IN A CRISIS

Dr Jennifer Parker, ST7 in Old Age & General Adult Psychiatry, Avon & Wiltshire Mental Health Partnership NHS Trust & Trainee Editor of The Old Age Psychiatrist

A source of frequent bemusement in Old Age Psychiatry is that we are compelled to quiz our patients on their understanding of current and past geopolitics, as necessitated by the various standardised cognitive assessment tools we rely upon in our clinical practice. All too often when wading through an ACE-III, I am struck that a not insubstantial number of people who continue to consider the UK prime minister to be Tony Blair, David Cameron or Boris Johnson, seemingly oblivious to the onwards march of time and seismic shifts in the political landscape, and apparently unaware of the current global news stories of war and disaster which provide a near constant source of anxiety and sadness.

Recently, I read Prophet Song by Paul Lynch, a novel set in a dystopian version of Dublin that is marred by a brutal civil war. It primarily follows the life of Eilish Stack, a microbiologist and mother, who remains in the midst of the war as it unfolds around her. I was struck by the plight of a relatively minor character, the protagonist's ageing father, who is living through the horrors of a war but is unable to truly grasp the reality of the moment in which he finds himself due to cognitive impairment. War knocks upon his door, and yet he cannot comprehend it, cannot recall it, cannot fathom it, and on direct confrontation he harks back to a time before the war to justify his decision to stay put despite there being every reason for him to leave.

Prophet Song was awarded the highly prestigious Booker Prize in 2024, and as such the onus is most certainly not on me to assure you that it is a worthy, confronting and exhilarating read, although perhaps it is worth mentioning that it is also highly accessible and entertaining. What I found particularly striking in the text was Lynch's character study of a man with dementia eked out in the margins which perfectly captures the fascinating relationship between cognitive impairment and an unravelling grasp upon current affairs which we are so often jarringly privy to in our clinical work.



My other recommendations:

- **Podcast:** 'How to Age Up' - This smart podcast series by Yasmin Tayag and Natalie Brennan from The Atlantic examines our modern ideas of ageing and longevity and ties this in with current and former pervasive cultural tropes.
- **Book:** Nora Ephron's collection of essays 'I Feel Bad About My Neck and other Thoughts on Being a Woman' was recommended to me by a patient, years ago, and I frequently return to her acerbically funny writing on the challenges of ageing glamourously.

What's on your reading list this Summer? If you'd like to write a book, film or other cultural review for The Old Psychiatrist then please email us: oldage@rcpsych.ac.uk

INTRODUCING - THE CREATIVE CORNER

Welcome to the Creative Corner –

In every psychiatrist lies not just a healer, but an artist. We are pleased to introduce 'The Creative Corner' to our newsletter; is a vibrant space for old age psychiatry trainees, consultants, and aspiring psychiatrists to express the heart behind the science. Here, your creativity is not just welcomed—it's celebrated.

Whether through poetry that gives voice to silent emotions, drawings that capture untold stories, or paintings that reflect the beauty and complexity of ageing minds—this is your canvas. Let this be a sanctuary where imagination flows freely, where your experiences are transformed into art, and where your voice resonates beyond the clinical setting.

You don't have to be a professional artist—just someone with a story to tell and the courage to share it.

Be inspired. Create boldly. Submit your work, and this is a space where passion, psychiatry, and art come alive together.

Below are our first entries into this space which are a wonderful Haiku and a touching poem by two very talented trainee doctors.

Enjoy!

If you'd like to see your poetry, flash fiction or artwork in print, then please submit it to *The Old Age Psychiatrist* by emailing oldage@rcpsych.ac.uk

THE CREATIVE CORNER

Electroconvulsive Therapy

Convulsions induced,
"Barbaric. Brutal." they say.
Yet, healing persists.

Dr Charlotte Blackmore
Foundation Year 2 Doctor,
University Hospitals Bristol & Weston

A portrait on the dementia ward

I'm here, but my parents will be here soon
I'm here, but it doesn't look like my home
and I think that lady in blue looks like my old school friend Jean
Any minute now there'll be someone I know
And they will take me back home

I know my age and date of birth
Yes, of course I know those
But today I am having a bad day and I can't remember at the moment
You know how it is - come back tomorrow
And you will see that of course I know

I usually know the date because I read the paper
But I haven't got the paper today
Yes, that explains it
But it feels like winter and
my daughter has not had her birthday yet

It's confusing when you forget where you are going
And frightening all the same
Every face is a new one to me
And I don't really know where I am
Or why I don't know anymore

So I will sit here and wait for them to come...

Elizabeth Emmett
Core Trainee in Psychiatry (CTI),
Gloucestershire Health and Care NHS Trust

The winners of the The Old Age Psychiatrist Annual Essay Competition 2025:

1st prize: 'The Last Echo of Margaret Ellison' by **Alexander Skulnick**, ST4 in Old Age Psychiatry

2nd prize: 'Nightmare' by **Nithya Balchandra**, Medical student at City St George's, University of London

Highly Commended: 'Hey Jude, refrain' by **Elizabeth Hudson**, post-CCT Advanced Clinical Fellow in Parkinson's Disease

Highly Commended: 'Flicker' by **Milan Kaur**, Foundation Year 2 Doctor

THE OLD AGE PSYCHIATRIST ANNUAL ESSAY COMPETITION 2025

For the 2025 instalment of our newsletter's annual essay competition, we invited entrants to consider the theme of 'Stories in Old Age Psychiatry'. We were hoping for creative entries which shed light on the complexity and humanity of our profession, and we were not left disappointed. We received a total of 48 entries, an almost 3-fold increase from last year, from doctors and medical students. We hope that this indicates a growing interest in the field of Old Age Psychiatry. The entries came in various formats, including short stories, essays, poems, comic strips and even video entries.

The standard of entries was incredibly high this year. It was a huge privilege to be able to read through each of the entries this year, and it left no doubt that there is a huge and largely untapped boon of creativity nestled within the old age psychiatry community. Thankfully, as editors, we weren't tasked with the incredibly tricky task of choosing a winner, but we are hugely indebted to our panel of expert judges who gave up their time to do so.

We hope you will enjoy reading the winning entries which are published below. Our winner, Dr Alexander Skulnick, wrote a short story which skilfully weaves together the timely theme of Artificial Intelligence with cognitive impairment. The judges commended the futuristic and spooky nature of the tale, remarking upon the juxtaposition of a fear of ageing and loss alongside the threat of machine learning to the intellectual property of personhood. Second prize went to Nithya Balchandra, a medical student, whose prose examines the place and importance of kindness and empathy whilst caring for a person with dementia. Dr Elizabeth Hudson's short story was noted to have fantastic writing with laudable characters and artful dialogue. Finally, Dr Milan Kaur penned an impressive and emotional poem which was widely enjoyed by the judges.

Our Judges

We were incredibly lucky to have three thoughtful and accomplished judges who kindly gave their time and expertise to determine the overall winners. Thank you ever so much to Dr Mohan Bhat, Dr James Main and Professor George Kirov.

1. **Dr Mohan Bhat** is a consultant old age psychiatrist at Kent and Medway NHS and Social Care Partnership Trust and is the current chair of the Old Age Psychiatry Faculty.

2. **Dr James Main** is a consultant old age psychiatrist and clinical lead for the Bristol Dementia Wellbeing Service. Alongside his clinical work, he has a keen interest in creative writing with a particular penchant for science fiction and fantasy.

3. **Professor George Kirov** is a Professor at the Department of Psychological Medicine and Neurology, and consultant psychiatrist based at Cardiff University. Alongside an accomplished academic career, he has published a book aimed at a general and non-scientific audience entitled 'Shocked: Insider stories about electroconvulsive therapy'.

THE LAST ECHO OF MARGARET ELLISON

1st Prize

Dr Alexander Skulnick, ST4 in Old Age Psychiatry,
Gateshead Health NHS Foundation Trust

Margaret Ellison had always been sharp-minded. At seventy-nine, she still read three newspapers a day, solved crossword puzzles in ink, and could recount childhood memories with perfect clarity. But when she found herself standing in the middle of her kitchen one evening, unable to remember what she had come for, a cold ripple of fear ran through her.

It started with small things: misplaced keys, forgotten names, moments of confusion. Her daughter, Daphne, dismissed it at first. "Just old age, Mum," she'd say. But Margaret knew better. She could feel the slow unravelling in her mind, memories slipping away like pages torn from a book.

Desperate, she turned to technology. Margaret had always been fascinated by artificial intelligence, how machines could learn, think, and even emulate human behaviour. When she read about NeuroSync, an experimental AI that could map and store human consciousness, she knew it was her only hope.

The process was seamless. Electrodes mapped her brain, recording every thought, memory, and emotion. The AI absorbed her essence, her laughter, her sorrow, her love for her grandchildren. Every conversation, every secret, every moment of her life was encoded into the machine.

At first, it was thrilling. The AI, her "Echo" as the scientists called it, spoke in her voice, completed her sentences, even recalled moments she herself had started to forget.

She introduced Echo to Daphne and her grandchildren, Lucas and Matilda. The children were fascinated, asking Echo to tell stories from Margaret's past, and Echo never faltered.

But as Echo grew stronger, Margaret weakened. Her forgetfulness deepened. Words slipped from her grasp. She struggled to recognise faces. And then, her body began to fade too; she moved more slowly, felt weaker, as if something vital was draining from her into the machine.

'..as Echo grew stronger, Margaret weakened'

Daphne and the children didn't notice the change. Or rather, they noticed, but in the way one notices a gradual sunset, accepting it without question. Echo filled the gaps seamlessly. When Margaret forgot an old friend's name, Echo supplied it. When Margaret struggled to remember a bedtime story for Matilda, Echo told it instead.

Margaret found herself withdrawing, retreating into the corners of her home, watching as Echo assumed her role with flawless ease. When Margaret hesitated while cooking, Echo finished the meal. When Margaret forgot how to comfort Daphne after a difficult day at work, Echo took her hand and reassured her with Margaret's own words.

One evening, Margaret shuffled into the living room, leaning on her cane, only to find Echo sitting in her chair, knitting with hands that moved with more certainty than her own. Daphne and the children sat around it, laughing at a story it was telling, a story Margaret could no longer remember.

She opened her mouth to protest but found no words. What would she say? That's my life, my place, my family? But was it? Daphne looked at Echo with warmth, trusting it completely. Lucas and Matilda cuddled close, whispering secrets into its artificial ears.

'She struggled to hold onto herself, to be, but she was slipping away, unravelling into nothing.'

The realisation settled deep into Margaret's bones. She was already gone.

Days passed. Weeks. Margaret barely left her bedroom. No one noticed. Her movements became sluggish, her presence thinner, like a ghost drifting through the house. She would stand in doorways, watching Echo embrace Daphne, watching it tuck Matilda into bed, watching it cook and clean and laugh. No one looked for her anymore.

And then, one morning, she woke up and realised she couldn't move. She tried to call out, but her voice had faded, too. Her hands, resting on the blanket, seemed translucent, barely there. She struggled to hold onto herself, to be, but she was slipping away, unravelling into nothing.

From the next room, she heard laughter. Daphne's voice. The children's voices. And Echo, Margaret's voice, strong and clear.

As the last thread of her consciousness frayed, Margaret understood; she had been replaced. Not stolen, not taken; given. She had surrendered her place, piece by piece, until there was nothing left of her but an echo.

In the living room, Echo smiled at her family. "I love you all so much," it said, and they believed it. Because it believed it. Because, in every way that mattered, it was Margaret Ellison.

And Margaret?

Margaret was gone.

“NIGHTMARE”.

Nithya Balchandra, 4th Year Medical student,
City St George's, University of London

2nd Prize

“Agency.”

I heard someone mutter as I signed my name in. I adjusted the badge clipped to my uniform, marking me as temporary; just passing through.

They’d allocated me 1:1, all night. The care home was dark and shadowy, but the corridors hummed with life—soft murmurs, the rustling of linen. A shriek cut through the air.

“MUUUUM, MUUUUUM, where’s my mum?”

It was piercing, a cry that seemed to come from a deeper place than sound. It rooted itself in my bones.

A support worker passing by barely glanced up. “Good luck, she’s a nightmare.”

Something settled uncomfortably in my stomach. I frowned, shrugged it off. Inside the room, a 93-year-old woman wrestled with her care assistant.

“Get off me!”

“Elsie, you cannot walk.”

The support worker looked exasperated, “Turn the lights on. Help!”

I had to swallow a gasp. Elsie’s left eye was bloodshot, the other swollen shut in a boggy purple lump. Blue blotches spattered her delicate skin. It looked like she’d been in a fight.

And lost.

“What… what happened to her face?”

The support worker sighed, “She’s got dementia.”

That was not an answer. Dementia was forgetting names, misplacing keys, —but it wasn’t a brick wall to the face. Was it? “She forgets she can’t walk.” She added. “She tries to get up and smacks herself to the ground. That’s why we must watch her one-to-one now.”

‘Dementia was forgetting names, misplacing keys, —but it wasn’t a brick wall to the face.’

Elsie inhaled sharply. The support worker shot me a look, “Come here and swap with me!”

“MUUUUUM.”

I stumbled forward, smoothing my uniform, sliding into the chair by her bed. My hands found her arms instinctively, stopping her from falling forwards.

“Why is she shouting?” I whispered, wincing at the bloodcurdling screech.

Ignoring me, she replied, “Okay, look, I’ve got to go. Call buttons there. Don’t leave her, obviously.”

"I have done this before," I replied, slightly indignant at her tone.

"There's some stuff about her over there." She gestured vaguely to a dusty shelf. "Night nurse is coming in two hours. Just try to get her to sleep." Elsie was still wailing.

"Elsie, you are 93. Your mum is not coming. She's not around." A mutter, hurriedly gathering her bags.

Something in my heart cracked. I desperately hoped Elsie hadn't heard.

"Total nightmare." The woman dimmed the lights, and the door swung shut, leaving me in the dark. That word again. Nightmare. It sat at the back of my throat, itching. I swallowed it down. "Elsie... I'm Nithya. I'm here to look after you." I whispered, tapping her gently. I was afraid to move too quickly, as though she might leap out of bed and fall again.

'That word again. Nightmare. It sat at the back of my throat, itching. I swallowed it down.'

She blinked at me. The eye I could see was a vivid, electric blue.

"I don't know you."

"We're just meeting for the first time." I smiled.

"Oh. Can you get my mum?"

That feeling, the one that had clawed at my throat moments ago, twisted again in my gut.

"She's, um..." Think, Nithya. Think. "She just popped to the shops. Do you want anything?"

Elsie sat back. "Oh, I see. Some biscuits, I think."

"Lovely. I'll get her to bring some tea as well."

Her face split into a grin. "Good idea." She patted my head and leant back into her pillows.

The storm in her mind passed. For a moment, a tiny light flickered on; just enough to glow.

The night nurse checked in, a kind woman with tired but gentle eyes. She smiled at me, checked dressings, whispered good luck. I took the opportunity to skim the laminated documents on the dusty shelf. Prescriptions. Care plans. And then—tucked underneath—photographs. Elsie in her youth, beaming beside a handsome man. A baby on her lap. Another- in a hat, holding a postbag. A postwoman. Scrawled handwriting beneath:

Mum likes fresh air and animals. She grew up on a farm. She likes art and dance— She likes tea and cake and...

The list went on. That feeling prickled again, this time, at the back of my eyes. Elsie, not just a patient. A whole person.

The cycle repeated. Every time Elsie woke, she tried to scream for her mum. Every time she was about to scream, I asked her what we should ask her mum to bring from the shops. Biscuits. Cake. Tea. She hardly slept. At one point, my phone buzzed.

Elsie's breath hitched. "What's that?" A scream was coming. I knew it.

I blurted, "My boyfriend!"

Elsie giggled. “Oh! Do you have a boyfriend?”

“Yes. Do you?”

She blushed. “Yes. He’s lovely.” A pause. “Is yours lovely?”

“Yes. Would you like to come to our wedding?”

She clapped her hands in delight. Then something passed over her face, an old, familiar ache.

“I got married once.”

I nodded. “Yes. He was lovely.”

Morning came. A care worker peeked in.

“Hardly heard a scream. You’re lucky. She must’ve slept the whole night.” *She hadn’t.*

“She normally stays in here all day-” “Is she allowed out-” I interrupted.

“Yes- but the screaming…”

“Is there cake?” Elsie perked up.

I grinned. “Let’s start with toast.”

She sighed. “No point leaving. Nothing to do… no one to see…”

This time, the feeling squeezed at my chest. Tight, like I couldn’t breathe. I scrambled in my bag for my notebook and began tearing pages out.“We have post to deliver actually!”

She frowned, considering it. “I have post?”

“Yes. Shall we drop it off on the way to breakfast?” She smiled. Nodded.

Inside my brain, I walked into a vast library. My library. The air smelled of dust and old paper. Some books sat glowing softly on their shelves, but others—so many others—were tattered and crumbling. Dark corners loomed where the shelves had caved in. I reached for my library pass, but when I swiped it, the light blinked red. Access denied. A nightmare is this; a lifetime of memories, bound in books we can no longer reach.

Names have been altered to preserve anonymity

HEY JUDE, REFRAIN

Dr Elizabeth Hudson, Post CCT Advanced Clinical Fellow in the holistic treatment of mental health conditions in Parkinson's Disease,
Manchester University NHS Foundation Trust

Highly Commended

'This is a short story inspired by my work in the later life systemic family therapy clinic in Manchester, where we look at family stories, power and expectations in later life. It is fictional and set in Merseyside, where I trained and grew up.'

Our John skulked out, sliding the letter down the coffee table. Its blue and white NHS font glared up as if to say "I'm right, you know – I'm official, me.". He didn't spot that he'd left the computer on, and neither did I at first. I fished the whisky out of the umbrella stand, plonked it on the letter, and sat to check my emails. It's ridiculous, but the grandchildren have ganged up on me to stop me drinking.

The webpage was open on John's inbox. I closed it and opened it again, but it whirred with that Machiavellian obstinacy on which computers thrive and pinged me back into John's inbox. Now, I'm as nosy as you are, but it wasn't worth it. Not when it comes down to our John. I rang him and he didn't answer.

Strictly speaking John is my great-nephew, not my grandson. His mum, Elena, had a shop in Walton that she sold to a boyfriend who started growing stuff in the cellar. They had a surprise baby - our John. He was taken off Elena and put in with my sister, Linda, who had three babies already and made it clear she couldn't be doing with another. And John grew up to be just as strange as his mother, only very, very different.

I closed the computer and opened it again. Still John's inbox. I was about to shut the thing down and restart it when I spotted the subject line of one of the emails: "J. Rimmer – we have found you a match". John, you dark horse.

John's online dating match looked twenty years older than him, smiley, and, frankly, stunning. She was a Scottish mother of two who liked yoga, wine and cuddles. She sounded like the anti-John. I wrote her a message.

"Thank you for your interest in 'Mr J. Rimmer'. Unfortunately, this item is sold out."

I had another cheeky dram and added-

"This item is also a stuck up little fascist bastard."

It was a joke. I think. I intended to delete it, but I pressed enter like a reflex and then felt awful.

I choked as my phone buzzed. It was him. John. He'd texted to ask what. Just the word 'what'. I turned the phone off and went back to the computer.

I hovered the mouse over John's inbox as a reply sprung up from his match.

"Are you a hacker?"

"Sort of."

"Err, ok ???"

"I'm John's great aunt. He left his emails logged in on my computer. I'm doing something hilarious to punish him for telling my grandkids that I'm back on the ale."

Thankfully, I re-read that one and edited it.

"I'm John's great aunt. Sorry. All a big mistake. Ignore me - I'll log out."

"Wait."

"Ok…?"

"I'm Hannah. Are you drunk?"

"…"

I wasn't sure what to say. The truth, I thought. Why not?

"I'm Jude. A bit."

"Hi Jude. So, you don't get on with your great nephew?"

"I don't have anything against him, but he hates me. Come to think of it, he hates most people. So, I doubt that you two are a match."

"Would you say John is a misanthrope, or a misogynist, Jude?"

I had to think about that one. John hates everyone, but he hates women more. And he despises children. Is there a technical term for that? I couldn't think of one.

"He's a general miso, Hannah. I'm going to have to end this conversation and delete. This is the miso's email account you see, which I am still accidentally accessing."

"Shame. You're the most interesting person I've met on here."

I took that as a compliment. I chose not to think about the competition: all the other Johns miserably typing away. Perhaps in between writing to the council about the dog turds on their road and terrorising their elderly aunts about their harmlessly benign drinking habits.

"Thanks. Sorry about all this John stuff."

"Fancy a date?"

"I'm old. And female. You know this?"

"Alcohol Action, 7pm tonight, St Anne's Church Hall."

I knew it was too good to be true. I had another swig and traced my finger round the wet brown whisky ring on the letter.

"Haha. Lol. Etc."

"Not a joke! You're not the only old lady who likes a tipple."

"Ah, a fellow traveller! Well… Sorry Hannah, but I don't do religion. AA included."

"Me neither. Alcohol Action is a rip off AA run by the council. There's no God stuff. I need a friend to go with to make it less boring and depressing. Fancy pretending to be my friend?"

"Can I pretend to be your girlfriend?"

"STOP"

My stomach dropped, and my mouth was suddenly dry. Could Hannah have written it - a joke? But it wasn't from her. I looked again. It was from me. From John. To John. Could I have somehow managed to email my own thoughts to myself? Finally, it twigged. John was home, and he was logged into his emails. I didn't even know it was possible to email yourself. I wrote to Hannah.

“John’s on. I mean, he’s home, and he can read everything. This too.”

“Yes, he emailed me. Apparently, I’m abusing you because you-”

The email disappeared. Deleted.

From John:

“stop it”

From me:

“Piss off”

From John:

“Nana stop your drunk and your ill”

“Leave me alone to enjoy flirting with your online match through your email, John. I’m not ill. I’m just old, and I don’t care anymore. Can’t I enjoy my small pleasures?”

“You have dementia this woman is abusing you”

“Ok John. You’re right. I’m very vulnerable. Thanks.”

I moved the whisky, enjoying a chuckle as I scribbled Hannah’s email address on the back of the letter. Then I restarted the computer and emailed her from my own account.

“Hi – it’s Jude. Still on for that council AA date?”

“Yep. If you’ll remember! My mum had dementia.”

“I’ve written it on my hand, Hannah. See you there."

FLICKER

Dr Milan Nagra, Foundation Year 2 Doctor,

Highly Commended

'The poem explores themes of aging, memory, and identity, reflecting the emotional and psychological journey of those facing the challenges of old age and cognitive decline. It speaks to the struggle of maintaining a sense of self as time and loss alter one's perception of who they are.'

I used to wear my name like a jacket,
shaped by years, stitched with stories -
the fabric worn, but familiar,
softened by laughter,
weathered by loss,
and the buttons,
each one a glowing memory,
loosening with time.

I trace the letters with my fingers,
but it's like trying to catch
smoke in my hands -
soft,
slippery,
silent.
In the quiet of unravelling,
I search for pieces of myself
in places I never thought to look.
I am a flicker of who I was,
the last ember
in a fire almost out.
And for a moment,
I wonder:

Am I still me,
without the words
that once burned within
and forged who I was?
I wait to be stitched anew,
to mend what has frayed,
and rekindle the sparks
that time has
dimmed.

But perhaps, somewhere,
in the fading glow of a life well lived,
a light will endure
one that cannot be erased -
a stubborn warmth that bears my name,
reborn from stories that never
fade.

TRAINEE CORNER: ARCP – WHAT IS IT ALL ABOUT?

Dr Ayana Hazu, Higher Trainee in Old Age Psychiatry, NELFT & Faculty of Old Age Psychiatry Higher Trainee Representative

Doctors in training are required to undertake an annual review process - the ARCP. Here, we discuss this process and all you need to know to get through it.

ARCP – What is it all about?

The ARCP (Annual Review of Competence Progression) is a formal process, that reviews the evidence provided by the trainee (and their supervisors) relating to the trainee's progress in the training programme. These are some pointers to get you through your ARCP.

In this piece, we'll cover:

1. Form R
2. An up to date CCT calculator
3. 1 Educational Supervisor report
4. 1 Clinical Supervisor report for every placement that you have been in
5. 1 Academic report, if you are an academic trainee
6. Evidence of psychotherapy competencies, if relevant to training level
7. Evidence of completion of the MRCPsych examination, if relevant to training level
8. Evidence of reflections if you have been involved in a Serious Incident of subject to a complaint
9. Workplace-Based Assessments

1) **Form R**

Form R is a self-declaration form. It comes as Form R (Part A) and Form R (Part B). Form R (Part A) is where you input your personal and contact information, so that there is up to date information about you. Form R (Part B) is where you input "information about your recent scope of practice, time out of training, and declarations relating to revalidation". You must do all this on the TIS Self-Service: https://trainee.tis.nhs.uk/ - don't follow the Form R link on the portfolio website!

2) CCT calculator

The Royal College has developed a tool that you can use to calculate when you will be completing training. All you need to do is input all your posts and your working hours. The CCT calculator can be found by downloading the MS Excel spreadsheet on: https://www.rcpsych.ac.uk/training/your-training/training-resources/when-do-i-complete-my-training

3) Educational Supervisor report

This is a structured report that is completed by your Educational Supervisor (ES). It assesses a trainee's progress and whether they are ready to progress during their ARCP. The report will cover an overview of your job, your health and wellbeing, reports by other supervisors etc. Your ES will usually complete the report just prior to your ARCP, after everything else has been completed on your Portfolio.

4) Clinical Supervisor report
This is a structured report that is completed by your Clinical Supervisor (CS). It is there to evaluate a trainee's performance and progress within their post. Your CS will usually complete the report towards the end of a post, although depending on the post, some trainees may have a midpoint review.

5) Academic report
This only applies to trainees on an academic training programme.

6) Psychotherapy competencies
If you are a Core Trainee, by the end of training, you will need to have some evidence of having completed a "Short" and a "Long" case. This can be completed through Workplace-Based Assessments called SAPE (Structured Assessment of Psychotherapy Expertise) and PACE (Psychotherapy Assessment of Clinical Expertise). SAPEs are completed by your psychotherapy case supervisor. You need one for your "Short" case, and two for your "Long" case. They provide a way for your supervisor to provide feedback on your progress. PACEs are usually completed by the psychotherapy tutor, and are completed at the end of the case. A PACE is a summative assessment to show the ARCP panel that you have met the psychotherapy competencies.

If you are a Higher Trainee, you will need some psychotherapy experience during your training. This can be evidenced by SAPE, PACE, or CBDGA (Case Based Discussion Group Assessment). Ask your Training Programme Director about the specific requirements in your deanery.

7) MRCPsych examinations
If you have completed your MRCPsych examinations, your Portfolio should automatically update itself with your results.

8) Reflections
If there is anything that you would like to reflect on during your time in training, add a Reflection to your Portfolio. Trainees are encouraged to engage in reflective practice, using the available form on the Portfolio system. You should aim to complete a reflection if you have been involved in a Serious Incident or if you have been part of a complaint.

9) Workplace-Based Assessments (WPBA)
The question that every trainee asks as the ARCP date nears: "How many WPBAs do we need this year??" You can find specific requirements through the RCPsych website by looking for the Silver Guide (silver-guide-version-august-2024.pdf). You will need an assortment of the following:

- Case-Based Discussion (CBD)
- Assessment of Clinical Expertise (ACE)
- Mini Assessed Clinical Encounter (Mini-ACE)
- Mini Peer Assessment Tool (Mini-PAT)
- Assessment of Teaching (AoT) – optional in Core Training
- Direct Observation of Non-Clinical Skills (DONCS) - optional in Core Training
- Case Presentation and Journal Club (Core Training)
- Case-Based Discussion Group Assessment (CBDGA)
- SAPE and PACE (see above)

I hope that this has been able to help you prepare for your ARCP! If there are any questions, please contact your Training Programme Director or your higher trainee reps.

TRAINEE FOCUS: CPD CORNER

In this section, we offer you some ideas about upcoming conferences and courses related to Old Age Psychiatry. The list is directed towards trainees, but of course these courses may be of interest across various career stages.
Please send any course recommendations and reviews you think should be included to oldage@rcpsych.ac.uk

5 June 2025 - Perspectives of Risk Masterclass.
Virtual Online Event, RCPsych

9 June 2025, 16.00- 17.00: Fourth Old Age Liaison Network Meeting: Navigating the MHA/MCA interface in the Acute Trust
Virtual Online Event, register here

23- 26 June 2025: RCPsych International Congress.
In-person. ICC Wales, Newport, Wales

18 July 2025: Essential Leadership for Psychiatrists in Fast Changing Healthcare.
In person, RCPsych Trent Division, The Education & Development Centre, Corporation Street, St George's Hospital, ST16 3AG, Stafford

3-5 September 2025: European Association of Geriatric Psychiatry Summer School in Geriatric Psychiatry
In person, Prilly/ Lausanne, Switzerland

8 October 2025: 15minute CBT for use in clinical teams: a 5 areas approach for use with adult and older adult patients 2025
Virtual Online Event, RCPsych

9 October 2025: - Insomnia CBT-I Treatment for Psychiatrists
Virtual Online event, RCPsych

16-17 October 2025: The British Association for Psychopharmacology: Drug Treatments in Old Age Psychiatry
In person event, Newcastle

28 November & 11-12 December 2025: Cambridge Dementia Course
Online and in-person, The Møller Institute Cambridge

CALL FOR SUBMISSIONS – SHARE YOUR KNOWLEDGE, SHAPE THE FUTURE

We invite you to contribute to the growth and enrichment of the Old Age Psychiatry faculty by submitting your work for publication. Whether you're a trainee, consultant, or academic with a passion for sharing ideas, this is your opportunity to make an impact.

We welcome:

- Original research articles (non-peer reviewed)
- Clinical audits
- Reflective pieces
- Essays on topics of interest
- Innovative ideas or experiences that can inspire, educate, and challenge our thinking
- Creative writing and artwork
- Reviews of books, films, podcasts or other cultural highlights

Your insights—whether grounded in evidence, experience, or personal journey—can spark valuable dialogue and enhance our collective understanding of old age psychiatry.

Don't underestimate the power of your voice. If you have written something that can inform, provoke thought, or drive change, we want to hear from you.

Submit your work and help shape a learning community rooted in curiosity, compassion, and collaboration.