RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

Issue 93 September 2025

HELLO

Welcome to Issue 93, September 2025, of the RCPsych Old Age Faculty Newsletter

Editorial Team

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UPDATE FROM THE EDITORIAL TEAM

Thank you to everyone who put in their valuable time towards making this Autumn edition an impressive one. In this edition, as always, it is lovely to receive interesting pieces from the authors sharing their experience of working in Old Age Psychiatry and beyond.

Prof Rob Howard talks about 'The future of Old Age Psychiatry' which he believes is already here. Dr Ben Underwood, in the Vice Chairs report, has written about 'Fit for the Future, 10-year Health Plan for England, with shifts from Hospital to Community, Analogue to Digital and Treatment to Prevention. Do visit the Trainees Corner as there is useful information on opportunities in leadership and relevant courses and the 'Creative corner'.

Dr Deoman Gurung shares a reflective piece on dementia, Dr Mohammed Wajahat has written about the 'complexities of identity in later life' and Dr Rasika Bandgar on 'Role of the carer and associated burnout' in carers looking after loved ones with dementia.

Jennie and Curtis, our higher trainee editors put in their valuable time and effort to make each edition unique and interesting, thank you to both for their support and tremendous input. Thank you to our faculty manager, Kitti Kottasz for her diligence and support.

Do consider sharing your interesting pieces of work and articles for the newsletter by emailing kitti.kottasz@rcpsych.ac.uk or oldage@rcpsych.ac.uk for the January 2026 edition, send these in time before or by early December. The theme is health, well-being, living well and aging better.

As this is our Autumn edition, this season brings a lot of fond and beautiful nostalgic memories for me. I am sharing a picture of University of Kashmir, India where I graduated from over 2 decades ago.
Enjoy this edition.

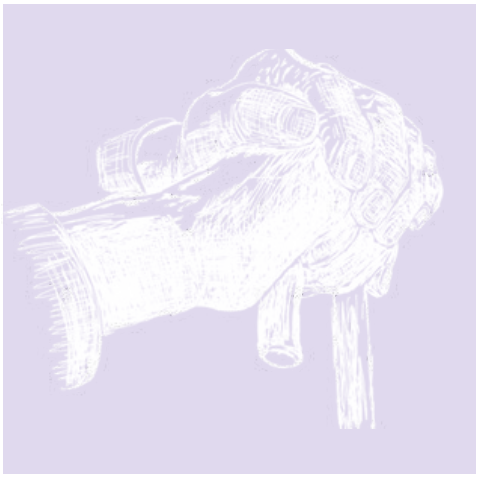
Best wishes

Dr Shaheen Shora

MBBS, MSc, FRPsych
Lead Editor

VIEW FROM THE CHAIR

Dr Ben Underwood
Vice-Chair of the Faculty of Old Age Psychiatry, Associate Professor, University of Cambridge & Honorary Consultant Psychiatrist, Cambridge & Peterborough NHS Foundation Trust



As we near the end of the summer I hope you have all had a chance to take a holiday and recharge – we will need our energy for the next year as these are exciting times of change and opportunity.

Since the last newsletter the most significant event has been the publication of 'Fit for the Future. 10 Year Health Plan for England'10 Year Health Plan for England: fit for the future - GOV.UK . Whilst the college extends well beyond England (or even the United Kingdom) the impetus this brings will surely be felt widely. I cannot remember a time in the last 30 years where there has been such a strong direction to the NHS from government. This is to be welcomed – not least as it seems to bring a great deal of opportunity for old age psychiatry.

Much of the contents of the ten-year plan had been widely trailed. The three shifts, hospital to community, analogue to digital and treatment to prevention were not a surprise. Old age psychiatry remains strongly community based and we are also well placed to capitalise on a prevention and move to digital agenda. Whilst we are all mindful of digital exclusion and the challenges increased use of the NHS app, for example, might present, we are in a position to find solutions. Already much of life is app based (when did you last go to a bank ?). I am sure we can overcome any difficulties to maximise the potential of digital advances.

In June we had an executive meeting and much of it was given over to addressing the ten year plan. We have worked closely with the national and associate clinical directors for older peoples mental health, particularly around the development of community hubs and the role of old age psychiatry in them. Much has to be decided but we are in a strong position to help shape community hubs. A separate faculty working group has been set up to address this and a similar group has been established to examine transition from analogue to digital, as well as plans for a digital focus to the winter online conference.

The ten year plan does not just focus on the three shifts. It also contains much else, including a plan for workforce. Whilst we embrace the government's plans for the future, even with successful delivery of the shifts, the increase in the number of old people is going to represent a big challenge for our faculty and its members. The executive are working to gather the best possible data and have created three fellows to support a specific piece of work on workforce planning for old age psychiatry. Mindful of the need for inclusion, a further fellow has been appointed to examine the needs of elders from global majority communities.

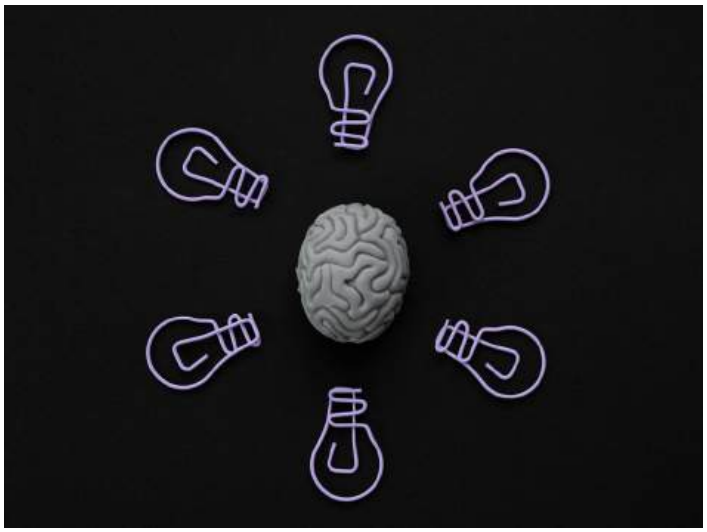
THE FUTURE OF OLD AGE PSYCHIATRY

Professor Rob Howard
Professor of Old Age Psychiatry at UCL and Honorary Consultant Old Age Psychiatrist at the North London Partnership NHS Trust

The advent and relative commercial failure of amyloid antibody treatments for Alzheimer's disease marks an interesting time to reflect on the future direction of our specialty. Although we hear about a healthy translational pipeline of new dementia treatments, there's actually nothing in late phase clinical trials that is likely to impact on our practice for at least the next decade. This may disappoint some of you, but I believe it puts control over the future of our specialty and the services we provide in our hands as psychiatrists. Resources and workforce supply may limit the extent of our ambitions, but we can and should decide where our training and expertise and the skills of our multidisciplinary colleagues can make the most positive impact.

The growth of a population of older people who are much more mental health aware than previous generations and the increased life expectancy of people with serious mental illness (many of whom used to die from smoking-related diseases before they reached old age), will also mean that the treatment of psychosis, depression and anxiety disorders will become a greater part of what we do, while the diagnosis of uncomplicated Alzheimer's disease and routine treatment with cholinesterase inhibitors and memantine could largely happen in primary care. These are the areas where I believe old age psychiatrists should get more engaged with and where the future of our specialty lies if we are to remain leaders of international practice.

Treatment of psychosis in people with schizophrenia who have grown old and may still have active delusions and hallucinations as well as disabling negative symptoms, people with later



onset psychosis who require a more assertive approach than our community teams currently offer, and those with Parkinson's and Lewy body diseases, where clozapine should be the offered standard, but we currently treat with drugs like quetiapine, which are ineffective. Psychosis is the heartland of Psychiatry and patients really do get better with adequate treatment if we can give it to them.

Although most people with depression can access effective treatment in primary care, older depressed people, and particularly those with co-morbid general medical and neurodegenerative disorders, are much more likely to show treatment resistance. We lack an evidence base for what works in treatment-resistant depression in older people and hopefully this will become clearer in the future. Meanwhile, old age psychiatrists will need to maintain optimism about treatment outcomes for depression and build their confidence in the safe use of venlafaxine, lithium, duloxetine and possibly ketamine, as well as continuing to keep open other options, including ECT and TMS.

Generalised anxiety disorder represents one of the most difficult to treat conditions that we encounter, and many patients fail to respond to SSRIs or CBT-based psychological therapies. Acceptance and commitment therapy and other third-wave psychological therapies, which focus on the context, processes and functions of how a patient relates to their internal experiences, show great promise in the management of generalised anxiety when first-line treatments have failed. We should understand and be able to apply ACT principles in our management of patients and have access to ACT-trained therapists, so that we have the tools to help patients with GAD.

It has always surprised me that colleagues in Neurology diagnose and manage rare dementias like frontotemporal dementia, where the presentation and treatment needs are so dominated by psychiatric symptoms. Indeed, many memory services refer suspected FTD cases to their local Neurology clinic. Neurologists are excellent at diagnosis and will often start FTD patients on an SSRI "for impulsivity", but our services, with expertise in treating cognitive and non-cognitive symptoms, supporting families and connecting patients with appropriate social care can offer so much more.

Retirement from work or the loss of a partner not infrequently unmask the presence of hitherto unrecognised autism spectrum or attention deficit hyperactivity disorder in an older person. Specialist services for these conditions have long waiting times and can be dismissive of older patients. We can access training and competencies so that our services can diagnose and manage these neurodevelopmental conditions, which can complicate the development of dementia and lead to greater risks for depression and anxiety in older people.

Finally, the high prevalence of potentially damaging levels of alcohol consumption among middle aged and older people will inevitably lead to significant numbers of patients presenting with all degrees of alcohol related cognitive impairment. Few old age psychiatrists feel confident in diagnosing or managing ARCI and many current services exclude such patients from their pathways. This is a growing and unmet need that our services (with adequate resource provided from Commissioning) should work to meet.

The UK pioneered the development of specialist clinical services, postgraduate training pathways and original research into diagnosis and treatment for older people with mental illnesses and dementia. By any definition, we once represented the future of Old Age Psychiatry. I would argue that the future is already here if we have the courage and ambition to meet the needs of those who we can help the most. Refreshing our focus on the mental health needs of older people who benefit from our expertise is the obvious way to ensure that our future is bright and successful.

WILL I DEVELOP DEMENTIA? A REFLECTION

Dr Deoman Gurung
Consultant Psychiatrist (MBBS, MRCPsych, Dual CCT, PGCert medical educational diploma, Leadership and Management Fellow- RCPsych, Medical Educational fellow- LSCFT, College tutor, CS/ES educator)

DR GURUNG

As a consultant psychiatrist specialising in old age psychiatry, diagnosing and managing dementia is central to my work. My dual training in general adult and old age psychiatry helps me analyse mental illness across different age groups.

My role as a consultant is split between acute inpatient care and community memory services. I share responsibility for 12 old age psychiatry wards with a fellow consultant. I directly oversee 6 inpatients. I am also deeply involved in our Memory Assessment Service. There, I conduct clinics and home visits to diagnose and support individuals with dementia in their own environments. Beyond direct patient care, I am passionate about education and development. I dedicate time to supervising trainees, appraising colleagues and serving as a college tutor.

Most of my patients are 65 and older. Occasionally, I see those as young as 45. During home visits, I often come across old photographs of my patients—full of life, energy, and dreams. The person before me now stands at the twilight of their existence. Dementia is a journey that gradually changes a person. It makes it difficult to access the shared memories and traits that once defined them. It challenges us to look beyond cognition and to cherish the enduring spirit and moments of grace that still shine through.

Understanding Dementia

Dementia is an umbrella term for a progressive cognitive decline—encompassing memory loss, impaired reasoning, and personality changes—caused by various disease processes that lead to neurodegeneration and synaptic dysfunction. It erodes independence, making even simple tasks challenging. When families ask me how dementia patients perceive the world, I compare it to waking up in a foreign land like North Korea, unable to understand the language or customs, forced into unfamiliar routines. The disorientation, confusion, and loss of identity are profound.

I emphasise to families that dignity, self-worth, and autonomy must be preserved, even as hope dwindles. In early-stage dementia, mindset matters—those who accept their condition and live in the moment often find greater fulfilment. Life is fleeting; everything that begins must end. In the grand timeline of humanity, our existence is but a blink. This realisation makes me value quality over quantity of life.

Lessons from My Patients

My work in memory clinics has taught me invaluable lessons. Lifestyle choices compound over time—smoking, excessive alcohol, poor diet, inactivity, and chronic stress elevate dementia risk. Cardiovascular events like strokes and heart attacks further increase susceptibility.

At 40, I recognise that in 30 years, I could be among the elderly I now treat. Understanding dementia risk has fundamentally shifted my daily philosophy. I now view each day as a critical opportunity to build cognitive resilience through integrated lifestyle medicine. This isn't just a theoretical concept for my patients; it's a personal practice.

I have consciously adopted a multi-faceted approach to mitigation:

- Physically, I challenge my cardiovascular system through endurance running, training for marathons and ultra-marathons.
- Cognitively, I commit to constant novelty and learning, exemplified by reading new books weekly and producing a podcast to synthesise and advocate for this knowledge.
- Socially, I actively expand my circle, forging new connections beyond my immediate environment to combat insularity.
- Nutritionally, I avoid processed foods and soft diets, focusing on whole, brain-healthy foods.

This paradigm is now the cornerstone of my clinical practice and my mentorship. I actively train the next generation of medical professionals—my resident doctors—to integrate this holistic view of prevention into their own lives and their future patient care, advocating for a model of health that is as much about building resilience as it is about treating disease.

urrent pharmacotherapeutic interventions for Alzheimer's disease, primarily acetylcholinesterase inhibitors and NMDA receptor antagonists, offer symptomatic modulation and may modestly attenuate the rate of symptomatic progression; however, they do not alter the underlying disease pathology or constitute a cure. They buy time for patients and families to prepare. My advice to patients is simple: 'The brain is like a machine—use it or lose it'. Learning new skills and hobbies strengthens neural connections, delaying cognitive decline.

A Hopeful Future

As a psychiatrist and a father of two, I balance professional insight with personal reflection. Pain and suffering are inevitable, and dementia is one of life's cruellest challenges. Every time I assess a patient, I imagine my own daughters someday providing collateral history about their father's cognition. This thought lingers, prompting the unavoidable question...

Will I develop dementia?

The discourse on optimism within old age psychiatry has evolved beyond the anticipation of a proximate cure. It is now characterised by a pragmatic and profound hope derived from advancements across the continuum of care and research.

This paradigm shift encompasses:

- *Actionable Prevention:* The empiric validation of modifiable risk factors provides a powerful, evidence-based platform for building cognitive resilience, fundamentally altering the clinician's role to that of an active guide.
- *Diagnostic and Scientific Precision*: The adoption of biomarkers facilitates a biological definition of disease, which is critical for developing targeted treatments. Concurrently, research into pathological diversity is advancing a more personalised approach to medicine.
- *Therapeutic Milestones:* The approval of anti-amyloid biologics, while debated, represents a pivotal proof of concept. Their true value lies in catalysing earlier diagnosis and accelerating the development of next-generation, more precise therapeutics.
- *Expanded Therapeutic Armamentarium:* Optimism is significantly grounded in the efficacy of non-pharmacological interventions and the systematisation of post-diagnostic support. These approaches effectively manage symptoms, enhance quality of life, and ensure care is aligned with patient values through advanced care planning.

Thus, the contemporary objective is not merely to mitigate decline but to affirm personhood and facilitate a connected, meaningful life throughout the disease course.

A REFLECTION ON THE COMPLEXITIES OF IDENTITY IN LATER LIFE

Dr Mohammed Wajahat Shabir
CT3 Psychiatry Resident Doctor, Greater Manchester Mental Health NHS Foundation Trust

Psychiatry teaches us early on that identity is never static. It bends, adapts, hides, and emerges in ways that surprise both the patient and the clinician. Nowhere is this more evident than in later life, when the layers of identity — cultural, familial, professional, spiritual — come into sharper focus, even as they sometimes collide.

As a resident doctor, I have been struck by how older adults often carry multiple narratives within them. Some stories are proudly told, others carefully protected, and still others buried so deeply that they surface only in moments of vulnerability. When we meet an older patient, we are not only encountering depression, psychosis, or dementia — we are encountering a lifetime of identities negotiating with one another.

The Many Voices of Identity

One patient I assessed described himself as a father, a soldier, and a believer, yet each of these identities seemed to speak in a different register. His faith told him one story about his suffering; his military past told another; his role as a parent demanded something else again. His distress was not simply about low mood — it was about reconciling which "self" was allowed to be heard. Old age psychiatry, in that moment, became less about symptom checklists and more about making space for the chorus of selves that inhabited him.

Another patient, an older woman who had migrated to Britain decades earlier, spoke movingly of how her identity had "thinned" with age.

Her children, British-born, saw her as a mother and grandmother, but not always as the woman she had been before arriving here.

She described a sense of invisibility — not only because of memory loss, but because her cultural and linguistic layers were not always recognised. Listening to her reminded me that identity in later life can feel fragile, even threatened, if it is not validated.

Complexity as Challenge and Opportunity

For clinicians, this presents both challenge and opportunity. The challenge is that complexity slows us down: it forces us to hold contradiction, to resist simplifying someone into a diagnosis or a neat formulation. The opportunity is that by doing so, we honour the person as more than their illness. We learn to hear the soldier, the believer, the mother, the migrant, the widow, the dreamer — all in one consultation.

This complexity is not just a feature of our patients; it is present in us too. As a resident doctor of mixed heritage, I am aware that my own layered identity shapes how I hear stories in clinic. Sometimes it makes me more attuned to the silences, the pauses, the things left unsaid. At other times, it challenges me to check my assumptions about what belonging or loss might mean. In this way, the clinical encounter becomes a meeting not only between two individuals, but between two constellations of identity.

The Gift of Old Age Psychiatry

Old age psychiatry has a particular gift here. It is a specialty that insists on breadth — biological, psychological, social, and cultural — and it invites us to see the patient across a whole lifetime. Our patients teach us that identity is not fixed in childhood or frozen in adulthood; it continues to grow, change, and adapt until the very end. Even in dementia, fragments of identity glimmer through a melody sung, a phrase repeated, a ritual gesture of faith.

Perhaps the greatest privilege of our work is to witness this resilience. Ageing is often framed in terms of decline, but it is also a period of integration. Many older adults show us that it is possible to live with contradictions, to hold multiple selves, and to make peace with them. This is not an easy task — it requires recognition, patience, and space — but it is one psychiatry can help to facilitate.

I recognise this in my own training. In the beginning, my attention was initially focused on diagnostic accuracy and management plans. With time, I have learned to value something gentler: the ability to sit with complexity, to listen for identity and contradiction, and to hold these alongside symptomatology — a more holistic way of understanding my patients.

Safeguarding Identity

As resident doctors, we often focus on mastering diagnostic criteria and pharmacology. These are, of course, essential. But if we forget that our work also involves listening for complexity, we risk flattening our patients' humanity. Identity is not a side note to illness; it is the ground on which illness is experienced.

To work in old age psychiatry, then, is to sit with complexity every day. It is to hear the soldier and the father, the believer and the doubter, the migrant and the neighbour, all speaking at once. It is to recognise that we, too, are complex, and that the therapeutic space is shaped by both our stories and theirs. And it is to remember that in listening for these complexities, we are not only treating symptoms — we are safeguarding the dignity of identity itself.

THE PSYCHOLOGICAL IMPACT OF CARING FOR A LOVED ONE WITH DEMENTIA: EXPLORING THE ROLE OF GUILT, GRIEF, AND BURNOUT

Dr. Rasika Bandgar
ST4 Old Age Psychiatry, Hertfordshire Partnership University NHS Foundation Trust

Background

Currently there are 982,000 people living in the UK who have dementia and the number is expected to rise to 1.4 million by 2040. Dementia is a challenging diagnosis not just for the individual suffering from it but also for the carer. The emotional and practical toll on family carers begins long before the first memory clinic appointment. They are the first ones who notice the subtle changes in the patients - being forgetful, repetitive, misplacing items, the slight change in personality and so on. Once a diagnosis is made, they carry the burden of managing care needs which can negatively affect their quality of life. As the severity of dementia progresses, the level of input needed in the care also increases and so does the burden on the carers.

The Emotional and Psychological Burden of Dementia Care

Caring for someone suffering with dementia is known to cause immense emotional and psychological stress. A 2018 Alzheimer's Society survey found that 9 out of 10 carers experience stress and anxiety several times a week. Speaking of financial and social impacts of being a caregiver, 63% of the total cost of dementia care in the UK are usually dealt with by patients and their family members.

The Role of Guilt in Dementia Caregiving

Guilt is a n emotion commonly experienced by dementia caregivers as they experience feelings

of inadequacy, doubting their own ability to provide appropriate care to their loved ones which can lead to constant mental chatter and self-doubt. Caregivers also go through guilt when they experience burnout and consider placing a loved one in a care home. They can feel that they are betraying their family member. In the end, even if they continue to support their family members, they at times experience frustration and resentment towards them resulting in shame and embarrassment.

Grief in Dementia Care

Dementia caregivers experience 2 types of grief primarily, anticipatory grief and ambiguous loss. Anticipatory grief involves thinking ahead to things that may happen in future, this grief usually progresses with the disease itself until the end of life. To witness the functional decline of a loved one can often be heart-breaking and evoke feelings of helplessness in caregivers.

Ambiguous loss, also known as living grief, refers to the emotional turmoil of carers for someone who is physically present but psychologically altered. The slow loss and lack of closure can be debilitating and frustrating. The median duration of dementia caregiving can range anywhere from 5 to 8 years, which can intensify the impact of ambiguous loss.

Burnout and Emotional Exhaustion in Carers

Burnout due to constant demand in the form of physical, psychological, and emotional exhaustion among dementia caregivers is a significant concern. This level of pervasive stress increases the risk of health issues, including insomnia, musculoskeletal and cardiovascular diseases. There are studies that show up to 76% of the caregivers experience poor quality of sleep, especially female caregivers.

Strategies to Support Dementia Caregivers

United Kingdom Initiatives

In the UK, approximately 700,000 friends and family members act as dementia carers. These are the support mechanisms available for them currently:

- *NHS Dementia Support:* NHS provides specialised dementia services such as memory clinics where the specialists do physical and cognitive assessments, brain scans, diagnose and manage dementia in people of all ages.

- *Alzheimer's Society:* They offer "Dementia Support Line" where carers can get in touch with dementia advisers for expert advice. Their online community encourages to seek peer support and share experiences. They also do a comprehensive practical guide on how to care for a person with dementia which explains how the needs change from early to later stages of dementia and what can be done to best patients in each stage.

- *Admiral nurses:* They are specialist dementia nurses who provide free, expert advice, support and understanding to help families care for their loved one.

- *NIDUS (New interventions for Independence in Dementia) Family Intervention*: This programme co-designed with unpaid/ family carers aimed at helping people with dementia live independently at home for as long as possible. This recent trial which involved over 300 UK patients showed that setting personalised, practical goals for dementia patients, supported by remote sessions with carer can help patients to live independently longer. This in turn would reduce hospital admissions and can save the NHS £8,934 per patients annually.

Global Strategies

Internationally, there are various programmes and policies in place to support dementia caregivers:

- World Health Organization's (WHO) iSupport Programme: This is an online self-help tool developed to skill and train caregivers on Dementia, how to respond to common challenges of caregiving and dealing with behaviour changes. They also provide support to carers supporting people with rare dementias like Lewy Body Dementia, Fronto-temporal dementia (FTD) and even primary progressive aphasia (PPA), posterior cortical atrophy (PCA). Additionally, they do iSupport Young People which is relevant to young people aged 11-17 with a family member or friend living with dementia. This is available in multiple languages including English, Spanish, Ukrainian, Arabic, French, Mandarin, Cantonese, Bengali, Punjabi, Urdu, Greek, Hindi, Vietnamese, Italian, and Tamil.

- Respite care services: These services can prevent burnout in caregivers by offering temporary relief in the form of short-term residential stays or in-home support to dementia patients. Countries like Australia and Canada offer government-funded respite care.

- Dementia-Friendly Communities: These are places where people with dementia and their carers are empowered, supported and included in society, understand their rights and recognise their full potential. Dementia Friends initiative was first started in Japan and the idea was to transform the way people think, act and talk about dementia. Inspired by this model, there are now 67 Dementia Friends programmes launched or in development in 56 countries and almost 19 million Dementia Friends worldwide.

Conclusion

Dementia caregivers can experience a range of emotions which can affect their own mental health detrimentally over a period. It's of prime importance that there are systems in place to provide them with the support needed so that they can ensure the continued provision of compassionate care. Developing and implementing strategies to support dementia care givers can alleviate the psychological burden on them and improve their quality of care. As clinicians, we must not overlook the carer's journey. Their resilience is critical to dementia care. Supporting them early on from the point of diagnosis is essential for the wellbeing of both patient and carer.

References available upon request.

AUDIT OF INITIATION OF DO NOT RESUSCITATE ORDERS IN PATIENTS WITH DEMENTIA ADMITTED TO A PSYCHIATRIC WARD

Dr Otto Willan[1], Dr M Lohash Lubsir-Latif[2] (Resident Doctors) and Dr Claire Pocklington[3] (Consultant)
Sheffield Teaching Hospitals; 2. Barnsley Hospital Foundation Trust; 3. Sheffield Health and Social Care

Introduction

People with dementia may die of a medical complication (pneumonia, heart failure) or the dementia may be the main cause of death, and is the most common cause of death in those over 80 years of age in the UK [1].

Guidance recommends early discussions of advance care planning with continuous review, including discussion of cardio-pulmonary resuscitation, usually documented by a "Do not attempt Cardiopulmonary resuscitation" (DNACPR). Best practice entails involving patients in conversations about their wishes for future care prior to deterioration in their cognitive function in order to avoid "aggressive, burdensome and futile treatment" [2] and to ensure their involvement in their own care before they lose capacity for such decisions [3].

Aim and Hypothesis

Aims: To establish the number of patients admitted to an inpatient specialist dementia psychiatric ward who have a DNACPR form and when this form was initiated.

Hypothesis: Patients are having DNACPR forms initiated on admission to specialist dementia ward and prior opportunities for discussing resuscitation are being missed.

Methods

This was a retrospective audit carried out on a specialist inpatient psychiatric dementia ward. The audit was approved by Sheffield Health and Social Care.

In terms of sample population, we identified patient records for all admissions between January 2020 and December 2022. Exclusion criteria were if the patient was for resuscitation or that their DNACPR form could not be found on their electronic patient record (EPR), even if reference to it had been made elsewhere.

In terms of data collection and analysis, we analysed the EPR, which should contain a scanned copy of their DNACPR form, MDT discussions, discharge letters and admission summaries. The data collection tool was developed by resident doctors following discussions between all members of the project team. An Excel spreadsheet was then created and subsequently used for data analysis.

Results

Resuscitation status: Of the population of 76 patients, 16 were excluded due to being for full resuscitation, and 6 were excluded due to data collection issues. Of the 54 patients who had a DNACPR on record by time of discharge, 57% were initiated prior to admission and 43% were instituted during psychiatric inpatient stay.

Discussion of DNACPR: DNACPR forms include details of who they have been formally discussed with. The majority of patients (53%) had a DNACPR that was made as a best interest decision between doctors and family members that the intervention of CPR would not be of overall benefit to the patient. However, it was noted from the data that 15% of forms analyzed did not list any one for discussion and 6% listed that the form had been discussed only with the patient.

Listed Conditions: 52% of DNACPR forms listed contributing medical conditions as to why resuscitation was not medically indicated. Of these forms, 37% listed dementia as the sole diagnosis and only 6% of these forms did not include dementia as part of medical reasoning.

Discussion

Of the sample of 54 DNACPRs analysed, 57% were initiated during psychiatric inpatient stay.

The admission pathway was analysed: those who were admitted from a general medical ward/hospital ward and those who were admitted from the community. This showed that 66% of those admitted to the ward from a general hospital had a pre-existing DNACPR on admission. In the sub-group admitted directly from the community, only 15% of patients had pre-existing DNACPR. All these patients were assessed and felt not to be suitable for resuscitation by the ward team on admission to our ward.

The team under which the patients had been assessed or treated prior to their admission to the inpatient unit was also analysed in the sub-sample of patients admitted without a pre-existing DNACPR, to see if there were identifiable points prior to admission to the ward where there may have been opportunities to discuss DNACPR. 55% of these patients had been seen by a psychiatric team, mostly home treatment team (42%)

Specified medical reasoning for DNACPR		
Dementia Sole diagnosis	1	37%
Dementia + Frailty	8	30%
Dementia + Cardiac disease	3	11%
Dementia + Cardiac + Frailty	2	7%
Dementia + COPD	1	4%
Dementia, Type 2 diabetes, frailty, AS	1	4%
Inoperable AAA, frailty	1	4%
Frailty, Heart Failure, Poor Functional reserve	1	4%

Figure 1: Table of specified medical reasoning for DNACPR

or community mental health teams (18%) and 27% had been seen by general medical physicians. Notably, 6% of patients had been seen by both HTT and General hospital, without any previous documented DNACPR. For some patients (12%) this information was not available.

All of these patients were suspected to or had a confirmed diagnosis of dementia – a terminal illness – of severity sufficient that they required referral to a specialist unit for treatment. We therefore confirmed our hypothesis that there may be missed opportunities for discussion of advanced care planning, especially in the community psychiatric teams - whether in memory clinics or community mental health teams.

It was also noted that of the diseases listed on DNACPR forms as reasons that CPR would not be successful, 93% of forms analysed listed Dementia as a causative reason, with 37% of the DNACPRs having no other medical condition listed. We also noted 44% of forms listed frailty. We speculate this may reflect some of the current complexities of care of older people, as both dementia and frailty are complex multi-system conditions. These conditions may be progressive and ultimately terminal in nature.

Conclusion

This audit shows that many patients with dementia were admitted without a DNACPR form in whom it was thought that this was an appropriate advanced care plan. Only 5.5% patients were documented to be included in discussions. We speculate that this is due to severity of dementia leading to a lack of capacity for complex theoretical decisions. Additionally, a majority of patients had their dementia diagnosis listed as the reason that CPR would be medically futile.

This represents a lack of early advance care planning which is against gold standard guidelines and has led to patients being unable to be involved in this aspect of their care. There was a higher rate of institution of new DNACPR on admission to the ward in those who were admitted directly from community mental health teams.

We shared the results of this audit with the Trust (Sheffield Health and Social Care) with the suggestion of reviewing pathways for incorporating advance care planning into patients' earlier contact with services such as memory clinic or community mental health teams.

References available upon request.

RESEARCH UPDATE

Dr Curtis Osborne,
Trainee Editor of *The Old Age Psychiatrist*

Neural Basis of Anxiety in Dementia With Lewy Bodies

Kimura et al., 2025

This study investigated the clinical and neural correlates of anxiety in dementia with Lewy bodies (DLB), focusing on its relationship with core clinical features and regional brain function. Data were analyzed from 40 patients with probable DLB and mild dementia (Clinical Dementia Rating 0.5–1). Anxiety was assessed using the Neuropsychiatric Inventory (NPI), and regional cerebral blood flow (rCBF) was examined with single-photon emission computed tomography (SPECT).

Findings showed that patients with anxiety had significantly higher rates of fluctuating cognition compared with those without anxiety, suggesting a close link between these features. Neuroimaging revealed a negative correlation between anxiety severity and rCBF in the right supramarginal gyrus, a region involved in emotion regulation. This supports the hypothesis that parietal dysfunction contributes to anxiety in DLB. The study also found that younger patients reported higher anxiety scores, possibly reflecting heightened awareness of functional decline. No significant associations were observed between anxiety and other core features such as parkinsonism, REM sleep behavior disorder, or visual hallucinations.

These findings highlight fluctuating cognition and right parietal dysfunction as potential therapeutic targets for managing anxiety in DLB, with implications for both pharmacological and nonpharmacological interventions.

The paper is currently available here (Open Access)

Professionals' Perceptions of Suicide in Older Adults in Care Homes

Redondo et al., 2025

This study explored how nursing home professionals perceive and respond to suicidal ideation and suicide attempts among older adults in residential care. A sample of 338 professionals in Spain completed a vignette-based questionnaire describing residents with either suicidal ideation or a suicide attempt, with scenarios varying by gender. Responses assessed perceived frequency, normalisation (ageism), attention-seeking, risk level, likelihood of future suicide, and emotional reactions.

Findings showed that professionals tended to normalise suicidal ideation as common and expected in older adults, particularly women. This perception risks reducing the urgency of intervention and delaying support. In contrast, suicide attempts were associated with higher perceived risk, greater likelihood of future suicide, and stronger anxiety responses from staff. Interestingly, suicidal ideation was not generally interpreted as "attention-seeking behaviour," countering a common stigma. Gender biases were evident: suicidal ideation in women was often considered more normative, while men were perceived as higher risk.

The study underscores the dangers of ageism and gender bias in suicide prevention. It calls for specialised training, psychological support for staff, and standardized suicide risk protocols in care homes. Interdisciplinary collaboration across health, nursing, and mental health teams is essential to address this critical issue effectively.

The full paper is currently available here (Open Access)

Age and Sex Differences in Adverse Events from Antipsychotic Use

Ramin et al., 2025

This study examined age- and sex-related differences in adverse events (AEs) linked to six commonly prescribed antipsychotics—aripiprazole, clozapine, olanzapine, quetiapine, risperidone, and haloperidol—using the FDA Adverse Event Reporting System (FAERS) between 2003 and 2024. Reports were grouped into 18 AE categories, and adjusted reporting odds ratios (aRORs) were calculated. Drug-specific risks emerged: risperidone showed the strongest signal for hyperprolactinemia, haloperidol for dystonia, and aripiprazole for akathisia.

Age was a major factor: patients ≥65 were more prone to cardiac, extrapyramidal, neuroleptic malignant syndrome, and sedative side effects, while younger adults (<65) more often experienced metabolic complications such as weight gain, dyslipidemia, and hyperglycemia, particularly with olanzapine and quetiapine. Sex differences were also pronounced. Women had higher odds of hyperprolactinemia across most drugs (4.7–8 times greater than men), though a surge in post-2014 reports linked risperidone to hyperprolactinemia in men. Men were also more likely to report anticholinergic syndrome with aripiprazole and olanzapine, and weight gain with risperidone.

The findings underscore the importance of tailoring antipsychotic prescriptions by age and sex. Considering demographic vulnerabilities can improve safety, reduce adverse effects, and enhance treatment outcomes in psychiatric and geriatric care.

The paper is currently available here (Open Access)

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REVIEW SECTION: THE THURSDAY MURDER CLUB

Dr Jennifer Parker
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This movie is pitched as a cosy and undemanding piece of entertainment, but psychiatrists be warned: it is virtually unwatchable if you are troubled by senseless inaccuracies in the depiction of your career and work. Suffice to say, I hated this movie. Adapted by Stephen Spielberg and based on Richard Osman's bestselling novel of the same name, The Thursday Murder Club follows four retirees, played by Helen Mirren, Ben Kingsley, Celia Imrie and Pierce Brosnan, as they use their amateur sleuthing skills to solve a cold case murder from the comfort of a remarkably plush rural retirement community.

The first exercise in suspending disbelief relates to the retirement home itself, filmed in a former stately home, dripping in impractical wealth and splendour. Light floods through floor to ceiling windows, merry retirees socialise as they dawdle between different sports and activities whilst staff politely hand out drinks and the occasional canapé. Illness and death are politely confined to the facility's hospice wing (eek), which is thankfully tucked largely out of view. This fantasy version of elderly care is so farfetched as to bring the truth into extremely stark relief for those of us who know the reality; my experience which is supported by the literature is that older people in long-term care facilities routinely have very low natural light exposure, are often provided with food which is nutritionally inadequate and rarely have access to enough meaningful activities.

I can almost forgive the filmmakers for avoiding a drab location and for presenting an optimistic fantasy version of reality; it is, after all, far more entertaining to see a cast of A-Listers swanning around manicured lawns than it would be to contemplate the recruitment crises and funding challenges which plague care home settings. However, my hackles were up from the get-go as Ben Kingsley's character, Ibrahim, is repeatedly described and introduced as a psychiatrist whilst very clearly portraying the role of some sort of non-medical psychotherapist.

Dressed in plaid, lightly bearded and reading aloud comments about trauma from a moleskin notebook he keeps in his pocket, he is an unfortunate ghost of Freud which continues to haunt our profession. The (pseudo) psychiatrist nods dumbly along as the other characters wish for some medical expertise to help them solve their mystery, and expresses delight when a retired nurse arrives to finally explain the most banal of physiological concepts. He needs said nurse to explain what Fentanyl is, and, indeed, what an *injection* is. When another character collapses he looks casually on and joins the crowd in hoping a doctor or even a vet may arrive soon. I recognise this is a pet peeve of mine, and a somewhat silly one at that, but I feel aggrieved that Osman and the chain of scrutiny afforded by a Penguin editorial process, and now a Netflix budget, allowed for this monstrous character to filter through.

If you can get through this film without making at least one ratty observation, you've done better than me!

What's on your reading list this Autumn? 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

THE CREATIVE CORNER: ‘STORIES IN OLD AGE PSYCHIATRY’

Dr Marisa Wray
Consultant Old Age Psychiatrist, Kendal, Cumbria

Once upon a time there was a girl who loved stories. She lived and breathed the books she read, transported to another world.

The girl loved science too. Her insatiable curiosity demanded the ‘why’ as well as the ‘how’. Her need to know everything earned her few friends, and she lacked the easy manner of other girls in her class. But when she read, she became Jane Eyre[1] and was slightly in love with Atticus Finch[2].

Primo Levi[3] taught her the story of a carbon atom which became a full stop on his page. She wondered why the man mistook his wife for a hat[4] and cried at ‘A Kind of Alaska’[5]. She smiled at Stahl’s interpretation of the genome as every word there is and of epigenetics as the story.

The girl’s imagination ran away with her and she followed the yellow brick road to the pharmacology department. She discovered many of the whys she had sought as a child, but so many more questions. What makes a thought? Do we have a soul? How exactly do dopamine and serotonin make us feel pleasure?

Perhaps fascination with neuropsychopharmacology stemmed from her own struggles. How did psychology and psychopharmacology interact? Was it a chemical imbalance in her brain or just lack of moral fibre? Maybe she needed CBT? Why was she more at home with rats than with people?

The girl still has palpitations when she enters the hospital where she learned to talk to patients. There were so many stories. She did not know how to put them together. Introducing herself took such courage and often resulted in rejection. People did not tell her what she needed to know, only what they wanted her to know. The girl was a rabbit in the headlights during teaching sessions where her peers were so quick with answers.

The girl questioned whether doctoring was really for her. What type of doctor could she be? She did love hearing people's stories. She was intuitive, loved to puzzle things over and wanted to understand people. As Atticus Finch said, 'you never really understand a person…until you climb inside of his skin and walk around in it.'[2]

The girl's story nearly became a tragedy by the end of her first year as a doctor. Her empathy was frazzled to a crisp and her sensitive soul was in pain. She clung to what she knew and loved and went to France to study the Bible, perhaps the oldest story in the world. She learned that Jesus did not heal all the sick. She was part of a bigger story, not its lynchpin.

Alas, her story faltered again at her second attempt at doctoring. She gave up on being a doctor, a square peg in a round hole. But things do not always turn out as expected. The girl might not have become an old age psychiatrist at all but for two things: The affinity she felt when she listened to a depressed older patient whom she clerked on call; the college tutor, an old age psychiatrist, who planted a seed in her mind as she left to lick her wounds.

Next, the girl became a brain surgeon, or rather, an expert on dopamine neurotransmission in the rat brain. During her PhD she really did miss listening to people's stories. She could not speak only to rats for the rest of her career, though she still has a soft spot. One of her favourite books remains Flowers for Algernon[7].

The girl gave doctoring attempt number three. From day one of old age psychiatry she was hooked. Her first team meeting involved giant African land snails running amok in the home of a man with dementia. She grinned and wondered how the man had acquired such an unusual pet. On a home visit she congratulated a lady with dementia on her well behaved cat. 'Oh, the cat's taxidermied', said her son. It was not until the girl stooped to stroke the very well behaved cat that she understood, with horror, the import of his words!

Actions also told stories. A colleague gently taking the hand of a lost patient and leading her around the unending loop of the ward's corridors. Nonsense conversations with a patient whose dementia had robbed them of coherent thought. Such interactions went beyond words.

The girl marvelled at many stories over the years: a lady pilot testing bouncing bombs on Windermere in 1940; the loneliness of the man who had illustrated her beloved childhood reading scheme. Some stories, she wished she could unhear. Childhood abuse which resurfaced as PTSD when dementia struck. A patient forced to masturbate her carer because he was her 'best friend' and 'no one would believe her anyway'.

Once, a patient handed her a pink envelope addressed 'President Putin, the Kremlin, Russia'. It contained Fisherman's Friends for Putin, very strong, minty throat sweets made in Fleetwood, north west England. The girl wrinkled her brow and her nose. Not only was she not fond of Fishermen's Friends, but she required enlightening. The lady patiently explained that she was solving the cod crisis in the Baltic. Monster fish were eating the cod, hence the shortage. Fisherman's Friends were toxic to monster fish. Putin was to tip them into the Baltic, the monster fish would die, and cod would again be plentiful. The postman had retrieved many such envelopes from the post box. Sadly, they never reached their intended recipient.

The girl loved to collect beautiful phrases. One such was 'I don't have a memory, I have a forgettery'. She once met a stained glass window artist married to a concrete poet with bipolar disorder. The girl helped the poet request never again to be prescribed haloperidol, so frightening and visceral had been her experience of acute dystonia. The poet said that the girl was 'an ornament to her profession'. The girl felt that perhaps being a doctor might form part of her story after all.

References available upon request.

TRAINEE CORNER: LEADERSHIP OPPORTUNITIES

Dr Harleen Birgi
ST5 in Old Age Psychiatry, North East London NHS Foundation Trust & Faculty of Old Age Psychiatry Higher Trainee Representatives

Welcome to the September Edition!

With this September issue, we extend a very warm welcome to all our new trainees who commenced their training in August. We hope you are settling well into your new posts and beginning to find rewarding opportunities to learn, grow, and develop your skills.

This month, we are highlighting some of the leadership opportunities available to trainees during their training journey. Taking on a leadership role can be a hugely rewarding part of your training. It allows you to influence decision-making, gain confidence, and develop skills that will serve you throughout your career. It also provides valuable opportunities to connect and collaborate with senior colleagues, peers, and other professionals across the wider healthcare system

Some of the Leadership Opportunities available for Trainees inlcude:

1. RCPsych Leadership and Management Fellowship Scheme (LMFS)

This is a 12-month fellowship accredited by the College, designed for higher trainees and mid-career SAS doctors. Fellows proactively engage in leadership projects and are mentored by senior medical leaders within their organisations. More information can be found here.

2. Leadership Courses

There are many local and national short courses available to build leadership skills. Popular options include those run by deaneries, the NHS Leadership Academy, and the College itself. The NHS academy provides details on various structured leadership programmes such as The Edward Jenner programme and Mary Seacole programmes. Further details are here.

3. Local Trust Representative Roles

Becoming a trainee rep in your trust gives you the chance to advocate for peers, sit on junior and senior meetings, education committees, and possibly be part of quality improvement initiatives. These roles strengthen your communication and advocacy skills whilst ensuring trainee voices are heard; it is a good opportunity to influence changes locally.
If you are interested you can speak to your local Medical Education team for available positions.

4. RCPsych Leadership Roles

The College offers trainee involvement through the Psychiatric Resident Doctors' Committee (PRDC), faculty committees and special interest groups. There are various regional, local and national roles within the college, with vacancies advertised regularly. These roles can help you to gain experience in influencing policy, shape training programmes, and work alongside leaders in psychiatry.
Vacancies are usually advertised by the college mailing team and on the official college page.

5. BMA / LNC Representative Roles

If you are a member of the BMA, you can become a BMA or Local Negotiating Committee (LNC) representative. In this role, you'll advocate for doctors on issues such as contracts, working conditions, and rotas. These roles offer invaluable experience in negotiation, advocacy, and system-level change.

Webinar Recommendation:

A recent webinar hosted by The RCPsych Old Age faculty are hosting a webinar for higher trainees and new consultants focusied on the transition from being a trainee to a consultant. This was the 4th part of a webinar series which the faculty has run for Old Age higher trainees over the last year.

This webinar was designed exclusively for Resident Doctors in Higher Training and new consultants, working in Old Age Psychiatry,

This webinar is only open to Resident Doctors in Higher Training, and new consultants to attend, thanks to the generous funding support of the Faculty of Old Age Psychiatry.

If you are a higher trainee in Old Age psychiatry in the UK, you can still watch the webinar on demand for free.

Details and registration:

https://www.rcpsych.ac.uk/events/conferences/detail/2025/09/18/default-calendar/old-age-psychiatry-resident-doctors-in-higher-training-webinar--4--from-learning-to-leading---the-leap-from-higher-trainee-to-consultant

Best wishes,

Harkeen Birgi

Old Age Higher Trainee Representative

Contact me via:
oldage@rcpsych.ac.uk

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

8 October 2025:
15 minute 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

UPCOMING OLD AGE PSYCHIATRY FACULTY PRIZES AND BURSARIES

National Old Age Resident doctor essay prize
Deadline: 1 November 2025
This prize is awarded for an original and inspiring essay of between 4,000 and 6,000 words on a broadly based clinical topic directly relating to the care of mentally ill older adults.
Prize: 2 prizes of £150 (1 x FY/CT and 1 x ST)

Felix Post prize
Deadline: 1 November 2025
The Felix Post Prize was established in 2004 to commemorate the contribution of Dr Post to Old Age psychiatry. This prize will allow consultants, resident doctors and non-consultant grade career psychiatrists to reflect on their current work and describe in an essay an innovative task undertaken by the multi-disciplinary team which may contribute to the management of older patients suffering from functional illness.
Prize: £500
Eligible: Consultant psychiatrists, resident doctors and non-consultant grade career psychiatrists. This is a UK prize.

Medical student essay prize
Deadline: 31 December 2025
Prize: £250 and subsidised attendance at the faculty conference
Eligible: All medical students in the UK

For information on all prizes and bursaries offered by the Old Age Faculty, see the section on the college website: https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/prizes-and-bursaries

CORRECTION NOTICE

In the May 2025 Old age psychiatry newsletter the article Impact of Dose Titration Using the Seizure Quality Rating (SQR) Scale on Electroconvulsive Therapy Outcomes, cited two references were unfortunately in error (Kirov et al., 2016; Sackeim, 2017).

These specific references do not exist as published papers. The correct supporting sources consulted by the author were:

- Kirov et al. (2016), British Journal of Psychiatry – cognitive outcomes of ECT
- Cardiff ECT procedural guidelines – including the Seizure Quality Rating (SQR) scale and relevant seizure parameters
- Sackeim et al. (1993), New England Journal of Medicine – cognitive effects of ECT
- Sackeim (2014), Journal of ECT – autobiographical memory

We sincerely apologise for this oversight. For transparency, full references for future articles will be available on request.

CALL FOR SUBMISSIONS – SHARE YOUR KNOWLEDGE, SHAPE THE FUTURE

Call for Contributions: Ageing Well – Healthy Ageing

We invite you to contribute to the growth and enrichment of the Old Age Psychiatry faculty by submitting your work for publication. This edition centres on the theme of Ageing Well and Healthy Ageing—exploring how we can support later life as a stage of fulfilment, resilience, and wellbeing.

Whether you are 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 themes of healthy ageing, prevention, and wellbeing in later life
- Innovative ideas or experiences that can inspire, educate, and challenge our thinking about ageing well
- Creative writing and artwork that capture the experience of later life
- Reviews of books, films, podcasts, or other cultural highlights relevant to ageing and mental health

Your insights—whether grounded in evidence, clinical experience, or personal journey—can spark valuable dialogue and deepen our understanding of how to foster healthier, more meaningful ageing.

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

Submit your work and help shape a learning community rooted in curiosity, compassion, and collaboration—working together to champion healthy ageing for all.